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INTRODUCTION

The Regulatory Blueprint for Action identifies important regulatory issues for hospice providers. It provides a summary of each issue, including background information, recommendations, and rationale for the recommendations. This document provides a guide to the hospice industry’s position on the issues addressed. The Hospice Association of America (HAA) 2013 Regulatory Blueprint for Action has been developed with input from the HAA Advisory Board, hospice agencies and associations that represent hospice organizations at the state level, and was subsequently reviewed by the Regulatory Affairs Subcommittee and the approved by the Board of Directors. Items have been placed in order of priority based on member votes.

The Blueprint serves as HAA's regulatory plan for action for the upcoming year. Issues that are identified as most important by members become the priorities in the plan for action. In early 2013, HAA surveyed its members to determine which recommended changes would be most beneficial to hospice programs. The six highest ranking priorities are as follow:

- Work with Hospice Industry to Evaluate Revision of the Medicare Hospice Payment System (page 8)
- Abolish Payment Delays Caused by Sequential Billing Policy for Hospice (page 15)
- Ensure Access to Drugs Necessary for Pain Control (page 10)
- Encourage Accountability for Hospice Utilization (page 16)
- Ensure Timely Update of Local Coverage Decisions and Consistent Definitions and Application of Diagnosis Codes on Claims (page 17)
- Ensure Medicaid Hospice Benefit Reflects Same Amount, Duration, and Scope of Services as Medicare (page 7)

HAA recognizes that priorities may shift during the course of any year as a result of federal regulatory action or policy changes. HAA is an affiliate organization of the National Association for Home Care & Hospice (NAHC).
CREATE WAIVER FOR EXCEPTION TO
SOCIAL WORK SUPERVISION REQUIREMENT

BACKGROUND: The 2008 revisions to the Hospice Conditions of Participation (CoPs) require that, effective Dec. 2, 2008, a hospice social worker either have a master’s degree in social work (MSW) or be supervised by an individual with a MSW unless hired prior to December 2, 2008. Many rural hospices struggle to find and retain qualified social workers, as defined in the Medicare CoPs. Specifically, the number of social workers with MSW degrees are extraordinarily limited nationwide and especially in rural areas.

RECOMMENDATION: CMS should create a waiver program under which hospices experiencing hardship in employing a MSW level social worker may obtain an exception to the social work supervisory requirement.

RATIONALE: Most hospices across the nation serve less than 100 patients per day and many of these hospices are located in rural areas where they do not have access to qualified MSW-prepared social workers. As with other professionals, in particular registered nurses, the average age of the social worker is increasing. According to a study completed by the National Association of Social Workers (NASW), in 2005 nearly 30 percent of social workers were over 55 years of age, compared with 14 percent of the U.S. civilian labor force. At least 13 percent of these social workers have left the work force since the study was completed. While the majority of social workers have an MSW degree many states do not require this level of education in order to obtain a state social worker license. Therefore, such states tend to have an extremely limited supply of MSWs available to the hospices for contracting for supervision.

There currently are hospices that have a vacancy for the required MSW supervisory position and have been looking to fill the vacancy for a significant number of months or even a year or longer. The extensive distance between the rural hospice provider and its closest urban area is too great for the hospice to find an MSW level social worker in the urban area who is willing to contract with the hospice. In fact, hospices in urban areas are reporting difficulties in hiring and retaining masters level social workers, as well. The number of rural hospices without access to an MSW is expected to increase as the number of social workers in the United States decreases. While CMS’ Interpretive Guidelines recognize telephonic and other methods as acceptable for supervising social workers, some state practice acts may prohibit such use. Some hospices report that, despite allowance for alternative methods of supervision, MSWs may still be disinclined to accept posts in hospice.

The hospice social work supervision requirement in the CoPs exceeds the standard most state licensure laws impose. The Medicare CoPs allow waivers of the requirement that all nursing services be provided directly and waiver of the requirement that physical therapy, occupational therapy, and speech-language pathology be provided by a hospice. The reasons for these waivers are the same reason a waiver of the MSW supervision requirement should be implemented – a shortage of qualified professionals.
ESTABLISH TIME FRAMES FOR RESPONSE/APPROVAL OF HOSPICE LOCATION CHANGE

BACKGROUND: Certification requirements dictate that, in cases where a hospice plans to move from its surveyed, certified location to a new site or open a new location, a hospice must receive approval for the change from the Centers for Medicare & Medicaid Services (CMS) before it is permitted to provide Medicare services from the new address. As part of the process, the hospice must:

- Submit all required documentation and an amended Form CMS-855A to its Medicare Administrative Contractor (MAC).
- Notify CMS and its state survey agency in writing of the planned change.
- If under deemed status, notify its national accrediting organization (AO) in writing.
- Receive formal approval of the change in writing.

The CMS Regional Office (RO) may grant or deny the address change without a survey, or may determine that a survey is needed to establish that the new address complies with all applicable requirements. The opening of a new office (“multiple location”) requires that the new location be surveyed. CMS is expected to advise the provider of its findings. However, CMS has not specified time frames within which a hospice can count on receipt of a definitive determination on its request for approval of change.

Under separate provider enrollment requirements, a hospice is required to notify CMS of address or other changes through submission of the 855 enrollment form within 90 days of the change.

RECOMMENDATION: CMS should establish and enforce reasonable time frames within which state survey agencies, ROs, and MACs must respond to requests for approval of an address change or establishment of a new multiple location. CMS should also consider automatic approval for address changes in cases where a hospice is moving within the same geographical area and has a positive track record relative to its surveys. In cases where surveys are required to facilitate approval of the address change, CMS should establish a clear-cut process that includes access to expedited surveys and is minimally disruptive to the delivery of patient care.

RATIONALE: Different divisions of CMS require varying notifications and approvals of hospice office changes; these requirements are, at times, inconsistent -- creating confusion for providers. CMS failed to consider business practice and the operational and financial burden this policy could impose on providers. Establishment and enforcement of explicit time frames for response by CMS and its agents would help hospice organizations better meet their responsibilities for notice and approval of office changes. Where approval of such changes reasonably requires a survey, CMS should develop an expedited process that ensures delivery of high quality care that simultaneously supports continuity of care.
ENSURE MEDICAID HOSPICE BENEFIT REFLECTS SAME AMOUNT, DURATION, AND SCOPE OF SERVICES AS MEDICARE

ISSUE: While states are not required to offer hospice services to adult Medicaid beneficiaries, most states (48) currently have hospice included under their State Medicaid Plan. While states have some flexibility related to the structure of the hospice benefit periods provided under Medicaid, Section 1902(a)(10)(VI) of the Social Security Act requires that Medicaid hospice services must be provided in the same amount, duration and scope as those offered under Medicare. However, as states grapple with increasing budget deficits, some are considering elimination of hospice benefits for adult Medicaid beneficiaries, while others have talked of limiting the hospice benefit to a “lifetime” limit of 210 days, despite numerous studies indicating that hospice services, when used appropriately, result in savings rather than increased health care costs.

RECOMMENDATION: The Centers for Medicare & Medicaid Services (CMS) should ensure that states comply with the requirement that Medicaid hospice services be provided in the same amount, duration and scope as those offered under Medicare.

RATIONALE: Hospice holds great potential to enhance the lives of individuals with terminal illness and assist loved ones in dealing with the death of a family member or friend; use of hospice services frequently results in health care savings. The National Association for Home Care & Hospice (NAHC) believes that this valuable care model should be accessible to all Medicaid enrollees. Efforts to address concerns in hospice care should be directed at ensuring patients receiving services meet eligibility criteria rather than denying access to care.
WORK WITH HOSPICE INDUSTRY TO EVALUATE REVISION OF THE MEDICARE HOSPICE PAYMENT SYSTEM

ISSUE: The Medicare hospice benefit (MHB) was created in 1982 to care for terminally ill cancer patients. Currently, hospice patients with a cancer diagnosis represent only about 32 percent of those being served by hospices, according to the Medicare Payment Advisory Commission (MedPAC). The median length of stay is 18 days, up slightly from recent years. The average length of stay in 2010 increased to 86 days (up from 84 days in 2009). There is also an increase in use of hospice services – in 2010 1.159 million Medicare beneficiaries received hospice care. Although costs for pharmaceutical and pharmacotherapy for symptom control and pain management have increased dramatically, the reimbursement system has not changed since its inception. The Centers for Medicare & Medicaid Services (CMS) is in the process of gathering hospice data to assist in development of revisions to the MHB payment system, which were recommended by MedPAC in 2009, 2010, and again in 2011. The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) requires that CMS revise the hospice payment system and implement these payment changes no earlier than October 1, 2013.

RECOMMENDATION: CMS should work with the National Association for Home Care & Hospice and the hospice industry to determine the most effective data to collect, the most efficient means of collecting it and what analysis of the data means when considering revision of the hospice payment system.

RATIONALE: To ensure that an accurate and rich data bank is created, it is imperative that CMS collect the necessary data to accurately reflect the full scope of services currently provided by hospices. It is critical that all stakeholders be included in the process of developing a revised hospice payment system to ensure that thorough consideration of the impact of the changes is fully considered. In late 2012 CMS sought hospice industry comments on additional data on hospice claims. This collaboration is appreciated and continued collaboration will ensure accurate data is obtained upon which payment revision decisions can be made.
**PROVIDE FULL DISCLOSURE AND ENSURE SNF/NF MEDICARE BENEFICIARY RESIDENTS’ RIGHT TO CHOOSE HOSPICE PROVIDER**

**ISSUE:** In 1989, Public Law 101-239 mandated the ability of terminally ill Medicare beneficiaries residing in skilled nursing facilities/nursing facilities (SNF/NFs) to access services under the Medicare hospice benefit (MHB). As SNF/NF residents become aware of the MHB, more of them are seeking hospice services. However, the SNF/NF is not required to offer hospice services, nor is it required to disclose at admission if residents will be able to access hospice services without the need to transfer to another facility. Further, if the facility does have an arrangement to provide hospice, it is not required to disclose the hospice program with which it has a contract to provide services to residents. Finally, a resident does not have the right to choose the hospice program that he/she will receive hospice services from in the facility. In 2012, CMS updated the SNF/NF Medicare condition of participation interpretive guidelines related to end-of-life care; however, these are interpretive guidelines rather than requirements and they do not specifically address notifying SNF/NF residents upon admission whether or not hospice services are available at the facility. CMS guides SNF/NFs that they should tell the resident which hospices, if any, can provide care in the facility but the guidance does not specify that this should occur at the time of admission and, again, at the time the resident is determined to be at the end of life.

**RECOMMENDATION:** Congress should require that SNF/NFs disclose upon admission and at the time residents are determined to be nearing the end of life whether or not hospice services are available at the facility, and the name(s) of the hospice(s) with which the facility has contracted to provide hospice services on site. Additionally, Congress should mandate that eligible Medicare beneficiaries residing in SNF/NFs have the right to receive hospice services from the Medicare-certified hospice of their choice.

**RATIONALE:** SNF/NFs should provide full disclosure regarding the availability of hospice services through the facility at admission so that potential residents are fully aware of whether or not they will be able to access hospice services at some time during their stay if needed. Such disclosure could help to avoid the significant upheaval and trauma that could result from a resident’s transfer to a different facility in order to exercise his/her right to the hospice benefit. Potential residents should also be notified regarding the names of the program(s) through which hospice services would be provided if they elect the hospice benefit while in residence at the facility. Finally, Medicare beneficiaries eligible for the hospice benefit should have the right to choose which hospice will serve them. Currently, a terminally ill SNF/NF resident may only access the Medicare hospice benefit if the SNF/NF has a formal arrangement with a hospice program to provide services in the facility.
ENSURE ACCESS TO DRUGS NECESSARY FOR PAIN CONTROL

ISSUE: Inadequate pain management has been identified by experts in the field as a national public health issue. Terminally ill patients may require very high doses of pain medication to achieve effective pain control. Physicians and other health professionals often do not have adequate knowledge about pain control, and/or have fears of laws related to controlled substances. Exacerbating the problem is the Drug Enforcement Agency’s (DEA) reaction to Oregon’s assisted-suicide law. The FDA has warned that physicians who prescribe lethal doses of narcotics under Oregon’s Death with Dignity Act would be in violation of federal drug laws. The Institute of Medicine (IoM) has convened a committee at the request of the Department of Health and Human Services (HHS) to address the current state of the science with respect to pain research, care, and education and to explore approaches to advance the field.

RECOMMENDATION: HHS should closely monitor the work of the IoM related to pain research, treatment and education, and make every effort to implement IoM’s findings relative to pain. HHS should also work with the Food and Drug Administration to:

- Develop guidelines and educational material that promote effective use of drugs to control pain.
- Avoid DEA actions that would discourage or prohibit physicians from prescribing adequate and appropriate controlled substances for the management of pain related to terminal illnesses.

RATIONALE: Pain and symptom management is the cornerstone of good hospice care, which rests on the belief that terminally ill patients should not have to suffer because of inadequate pain management and lack of access to appropriate medications. Creating laws and policies that impose arbitrary limitations on physicians who prescribe controlled substances could very well have the unintended consequences of discouraging or limiting them from adequately treating terminally ill patients.
IMPROVE APPLICATION OF WAGE INDEX FOR MEDICARE HOME HEALTH AND HOSPICE

ISSUE: Since the inception of the Medicare per visit cost limits, home health payment rates have been adjusted to reflect varying wage levels across the nation through the application of a wage index. This payment rate adjustment continues under the Medicare home health prospective payment system (PPS), which was implemented effective October 1, 2000. However, the wage index that has been utilized by the Centers for Medicare and Medicaid Services (CMS) has been based upon varying wages within hospitals across the nation. The hospice benefit payment also is adjusted by the same hospital wage index with a further adjustment known as the Budget Neutrality Factor (the BNAF is being phased out over seven years – fiscal years 2010 through 2015). The hospital index is derived from data that explicitly excludes any home health services costs. Furthermore, it is based on the mix of employees found in hospitals, rather than home health agencies and hospices. In addition, providers have seen wide swings in their wage index from one year to the next. An attempt some years back to create and utilize a home care-specific wage index failed due to the unavailability of reliable wage data.

While the home health and hospice payment rates are based upon the application of a hospital wage index, the index utilized, and its manner of application, is significantly distinct from that utilized relative to hospital services payment rates. Hospitals may secure a geographic reclassification for application of the wage index by establishing that the particular hospital draws on an employment pool different from the geographical area to which it would otherwise be assigned for its wage index level. Home health agencies and hospices are not authorized to secure a wage index reclassification. As a result, a hospital may compete for the same health care employees as a hospice or home health agency, but be approved for a relatively higher payment rate through the wage index reclassification. Congress has established specific wage index criteria for certain geographic locations. However, these criteria apply only to hospitals which are also protected from wide variations from one year to the next by establishment of a floor.

The Medicare Payment Advisory Commission (MedPAC) recommended that Medicare replace the hospital wage index with one that relies on data from the Bureau of Labor Statistics and to design the new wage index in a manner that allows for tailoring to other provider sectors including home health and hospice.

The Patient Protection and Affordable Care Act of 2010 (PPACA) directs CMS to reform the hospital wage index consistent with the recommendations of MedPAC and to report to Congress on its plan for instituting a new wage index. CMS submitted its report on a commuting-based wage index (CBWI) to Congress in April 2012; however, the report indicates that the complexities of applying the proposed wage index to providers whose payment varies based on the location where services are delivered would be prohibitive.

RECOMMENDATION: CMS should conduct further study to determine a wage index approach that can be most equitably applied to all Medicare providers -- the goal should be to put all providers on a level playing field with their respective wage indexes. If the revised wage index allows for geographic reclassifications for one provider group it should provide the same allowance for all. Any wage index weight changes in a reformed model or in future years in applying the wage index model should be subject to a transition limitation on increases and decreases from one year to the next.

RATIONALE: The current hospital wage index does not fairly reflect variations in wages in home health and hospice. In today’s health care environment, health care providers of all types compete for employment of the same personnel. The adjustment of Medicare payment rates intended to reflect
variations in wages across the nation should be consistent across all provider types. With increasing shortages of health care personnel, unequal wage index adjustments for health care providers in the same geographic region results in an uneven and discriminatory distribution of the employment pool of personnel. Prevention of wide swings in wage indexes will enable health care providers to more precisely project revenue and budget expenses.
REVISE REQUIREMENTS FOR HOSPICE
FACE-TO-FACE ENCOUNTERS

ISSUE: Section 3132(b) of the Affordable Care Act of 2010 requires a hospice physician or nurse practitioner (NP) to have a face-to-face encounter with every hospice patient prior to the patient’s 180th-day recertification, and each subsequent recertification. In the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011, the Centers for Medicare & Medicaid Services (CMS) finalized its implementation approach for this hospice provision. The final rule, codified at 42 C.F.R. 418.22(a)(4) (75 Fed. Reg. 70463, November 17, 2010) states that the encounter must occur no more than 30 calendar days prior to the start of the hospice patient’s third benefit period. The regulation requires that the hospice physician or nurse practitioner attest that the encounter occurred, and the recertifying physician must include a narrative which describes how the clinical findings of the encounter support the patient’s terminal prognosis of six months or less. Both the narrative and the attestation must be part of, or an addendum to, the recertification. In 2011, CMS allowed hospices to delay the face-to-face encounter up to two days after a patient’s hospice election under certain documented exceptional circumstances. A number of concerns have arisen relative to the hospice face-to-face requirement:

- Hospices must complete the face-to-face encounter PRIOR TO the beginning of the applicable benefit period and must be arranged by the hospice. As the result, a patient’s care may be delayed while the hospice identifies a physician or NP available and schedules the encounter. For many hospices, those in rural areas in particular, this delay can be much longer than two days. This is because these areas do not have access to physicians and NPs that meet the employment/contract requirements of CMS. However, these hospices may have access to physician’s assistants and other non-physician practitioners.

- The face-to-face requirement is applicable to a patient’s full time on hospice regardless of when the previous hospice service was provided. A patient may have been off hospice service for a lengthy period of time, then begin rapid deterioration and need admission very quickly. In such cases the face-to-face requirement may not only delay admission but forces the patient to unnecessarily be subjected to an assessment.

- Centers for Medicare & Medicaid Services (CMS) data systems are not all available 24 hours, seven days a week to access patient information and most do not have full information related to a patient’s history on hospice care to establish with absolute certainty whether a face-to-face encounter is required. CMS has clarified that if the data systems are not available, and because of this the hospice is not aware that the patient is entering his/her third or subsequent benefit period, the hospice has two days in which to obtain this information and complete the face-to-face. This two day time period is insufficient time for the hospice to get the face to face schedule as the two days, in essence, could be only one working day. For instance, those patients admitted on a Friday or holiday when the CMS data systems are not available don’t have access to the CMS data systems until the next business day which could be Monday, or in the case of some holidays, Tuesday. The hospice accesses the data system the morning of the next CMS business day, sees that the patient is in his/her third or subsequent benefit period, and then has to get a hospice physician or NP to conduct the face-to-face. Getting the face-to-face scheduled can, as mentioned above, take several days, especially in rural areas.

- Hospices will not be reimbursed for costs related to the face-to-face requirements, which may be prohibitive — particularly for small hospices in rural areas.

- Hospices may not utilize telehealth services to meet the face-to-face requirement.

- If a patient is on continuing hospice care but the hospice is not able, due to staffing limitations or other complications, to conduct the face-to-face prior to the benefit period for which the
encounter is required, the hospice will not be paid for services provided until the face-to-face has been completed.

RECOMMENDATION: CMS should work with the hospice industry to ensure that regulations and guidance governing the hospice face-to-face provide sufficient flexibility that hospice programs are able to comply with the requirements without any threat of delayed access to care for beneficiaries in need of hospice services and without undue financial burden on the hospice.

RATIONALE: The intent of the face-to-face requirement is to ensure adequate and appropriate involvement and accountability of physicians relative to certification of eligibility for hospice care. However, as currently written and interpreted by CMS, it may delay access to care and serve as a deterrent for some hospices to take eligible patients in need of immediate care onto service. This was neither its intent nor an advisable result of the requirement.
**ABOLISH PAYMENT DELAYS CAUSED BY SEQUENTIAL BILLING POLICY FOR HOSPICE**

**ISSUE:** The Centers for Medicare and Medicaid Services (CMS) implemented the longstanding hospital sequential billing policy on hospice claims. The policy prohibits providers from submitting claims for care to beneficiaries where previously submitted claims are pending. Claims processing can be delayed for weeks or months for many reasons, including medical review activities, common working file problems, CMS or Medicare Administrative Contractor (MAC) claims processing problems and pending claims from other providers, etc. Hospices have continued to serve patients even though Medicare payments have been delayed.

**RECOMMENDATION:** Require hospices to submit claims in chronological order but process and pay all clean claims as submitted, regardless of whether previous claims have been processed. Pay interest on claims that are not processed timely.

**RATIONALE:** Most hospice programs are small businesses with little financial reserve, dependent on uninterrupted payment for services delivered. Interruption of payment for weeks or months, while requiring agencies to continue services to patients, can result in severe financial hardships.
ENCOURAGE ACCOUNTABILITY FOR HOSPICE UTILIZATION

ISSUE: Without outcomes linked to hospice utilization data, it is impossible to determine the appropriate utilization in terms of length of stay and level of care. It should be recognized that there is probably some under- and over-utilization of services. Currently, the Centers for Medicare & Medicaid Services (CMS) has begun collecting hospice visits and charge data as a first step in creating a database on hospice services provided. Due to the rapid growth in hospice expenditures, the hospice medical director and the attending physician's authorization for hospice services are being questioned by Medicare’s contractors and payments are being withheld based on Medicare’s contractors’ determinations of prognosis.

RECOMMENDATION:
- CMS should work with NAHC and the hospice industry to analyze the utilization data and identify problem areas.
- For identified problem areas, develop uniform protocols of care based on outcomes against which utilization can be measured. These should not be used as the basis for automatic denials but to indicate the need for justifying hospice services.
- Direct equal attention toward under-utilization as well as over-utilization.
- Require Medicare’s contractors to offer training at least twice a year, open to all providers who wish to attend.

RATIONALE: Variation in utilization points not to abuse as much as it does to physician concerns about giving a prognosis of six months or less for terminally ill patients and the differences in health care practices. Development of uniform protocols and the education of providers are the keys to compliance with eligibility criteria and the control of inappropriate utilization.
ENSURE TIMELY UPDATE OF LOCAL COVERAGE DECISIONS AND CONSISTENT DEFINITIONS AND APPLICATION OF DIAGNOSIS CODES ON CLAIMS FOR HOSPICE

ISSUE: The current hospice local coverage decisions (LCD) promulgated by CMS limit the policies to a set of medical variables and clinical signs and symptoms that are used to predict a prognosis of six months or less for terminally ill Medicare beneficiaries. Not all claims reviewers using the LCDs are given instructions or guidance to take into account the physician's clinical judgment and the psychosocial dimensions of the illness for determination of coverage decisions. The multiple Medicare Administrative Contractors (MACs) do not have consistent requirements and guidance on hospice eligibility and how the diagnosis(es) are to be identified on the hospice claim. Specifically, the terms “comorbid”, “coexisting”, “secondary”, and “related/unrelated” are not clearly defined so hospices cannot consistently apply them. Outpatient coding guidelines are not applicable to hospice patients; this results in inaccurate data submission to CMS – data from which payment decisions are made.

RECOMMENDATIONS:
CMS should perform annual reviews of all LCDs and revise the policies based on available research and other pertinent findings relevant to the determination of a prognosis of six months or less. Additionally, CMS should ensure that the ICD-9-CM codes are current. Additional steps that should be taken relative to LCDs include the following:

- Add the following criteria to LCDs to provide additional guidance to medical reviewers in determining the appropriateness of hospice admissions or recertifications:
  - Encourage the use of multiple LCDs to document co-morbidities so that all conditions, and not just the primary diagnosis, are being reviewed;
  - Require review of documentation of the clinical judgment and psychosocial dimensions of the terminal illness by medical reviewers; and
  - Require documentation by the reviewer of the date of patient’s death, as appropriate, while enrolled in the hospice benefit or after discharge.
- CMS should conduct research to validate the accuracy of the LCDs, including an analysis of their specificity and sensitivity.
- Publish future hospice medical review policies in the Federal Register for public review and comment or allow broad dissemination of proposed policies through national and state associations representing the hospice industry so that comments can be compiled and recommendations returned to CMS.
- Require that when making Medicare claims determinations, greater weight be given to the opinion of the treating physician.
- Require review or additional documentation prior to issuing denials.

CMS requires that diagnoses related to the terminal diagnosis be included on hospice claims. In order to obtain accurate and consistent data, CMS should determine what coding guidelines are applicable to hospice and clearly define the terms associated with those guidelines (i.e. comorbid or related/unrelated).

RATIONALE: CMS annual reviews of the policies are needed in order to keep them informed and up-to-date. Criteria for determining a prognosis of six months or less (eligibility for hospice services) is not a matter to be decided at the local level but rather by a set of scientifically determined variables, signs, and symptoms for discrete diagnoses based on research and clinical judgment. With the broad dissemination of proposed policies, either in the Federal Register or through national or state associations, the resulting LCDs will better reflect the current state of the art of prognostication and best practices in determining a life expectancy of six months or less for Medicare beneficiaries.
BASE SURVEY FREQUENCY ON PERFORMANCE OF MEDICARE HOSPICE BENEFIT PROVIDERS

ISSUE: Approximately 16.5 percent of Medicare-certified hospices are surveyed each year. There is no legislative requirement for the frequency of surveys for providers of the Medicare hospice benefit (MHB). CMS’ failure to require that hospice providers be surveyed on a regular basis can result in lack of compliance with regulations and poor quality of care. CMS currently has hospice providers on a seven-year cycle for surveys but that sometimes extends to 10 years in some parts of the country.

RECOMMENDATION: Limited resources available for hospice surveys should be used to target quality issues by adopting the following survey frequency guidelines:
- New Medicare hospice agencies should be surveyed annually for at least the first two years of certification.
- Agencies with condition-level deficiencies should be surveyed at least annually until they are deficiency free.
- Complaint surveys should be conducted following significant complaints. If deficiencies are found, annual surveys should be conducted until the hospice is deficiency free.
- All hospices should be surveyed, at a minimum, every three years.

RATIONALE: When the Medicare Hospice Benefit (MHB) was created by the Congress, in order to assure quality of care and implement the benefit, CMS was given the responsibility of creating regulations to be followed by providers of hospice services. As the next step of this responsibility, there need to be regular surveys to ensure compliance with these regulations. Recipients of the MHB should be afforded the same protections provided to recipients of other Medicare benefits.
COMPENSATE PHYSICIANS FOR HOSPICE CERTIFICATION AND ADVANCE CARE PLANNING CONSULTATIONS

ISSUE: One of the primary requirements for Medicare beneficiaries to access the Medicare hospice benefit is certification by the patient’s attending physician and the hospice medical director that the patient has a limited life expectancy of six months or less if the disease runs its normal course. The length of stay for many beneficiaries on the Medicare hospice benefit is still too short. At the request of Congress, the Government Accountability Office (GAO) conducted a study on the MHB that was released in 2000. Another report was issued in December 2007, “End-of-Life Care: Key Components Provided by Programs in Four States.” The reports concluded that the most significant influence on patient use of hospice is the physician. “Physicians initiate most referrals to hospice, and they may continue to care for their patients after enrollment as part of the hospice team. Because patients and their families rely heavily on physician recommendations for treatment, including recommendations for end-of-life care, physicians are an influential factor in a patient’s entry into hospice.” The most recent Medicare Payment Advisory Commission (MedPAC) data show that the median length of stay remains is about 18 days.

The original health reform legislation approved by the House of Representatives (H.R. 3962) provided for payment to physicians and other health care professionals to provide a voluntary advance care planning consultation (Section 1233); it also contained a provision regarding the dissemination of advance care planning information (Section 240).

We applaud CMS’ creation of HCPCS codes GO179 and GO180 for physician certification and recertification of Medicare-covered home health services. The new codes will help home health agencies get physicians more involved in home health care. A similar code needs to be developed for hospice care.

RECOMMENDATION: CMS should create a new HCPCS code to compensate physicians for patient certification of eligibility for the Medicare hospice benefit. CMS should also authorize volunteer advance care planning consultations under Medicare to educate beneficiaries on issues related to end-of-life care and end-of-life care planning.

RATIONALE: In the past, CMS has expressed concern about the decreasing length of stay on the Medicare hospice benefit and asked how they can help alleviate the problem. It is imperative to get physicians to focus on end-of-life care much earlier than is now occurring. Although the Medical Director of a Medicare-certified hospice is covered under Part A as an employee of the hospice, the patient’s attending physician continues to bill under Part B for care plan oversight and direct patient services. At a time when the length of stay on the MHB is still too short for many hospice patients, it is important to encourage physicians to refer patients sooner by encouraging their efforts to educate patients to the availability of hospice care, and compensating them for hospice certification. Increasing the hospice length of stay for short stay patients would allow the patient and their families to get the full benefit of holistic hospice services and save Medicare dollars by keeping patients at home rather than in traditional aggressive institutional care.
SUPPORT DEVELOPMENT OF A ROBUST HOSPICE QUALITY REPORTING PROGRAM

ISSUE: The June 2008 hospice conditions of participation require hospices to develop, implement, maintain, and evaluate an effective, data-driven quality assessment and performance improvement program. The Centers for Medicare & Medicaid Services (CMS) requires hospices to either develop their own or use currently available systems of measures to track patient outcomes as well as optimum functioning at every level of a hospice’s operations. The requirement includes retaining the information in a database that permits analysis over time.

The final 2010 health care reform legislation provides a strong start toward the development and implementation of a quality reporting program by mandating that the Department of Health and Human Services (HHS) publish hospice quality measures covering all dimensions of hospice quality and care efficiency by October 1, 2012, and that hospices begin reporting these measures. Failure to submit quality measures by a hospice would result in a 2 point reduction in the annual market basket index update beginning with FY2014 (Section 3004).

RECOMMENDATION: CMS should ensure that the quality measures currently under development for hospice incorporate: a) reliable and valid indicators, b) outcome measures limited to those that most accurately predict quality, c) a method for risk adjustment, d) a standard assessment, e) a simple system with clinical utility, f) a mechanism enabling CMS to validate agency data, and g) an ongoing evaluation of the entire system.

CMS should include the National Association for Home Care & Hospice’s (NAHC) adapted Edmonton System Assessment System (ESAS) as one of the data collection tools to be tested. CMS should also recommend use of NAHC’s Patient Satisfaction Survey and Family Satisfaction Survey for hospice use as part of their ongoing QAPI programs based on patient outcomes.

CMS released two measures – a quality measure and a structural measure – for mandatory hospice reporting in FY2013. Hospices began voluntarily reporting data for the last quarter of calendar year 2011 in January 2012. CMS worked with the hospice industry in 2012 on the quality measures by appointing two Technical Expert Panels (TEPs) and seeking industry comment on future hospice quality reporting measures. NAHC applauds CMS for the work done thus far in this important area and encourages further collaboration with NAHC and the hospice industry to ease the transition to public reporting.

RATIONALE: The ideal hospice quality assessment program must be based on what happens to the patients; however, there are currently no standard outcome measures for hospice care. In addition, research and demonstration projects are not factored into the current per diem reimbursement structure. The proposed quality system will require massive data collection and reporting unless purposely controlled. Every effort must be made to keep data collection and the paperwork burdens to a minimum so resources can be used for patient care rather than paperwork.
REINSTATE PRESumptive STATUS FOR HOSPICE WAIVER OF LIABILITY

ISSUE: Section 1879 of the Social Security Act provides protection from liability for charges for certain denied claims to beneficiaries who, acting in good faith, receive inpatient or outpatient services from Medicare providers. Similarly, providers may also be protected from liability under Section 1879 of the Act when it is determined that they did not know and could not reasonably have been expected to know that Medicare would deny payment. The waiver of liability is applicable to hospice claims denied on the basis of the “not reasonable and necessary” and “custodial care” exclusions. The presumptive status of the waiver of liability, which expired at the end of 1995, protected hospices by allowing an agency to be compensated under the waiver presumption, when their overall denial of claims rate was less than 2.5 percent of Medicare services provided. Any agency that exceeded this 2.5 percent denial rate was not reimbursed under waiver. This requirement forced agencies to use due diligence in determining eligibility and coverage but also protected them from financial loss for care that was provided in good faith. Subsequent to the expiration of the presumptive status of waiver, Section 1879(g) of the Social Security Act was amended by Section 4447 of the Balanced Budget Act of 1997 to extend limitation on liability protection to a beneficiary enrolled in a hospice when there is a denial of claims due to a determination that the individual is not terminally ill. This took effect for services furnished on or after August 5, 1997. The fiscal intermediary (FI) is to apply the usual procedures (not presumptive status) of the limitation on liability provision contained in the Medicare Intermediary Manual and the indemnification procedures to determine whether or not the beneficiary is protected from liability and whether the hospice is protected from liability under Section 1879(g)(2) of the Act.

RECOMMENDATION: The Centers for Medicare & Medicaid Services (CMS) should reinstate waiver presumption for providers of the Medicare hospice benefit.

RATIONALE: The waiver presumption acts to protect providers who render services to Medicare beneficiaries in good faith, believing that they will be covered. The cushion for error is crucial in the Medicare hospice benefit due to the physician’s inherent difficulty in determining that a patient will likely die within six months if the disease runs its normal course. This is particularly true for non-cancer diagnoses. Claims are susceptible to vagaries of interpretation by the FI. Certifying terminal illness is an inexact science and extremely difficult for the physician, patient and family. An FI determination that a patient is not terminally ill is also devastating.
STUDY HOSPICE REIMBURSEMENT FOR DULLY ELIGIBLE PATIENTS RESIDING IN NURSING FACILITIES

ISSUE: Since 1986, terminally ill Medicare patients living in nursing homes could elect the Medicare hospice benefit (P.L. 99-272, Sec. 9505(a)(2). When a patient is entitled to both Medicare and Medicaid, the state Medicaid program must pay the hospice at least 95 percent of the nursing home charge for room and board services. The hospice then reimburses the nursing home for room and board: personal care, assistance with activities of daily living, administration of medications, socialization activities, maintenance of a resident's room, supervision and assistance in the use of Home medical equipment and prescribed therapies.

The contractual relationship between hospice programs and nursing homes has been under the scrutiny of Health and Human Services Office of the Inspector General (OIG). In its report “Hospice Patients in Nursing Homes,” the OIG made recommendations to eliminate or reduce the Medicare or Medicaid payments for hospice patients living in nursing homes. MedPAC is also focused on hospices that have many of their patients in nursing homes. MedPAC believes that these hospices may be taking advantage of a situation that is less resource intensive, thereby increasing their financial margins. In 2011, MedPAC suggested to Congress that those hospices serving a significant number of patients in the nursing home should have the hospice per diem payment reduced by 3 percent.

RECOMMENDATION: The Centers for Medicare & Medicaid Services (CMS) should not reduce payment to the hospice unless data collected and analyzed demonstrates duplicate payment for dually eligible patients residing in nursing facilities. Further, a thorough examination of the advisability of current CMS policy requiring that state Medicaid programs reimburse the hospice for the combined cost of nursing home and hospice (and that hospices then convey payment to the nursing home) may be in order at this time.

RATIONALE: If this action is taken without further data gathering and analysis of the nature and cost of hospice care provided in the nursing home, it could result in the complete lack of, or diminished access to, appropriate hospice services for these individuals. Changes to the hospice reimbursement and nursing home room and board reimbursement prior to an in-depth study (including analysis of the services provided and the cost of those services) will, in effect, deny access to a humane and compassionate approach to care for eligible terminally ill residents of nursing homes. Any adjustments to Medicare or Medicaid payments should be made only after performing appropriate data collection and analysis.
EXPAND THE USE OF AND REIMBURSEMENT FOR TECHNOLOGIES IN HOSPICE

ISSUE: Hospice care is for terminally ill patients who are expected to live six months or less if their disease takes its normal course. This care is typically provided in the patient's home by a hospice interdisciplinary team (IDT), frequently with involvement of family caregivers or friends. The IDT usually includes a physician, nurse, aide, social worker, and chaplain. Thus, hospice care is a very personal, intimate service that is tailored to the specific needs of the patient and family members. While some hospices have developed sophisticated programs that utilize advanced technologies for clinical consultation, development of online support groups, and better communication with patients and their families, many hospices lack the financial capital to invest in technologies that could lead to better care management and enhanced patient satisfaction.

Family caregivers are responsible for giving medication to the patient and they often have questions about patient care. The use of information technology would allow family caregivers to communicate changes and concerns, or to get advice from their hospice provider about specific care needs. For example, one study found that caregivers' concerns about giving pain medication decreased when they were able to join team meetings via video conferencing technologies. Family caregivers and hospice staff reported improvements in communication and decision-making as a direct result of using the technology.

RECOMMENDATION: The Administration should recognize the potential for improvements in communication, decision-making and care coordination by hospices as a means to provide higher quality care to hospice patients and support of family caregivers. Therefore, demonstration programs, grants, and other forms of reimbursement for telehospice and advance communication technologies in hospice should be tested along with new models of health care delivery to improve the delivery of hospice care in the home.

RATIONALE: Hospice care has a long standing tradition of providing care through coordinated teams of health care providers and family caregivers. Therefore, improvements in the communication, coordination and interaction among these caregivers will enable more timely and improved patient care, as well as allow for more efficient use of community services through engaging family caregivers and patients in the delivery of hospice care.
OPPOSE EFFORTS TO REQUIRE PHYSICIAN CERTIFICATION FORMS TO INCLUDE A FALSE CLAIMS WARNING

ISSUE: The Department of Health and Human Services Office of Inspector General (OIG) issued its final report on hospice audits under Operation Restore Trust (ORT). The report, “Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments,” recommended, among other things, to make “hospice physicians more accountable for their certifications of terminal prognosis by requiring that the certification/recertification forms signed by these physicians contain a statement concerning the penalties for false claims.” In its response, CMS stated, “Although CMS concurred with the intent of the recommendation, it did not agree with a warning statement. Instead, it indicated that a more affirmative flavor to the wording of the hospice certification would achieve the desired results.”

RECOMMENDATION: CMS should continue to refrain from including a warning statement concerning penalties for false claims on physician certification and recertification forms for terminal prognosis. In its stead, CMS should develop educational information about the requirement of a six-month prognosis and make resources available to determine a prognosis. Additionally, CMS should encourage the use of interdisciplinary clinical judgment and appropriate documentation.

RATIONALE: The Conditions of Participation (CoPs) require that the hospice obtain written certification of terminal illness for each of the benefit periods. The hospice medical director or physician member of the hospice interdisciplinary group and the patient’s attending physician, if the patient has one, must sign the initial certification; the hospice physician is then required to sign subsequent recertifications. The certification must specify that the patient has a prognosis of six months or less if the terminal illness runs its normal course. Additional language addressing the validity of the six month prognosis would be redundant, unnecessary, and potentially harmful in limiting access to patients who would otherwise be eligible for hospice services.

The science of prognostication is in its infancy and physicians must use whatever tools are available, including medical guidelines developed by the industry, local coverage decisions developed by the fiscal intermediaries, and their own best clinical judgment. Physicians tend to be cautious about certifying terminally ill patients for hospice care; the median length of stay has remained relatively constant and is currently 18 days. Placing a warning or other statement on the certification of terminal illness could further deter physicians from enrolling appropriate patients, thus denying access to this compassionate, humane, patient-and family-centered care at the end of their lives.