

**2017**

**Hospice Regulatory  
Blueprint for Action**

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# HOSPICE ASSOCIATION OF AMERICA

## 2017 REGULATORY BLUEPRINT FOR ACTION

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## **INTRODUCTION**

The Hospice Association of America (HAA) 2017 Regulatory Blueprint for Action identifies key regulatory issues of interest to hospice providers and includes a summary of each issue comprised of background information, recommendations, and the rationale behind the recommendations. This document provides a guide to the hospice industry's position on the issues addressed. The HAA 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 approved by the Board of Directors.

The Blueprint serves as HAA's regulatory plan of action for the forthcoming year. Issues that are identified as most important by members become the priorities in the plan of action. However, 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).

## **ADDRESS BURDENSOME AND COSTLY ISSUES RELATED TO PROCESSING OF NOTICES OF ELECTION (NOEs) AND NOTICES OF TERMINATION/REVOCATION (NOTRs)**

**ISSUE:** Beginning October 1, 2014 hospices must submit a timely filed Notice of Election (NOE) for all Medicare patients electing hospice care or transferred to the hospice with the goal of updating the beneficiary's status on hospice care within the Common Working File (CWF). A timely-filed NOE is a NOE that is submitted to and accepted by the Medicare Administrative Contractor (MAC) within 5 calendar days after the hospice admission date. A hospice knows the NOE was accepted by the MAC only by not having the NOE RTP'd (returned to provider) and ultimately having the NOE marked as RECEIVED. However, the timeframe for processing of the NOE within the Centers for Medicare & Medicaid Services (CMS) systems can be of significant length. There are numerous reports of hospices not receiving an RTP'd NOE for more than five days after it was submitted. This is especially true when the beneficiary is electing hospice care for the first time since the data may be required to process through numerous edits in multiple databases. Further, posting of the patient status from the NOE to the CWF in many cases will not occur within the 5 calendar day time frame. The date of posting to the CWF is not a reflection of whether the NOE is considered timely-filed. In instances where a NOE is not timely-filed, Medicare shall not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the Medicare contractor. These days shall be a provider liability, and the provider shall not bill the beneficiary for them.

If a hospice fails to file a timely-filed NOE, it may request an exception which, if approved, waives the consequences of filing a NOE late. CMS has instructed the MACs to approve the exception request in four circumstances, all of which require that the reason for not filing the NOE timely is out of the control of the hospice. In November 2016 CMS implemented an additional exception to the timely filing requirement for late NOEs in cases where the NOE contains an error that cannot be corrected while the NOE is in process.

CMS requires that hospices submit the NOE via direct data entry (DDE), mail, or messenger. In order to submit the NOE via DDE, hospice staff must manually enter the required data. This is at least 125 keystrokes. Should the hospice staff make a data entry error (i.e. numbers transposed for the date of election) and submit the NOE with that error, it almost always takes beyond the 5-day timely filing limit for the MAC's systems to return the NOE to the provider and the provider to make the correction, resubmit, and have the NOE accepted by the MAC. As of November 2016 the hospice will have two business days to correct the NOE if it contains an error that cannot be corrected while the NOE is in process, such as an incorrect admission date, IF the hospice has specified documentation explaining the reason for the error and the error is not one the can be corrected while the NOE is in process or where the hospice submits a partial NOE to fulfill the timely-filing requirement. However, there remain situations that require the hospice to continue providing, but not bill for, any care provided until the NOE has been submitted and accepted. This creates undue hardship on hospice providers. Nowhere else in the CMS payment system is a provider required to submit data with no or very limited opportunity to correct that data in a timely fashion so that payment will not be affected.

**RECOMMENDATION:** CMS should update its data systems to allow for the automatic electronic submission of the NOE.

**RATIONALE:** NAHC fully understands and supports the need for the NOE to be submitted timely and accurately, and understands that the election information is necessary for the payment system to operate most effectively. The additional exception implemented by CMS in late 2016 provides some relief. However, antiquated systems with serious functional limitations are the reason that most untimely NOEs are not received within the 5-day limit. Changes to the data systems are not within providers' control.

## **WORK WITH STAKEHOLDERS TO CLARIFY “RELATEDNESS” AND ADDRESS CODING ISSUES UNDER HOSPICE CARE**

**ISSUE:** CMS found in 2010 that nearly 80% of hospice claims it received only had one diagnosis listed, but in a December 2015 Technical Report CMS found that only 44% (approx.) of hospice episodes had a single diagnosis listed. CMS clarified during 2015 that hospices are to include all of a patient’s coexisting or additional diagnoses on the hospice claim, whether or not the diagnosis(es) are related to the principal hospice diagnosis or related conditions. Analysis of FY2015 claims show that only 37 percent of hospice claims include a single, principal diagnosis, while 63 percent submitted contain at least two diagnoses and 46 percent include at least three.

The National Association for Home Care & Hospice and its affiliate, the Hospice Association of America, have provided education to hospices regarding proper coding practices per the *ICD-10-CM Official Guidelines for Coding and Reporting* and the companion publication, *ICD-10-CM Coding Manual*. The terms ‘comorbid’, ‘coexisting’, ‘secondary’, and ‘related/unrelated’ are used by CMS to provide guidance to hospices on which diagnoses should be on the hospice claims. This terminology (i.e. secondary, co-morbid, and co-existing) and other coding vernacular are causing confusion for hospices nationally. Some of the terms come from the outpatient coding guidelines of the ICD-10-CM Coding Manual. Outpatient coding guidelines are not applicable to hospice patients as stated in the Manual. Some others are not recognized in coding guidance.

Beginning October 1, 2014 CMS began returning to provider (RTP) hospice claims that use the diagnosis adult failure to thrive, and other specified diagnoses, as the principle diagnosis. Some of the diagnosis codes listed as prohibited, i.e., adult failure to thrive, are not manifestation codes and according to the ICD-10-CM Coding Manual can be used as principle diagnoses on medical claims when no other diagnosis is identified as the principle diagnosis. At least one of the Medicare Administrative Contractors (MACs) has a current Local Coverage Determination (LCD) for Adult Failure to Thrive. However, CMS is prohibiting hospices from using them. Because of this lack of clarity hospices cannot consistently and properly apply the terms and the coding guidelines. In addition, the CMS MACs do not use consistent language in the LCDs and other guidance they release. This lack of clarity results in inconsistent interpretation of the coding guidelines leading to inaccurate data on claims that CMS is using to make payment revision decisions.

Of particular concern is the interpretation of ‘related/unrelated’. These terms are used in the hospice industry for not only coding but also decisions regarding what medications and treatments are part of the hospice plan of care and paid for by the hospice. In 2013, CMS and its representatives communicated CMS’ view on what is/is not related to a patient’s terminal illness and related conditions through the Final Wage Index and to Part D Plan Sponsors through several memos. This view was repeated again in comments in the FY2016 Final Wage Index. Specifically, the following statement CMS made in its comments in 1983 when the Medicare hospice benefit was drafted has been reiterated: *It is our general view that ... “hospices are required to provide virtually all the care that is needed by terminally ill patients”* Reiteration of this statement and comments by CMS and its representatives has lead some to the conclusion that ALL care for terminally ill patients on hospice is the responsibility of the hospice. This has

led to significant confusion in the health care sector. We also believe that for hospices, it is not so much the case that they are uncertain of the definitions of terminal condition and related conditions – each hospice’s clinical team makes these determinations on a daily basis -- rather, hospices are increasingly concerned that medical determinations related to the hospice’s responsibility that are made by their trained clinical teams may not mesh with what CMS, its contractors, or other care providers believe to be related to the terminal condition and any related conditions.

**RECOMMENDATION:** CMS should work with the hospice industry to clarify the terminology applicable to coding for hospice patients. CMS should also work with industry stakeholders such as NAHC and HAA in development of educational tools that help hospices consistently and accurately apply ICD-10-CM coding guidelines.

CMS should collaborate with the hospice and medical fields to help bring greater clarity to the important area of establishing relatedness in end-of-life care. This would result in significant benefit to all involved. NAHC and HAA welcome the opportunity to work with CMS toward resolution on this issue.

**RATIONALE:** CMS stated in a December 6, 2013 memo “In order for services to be covered under the Medicare hospice benefit, those services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. We have not made a regulatory specification of services that are unrelated to hospice care because of the wide variation of individual patient circumstances. These clinical decisions are to be made on a case-by-case basis.” This is consistent with the Social Security Act and the approach that CMS has historically applied in its administration and oversight of the hospice benefit. It appears that recent statements by CMS and its representatives are not consistent with this basic premise of the Medicare benefit – that clinical decisions are made on a case-by-case basis by the physician and the hospice interdisciplinary group (IDG). This has caused confusion in hospice and other sectors of healthcare. In addition, lack of consistency across MACs in guidance provided to hospices regarding patient eligibility for the hospice benefit coupled with inconsistent application of the hospice benefit and hospice financial responsibility has created confusion and disruption in the hospice industry. CMS collaboration with the hospice and medical fields regarding clarification of terminology and determining “relatedness” will level the inconsistencies and help hospices properly apply the hospice benefit.

## **PROTECT HOSPICE PATIENT ACCESS TO PART D DRUGS FOR CONDITIONS UNRELATED TO THE HOSPICE DIAGNOSES**

**ISSUE:** There is ongoing concern surrounding the potential for drugs covered under the Part A hospice benefit to be billed to Part D inappropriately. This was identified in a report by the Office of the Inspector General (OIG) and in investigations by the CMS Office of Program Integrity. As a result, the Medicare Drug Benefit C & D Data Group and the Medicare Program Integrity Group provided direction to all Part D Plan Sponsors to (1) recover from hospices payment for any analgesics paid for by Part D plans in 2011 and 2012 while a beneficiary was enrolled in hospice and (2) develop a prior authorization (PA) process for four classes (antiemetics, analgesics, anxiolytics, and laxatives) of medications requested of Part D plans while a beneficiary is receiving hospice services. There is no opportunity for the hospice to appeal the Part D plan decisions on prior-year recoupments. We believe these actions run counter to current law and regulation that grants hospice beneficiaries coverage outside of the hospice benefit for services and medications that are needed for treatment of conditions unrelated to their terminal condition(s).

Some Part D plans used credit and collection companies to request hospices pay for any analgesics paid for by the plan in 2011 and 2012 while a beneficiary was enrolled in hospice. By instructing Part D Plan sponsors to recover from hospices payment for any analgesics it appears there is an interpretation by CMS that all analgesics in 2011 and 2012 are related to the principle hospice diagnosis and related conditions. This is not in line with the Medicare Hospice Benefit as the benefit is set up to review each situation on a case-by-case basis. Further, in many cases, the hospice clearly is not responsible for some of these analgesics in 2011 and 2012 and is at risk of having its credit score and financial situation adversely impacted.

Even with the existing PA process, difficulties continue to arise, but these instances have greatly reduced in number since the PA was originally implemented. This increases the risk that some individuals at end of life may not elect hospice care, which, in turn, will increase Medicare costs.

**RECOMMENDATION:** CMS should further develop oversight practices that hold hospices and Part D plans accountable for proper administration of the Medicare benefits they deliver, while protecting the rights of hospice patients to care for conditions that are not related to their care under hospice.

**RATIONALE:** The wide variation of individual patient conditions and circumstances require that, under hospice, care be based on an individualized plan of care. There are many examples brought to our attention by providers where an analgesic or other medication is reasonable and necessary for pain or symptoms unrelated to the patient's terminal prognosis. It is only through review of the individual patient's plan of care and medical records that clear determination of responsibility can be definitively established and this is clearly the responsibility of the hospice's interdisciplinary group (IDG).

## **ESTABLISH TIME FRAMES FOR APPROVAL OF HOSPICE LOCATION CHANGES**

**ISSUE:** 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:

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

**RECOMMENDATIONS:** 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 practices 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.

## **ENFORCE REQUIREMENT THAT MEDICAID HOSPICE BENEFITS MIRROR THOSE IN MEDICARE**

**ISSUE:** States are not required to offer hospice services to adult Medicaid beneficiaries, but most states 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 fee-for-service. 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. Some states are participating in demonstration projects and Medicaid expansion projects that move the Medicaid hospice benefit under managed care plans which may allow the amount, duration and scope of hospice services to be different than that offered under Medicare.

When an individual elects the Medicare or Medicaid benefit and resides in a nursing home, the nursing home room and board is covered by the Medicaid nursing home room and board benefit. The hospice bills Medicaid for the room and board and receives at least 95% of the facility’s daily Medicaid rate. The hospice then passes this payment on to the nursing home, often having to pay the additional 5% so the nursing home receives 100% of its Medicaid daily rate. Under Medicaid managed care some plans are not paying the hospice anywhere near the 95%. Some are paying at less than 50% of the daily Medicaid rate, placing significant undue hardship on the hospice to pay the nursing home the difference between the Medicaid managed care payment and the facility’s daily Medicaid rate. Furthermore, some Medicaid managed care plans are trying to contract with hospices for a bundled payment that includes the room and board payment with the total bundled payment being significantly less than the existing Medicare daily rate for the hospice routine home care level of care. Hospices are pressured into entering into inadequate payment contracts with Medicaid managed care organizations in order to ensure individuals have the option of receiving hospice care.

**RECOMMENDATIONS:** 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. 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 IMPACT OF HOSPICE PAYMENT REFORM; REJECT REBASING AND SITE-OF-SERVICE ADJUSTMENT FOR NF RESIDENTS**

**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 30 percent of those being served by hospices, according to the Medicare Payment Advisory Commission (MedPAC).

Over the years the average length of stay (LoS) has increased to about 88 days, but the more important median LoS remains at about 18 days, according to MedPAC. In 1983, 20 percent of patients received hospice services for seven days; this has increased to about 30 percent. Additionally, 25 percent of hospice patients are on care for five days or less before expiring. The current reimbursement structure was created by estimating the original cost of delivering routine home care (RHC) -- 96 percent of hospice days of care -- by analyzing data collected during the 1980-1982 Medicare Hospice Benefit Demonstration Project.

Despite the changes noted by MedPAC and significant technological, pharmaceutical, and medical care delivery advances over the first 33 years of the hospice program, there had been no associated reimbursement adjustment to reflect the changes. In March 2009 MedPAC recommended that Congress mandate revision of the hospice reimbursement system to better reflect variation in costs over a patient's length of stay and expansion of data collection efforts.

The final 2010 health care reform legislation (Public Law 111-148) authorized payment system reforms to be enacted no earlier than October 1, 2013. The Centers for Medicare & Medicaid Services (CMS) expanded collection of data related to visits and costs in 2008, 2010, and then again in April 2014. While analyzing data for its payment reform efforts, CMS "floated" a seven-tiered payment system for RHC and also suggested that it may be appropriate to "rebase" hospice payments and reduce reimbursement for RHC provided to patients in nursing facilities.

During 2015, CMS promulgated and finalized modifications to payments for RHC under hospice that sets out two payment rates -- a higher rate (\$186.84 in 2016) for days one through 60 of hospice care and a lower rate (\$146.83) for days 61 and over. Despite a break in service, unless a patient is off hospice care for more than 60 days, the "count of days" for purposes of determining the appropriate RHC rate includes previous hospice service days. CMS also created a Service Intensity Add-on (SIA) applicable to in-person RN and Social Worker visits that are provided during the final seven days of life. The SIA is payable at the hourly rate for Continuous Home Care (CHC, paid at \$39.37 in FY2016) for up to four hours per day. CMS was required to make the payment system changes budget neutral in the first year of application. However, given that provision of RN and Social Worker visits in the payment changes, CMS has indicated that in future years it will apply budget neutrality to account for changes in SIA utilization.

Public Law 111-148, the final health reform bill, also includes some interim payment changes, including the institution of a productivity adjustment to the annual market basket

inflation update beginning in FY2013. In addition, the final reform bill reduces the market basket index by 0.3 points in FY2013 through 2019, but makes provision to eliminate the market basket cut in each of FY2014 – 2019 if growth in the health insurance-covered population does not exceed 5 percent in the previous year.

An overriding concern, moving forward, is CMS' indication during 2014 that it believes rebasing of RHC rates (which would reduce them by approximately 10 percent) may be appropriate, and its continuing interest in reducing payments for care of patients in nursing facilities. While some hospices appear to reap financial benefits from care provided to facility patients, many hospices have a limited number of patients in individual facilities. These hospices could be discouraged from providing such care, which would further reduce access to hospice care for facility patients

**RECOMMENDATION:** CMS should closely monitor the impact of payment reform changes on access and quality of hospice care, and include NAHC and the hospice industry in discussions of advisable future reforms for the hospice payment system. CMS should resist efforts to overstep its charge to refine the hospice payment system by including changes like rebasing of RHC or reduced payments for care provided to NF residents that could go far beyond the payment refinement sought by the health reform bill and threaten future access to the full hospice benefit as it was conceived.

**RATIONALE:** To effectively revise the hospice payment system for all four levels of care, CMS must have an accurate and rich data set that reflects the full scope of services currently provided by hospices. To address these gaps, CMS has initiated changes in the hospice cost report for freestanding hospices and, additional data on hospice claims it believes can be used in hospice payment revision decisions. However, concerns remain that these expanded data collections may not provide a full and accurate depiction of true hospice costs, which could lead to inaccurate payment revision decisions.

Introduction of a payment approach to better synchronize the payment system with actual costs is appropriate, and the first steps toward this end were implemented in January 2016. These reforms will change incentives in the hospice payment system and, as a result, patterns of enrollment and care, and may be all that is needed to address inappropriate incentives in the current system. CMS must address payment reform in a measured and deliberate manner. Changes such as rebasing and a site-of-service adjustment for NF patients may go well beyond what is needed, and create so much upheaval in the hospice payment system that they threaten the integrity of the hospice benefit and jeopardize access to care. Finally, any future discussion related to potential rebasing of hospice rates should not take place until a reasonable set of standards for rebasing has been developed and made public.

## **PROVIDE FULL DISCLOSURE OF HOSPICE AVAILABILITY AND CHOICE OF PROVIDER TO TERMINALLY ILL BENEFICIARIES RESIDING IN SNFs/NFs**

**ISSUE:** In 1989, Public Law 101-239 mandated the ability of terminally ill Medicare beneficiaries residing in skilled nursing facilities/nursing facilities (SNF/NFs) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID) to access services under the Medicare hospice benefit (MHB). As SNF/NF and ICF/IID residents become aware of the MHB, more of them are seeking hospice services. However, the SNF/NF and ICF/IID 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 released revised SNF/NF and ICF/IID Medicare conditions 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 and ICF/IID residents upon admission whether or not hospice services are available at the facility. In 2016, CMS released new conditions of participation for SNF/NFs and ICF/IID that also did not address notification to residents about hospice services in the facility. CMS guides SNF/NFs and ICF/IID 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.

**RECOMMENDATIONS:** CMS should require that SNF/NFs and ICF/IID 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 all the hospice(s) with which the facility has contracted to provide hospice services on site. CMS should also require that SNF/NFs and ICF/IID disclose upon admission, and at the time residents are determined to be nearing the end of life, common ownership and any financial relationship between the contracted hospice(s) and the SNF/NF to the resident. Additionally, CMS should mandate that eligible Medicare beneficiaries residing in SNF/NFs and ICF/IID have the right to receive hospice services from the Medicare-certified hospice of their choice.

**RATIONALE:** SNF/NFs and ICF/IID should provide full disclosure regarding the availability of hospice services and the relationship between the hospice and 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 and ICF/IID resident may only access the Medicare hospice benefit if the SNF/NF and ICF/IID has a formal arrangement with a hospice program to provide services in the facility.

## **REVISE FACE-TO-FACE REQUIREMENTS FOR HOSPICES**

**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 that 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 the encounter 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; 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 scheduled 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.

- There are situations where CMS data systems do not display a beneficiary's previous service on hospice due to the fact that the previous hospice provider has not timely filed its Notice of Election (NOE), Notice of Termination/Revocation (NOTR), or claims. In such situations, the current hospice provider is not able to tell that a face-to-face encounter is required and often does not know this until after the two-day exceptional circumstance period has passed. Through no fault of its own and completely out of its control, the current hospice cannot get paid for care it has provided in good faith to the patient.
- 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 not being able to quickly access a physician or NP meeting the CMS requirements 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.

**RECOMMENDATIONS:** 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.

## **ADDRESS PAYMENT DELAYS AND INCREASED REGULATORY BURDENS 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. CMS requires that hospices only submit one bill per beneficiary per month. There are situations where the additional data required on hospice claims beginning April 1, 2014 causes hospices to hit the 450-line claim limit. This causes the hospice to have to submit another bill the following month and with only one claim allowed per beneficiary per month, this delays the following months' claims placing a hardship on hospices to be able to continue providing care.

Imposition of the 5-day timely filing requirement for Notices of Election (NOEs) and Notices of Termination/Revocation (NOTR) have added to the issues that hospices face relative to sequential billing.

**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 and allow more than one claim per beneficiary per month when the reason for the multiple claims is due to the hospice exceeding the 450-line claim limit. 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. The type of patient for whom the number of lines on the claim is expected to be high is those patients receiving a significant number of medications with frequent doses and frequent visits by hospice team members. This is typically the hospice patient requiring higher levels of care such as the general inpatient level of care or continuous care. These are usually the more expensive levels of care for hospices to provide. Interruption of payment and slow down 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. CMS collects 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.

### **RECOMMENDATIONS:**

- 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.

## **PROMOTE NATIONWIDE CONSISTENCY OF LCDs THAT REFLECT CURRENT HOSPICE CODING AND DIAGNOSIS REQUIREMENTS**

**ISSUE:** The current hospice local coverage decisions (LCD) promulgated by CMS (Guidelines) 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 or the psychosocial dimensions of the illness for determination of coverage decisions.

The multiple Medicare Administrative Contractors (MACs) for hospices 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 defined, so hospices are unable to consistently apply them. There is some lack of clarity as to what coding guidelines CMS believes should be applicable to hospice and which should not, and the degree, generally, to which inpatient coding guidelines sufficiently take hospice care into consideration. This increases the likelihood that data received by CMS and upon which payment decisions are made is inaccurate.

**RECOMMENDATIONS:** CMS should perform annual reviews of all LCDs and revise the policies based on available research, industry input, and other pertinent findings relevant to the determination of a prognosis of six months or less. Additionally, CMS should ensure that the ICD-10-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 re-certifications:
  - Encourage the use of multiple LCDs or one general LCD to document comorbidities 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.
  - Require documentation by the reviewer of the date of patient's death, as appropriate, while enrolled in the hospice benefit or after discharge from hospice care if that death occurs within six months of the 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 all diagnoses be included on hospice claims. In order to obtain accurate and consistent data, CMS should determine in collaboration with industry experts 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 FOR MEDICARE HOSPICE PROVIDERS ON PERFORMANCE**

**ISSUE:** Prior to October 6, 2014 there was no legislative requirement for the frequency of surveys for providers of the Medicare hospice benefit (MHB). 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. Some hospice providers went more than 10 years without a survey. On October 6, 2014 the IMPACT Act of 2014 was signed into law. The Act requires that hospices be surveyed no less than every 36 months beginning April 6, 2015 through September 30, 2025. While the more frequent surveys are an essential step toward improving compliance with regulations and potentially higher quality of care, more frequent surveys for new Medicare hospice agencies and agencies with condition-level deficiencies or significant complaints would also help to elevate compliance and quality of care.

**RECOMMENDATIONS:** CMS should ensure that there are enough resources available for these hospice surveys and that timely and adequate training occurs for the surveyors; continuing education should be available as necessary. In addition, CMS should further 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.
- CMS should continue surveying hospices at least every 36 months beyond September 30, 2025.

**RATIONALE:** When the 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 CERTIFICATIONS

**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 (MHB) is still too short. The number of short lengths of stay for hospice patients is increasing which means some Medicare beneficiaries are not afforded the opportunity to take advantage of all of the end-of-life care available to them and that could potentially decrease Medicare outlays. 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.” Medicare Payment Advisory Commission (MedPAC) data shows that the median length of stay remains consistent over recent years -- at about 18 days which is far too short to be of the greatest benefit.

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).

NAHC applauds CMS’ activation 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 was developed for advance care planning in 2014; however, CMS did not associate any payment with the code until January 1, 2016.

**RECOMMENDATIONS:** CMS should create, recognize and provide payment for a new HCPCS code to compensate physicians for patient certification of eligibility for the MHB.

**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 on 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.

## **PROCEED WITH A THOUGHTFUL AND DELIBERATE EXPANSION OF THE 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 provided a strong start toward the development and implementation of a quality reporting program, by (a) 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 (b) requiring that hospices begin reporting these measures. Failure to submit quality measures by a hospice would result in a two-point reduction in the annual market basket index update beginning with FY 2014 (Section 3004).

CMS initiated a voluntary quality measure collection and reporting program in late 2011 and early 2012; mandatory quality measure data collection began October through December 2012, with mandatory data reporting beginning in January and April of 2013. Starting January 2013 hospices were required to collect and report the first full year of data. In July 2014, the Hospice Quality Reporting Program (HQRP) entered a new phase with the requirement that hospices collect and submit data for a patient-specific Hospice Item Set (HIS). Subsequently, beginning in Jan. 2015, hospices had to contract with an outside vendor to collect responses to a hospice experience of care survey. Failure to report data results in a 2 percent payment reduction. CMS indicates that some hospice quality data is likely to be publicly reported on a Hospice Compare site in 2017. CMS added two new measures to the HQRP in 2017 – Hospice Visits When Death is Imminent and Hospice and Palliative Care Composite Process Measure. CMS further commented in 2016 that it is considering a comprehensive standardized patient assessment instrument in hospice and indicated that this instrument may be used for future hospice quality initiatives and payment reform. 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.

**RECOMMENDATIONS:** CMS should advance the HQRP through work with the hospice industry to select additional appropriate measures for reporting and establish a reasonable time frame for incorporating new measures. CMS should ensure that the quality measures currently under development for hospice incorporate:

- Reliable and valid indicators.
- Outcome measures limited to those that most accurately predict quality.
- A method for risk adjustment.
- A simple system with clinical utility.
- A mechanism enabling CMS to validate agency data.
- An ongoing evaluation of the entire system.

**RATIONALE:** The ideal hospice quality assessment program must be based on what happens to the patients. 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% of Medicare services provided. Any agency that exceeded this 2.5% 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 MAC is to apply the usual procedures (not presumptive status) of the limitation on liability provision contained in the Medicare 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.

**RECOMMENDATIONS:** 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 MAC. Certifying terminal illness is an inexact science and extremely difficult for the physician, patient and family. A MAC determination that a patient is not terminally ill is also devastating.

## **STUDY HOSPICE REIMBURSEMENT FOR DUALY 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 scrutiny by the Department of Health and Human Services Office of the Inspector General (OIG). In its report "Hospice Patients in Nursing Homes," the OIG made recommendations to 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, and believes that these hospices may be taking advantage of a situation that is less resource intensive, thereby increasing their financial margins. MedPAC and the Centers for Medicare & Medicaid Services (CMS) have both indicated an adjustment in payments for hospice patients in NFs of between 3 and 5 percent may be appropriate.

Furthermore, many states are moving their Medicaid hospice benefits to Medicaid managed care plans. Absent state rule otherwise, payment mechanism/level is at the discretion of the managed care organization. This may have the unintended consequence of limiting access to hospice care for beneficiaries as hospices in some states are reporting that the payment mechanism/level of payment is so poor that it prevents the hospice from being able to deliver services to these beneficiaries.

Finally, some states impose "provider taxes" that help provide additional revenue to cover the costs of Medicaid services and increases in payment rates. In some states, hospices are being "taxed" on nursing home room and board payments but these payments do not accrue to the hospices -- instead they are being paid directly to the nursing facilities.

**RECOMMENDATIONS:** The Centers for Medicare & Medicaid Services (CMS) should not reduce payment to the hospice for patients residing in nursing homes unless data collected and analyzed unequivocally 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.

**RECOMMENDATIONS:** 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 tele-hospice 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.”

**RECOMMENDATIONS:** 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 re-certifications. 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 MACs, 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.

## **CREATE WAIVER FOR EXCEPTION TO SOCIAL WORK SUPERVISION REQUIREMENT**

**ISSUE:** The 2008 revisions to the Hospice Conditions of Participation (CoPs) require that, effective December 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 is extraordinarily limited nationwide and especially in rural areas.

**RECOMMENDATIONS:** 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 fewer 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% of social workers were over 55 years of age, compared with 14% of the US civilian labor force. At least 13% 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.

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.

## **CLARIFY HOSPICE RESPONSIBILITIES RELATED TO DISPOSAL OF CONTROLLED MEDICATIONS**

**ISSUE:** On October 9, 2014 the Controlled Substances Disposal Act (the Act) became effective. This rule governs the secure disposal of controlled substances by registrants and ultimate users. These regulations will implement the Secure and Responsible Drug Disposal Act of 2010 by expanding the options available to collect controlled substances from ultimate users for the purpose of disposal, including: Take-back events, mail-back programs, and collection receptacle locations. The Disposal Act provides that, “if a person dies while lawfully in possession of a controlled substance for personal use, any person lawfully entitled to dispose of the decedent’s property may deliver the controlled substance to another person for the purpose of disposal under the same conditions as provided” for ultimate users (21 U.S.C. 822(g)(4)). An ultimate user includes “a person who has lawfully obtained, and possesses, a controlled substance for his own use or for the use of a member of his household” (21 U.S.C. 802(27)). Accordingly, a member of the hospice patient’s household may dispose of the patient’s pharmaceutical controlled substances, but the home hospice or homecare provider cannot do so unless otherwise authorized by law - for example, under state law - to dispose of the decedent’s personal property and in cases where an ultimate user has given permission to the hospice to dispose of the medication.

Since their inception, the majority of hospice providers have developed and implemented procedures whereby a hospice staff member, usually a hospice nurse, disposes of at least controlled substances remaining after a patient’s death when the patient resided in a personal community residence. This common practice of hospices typically involves documentation of the medications destroyed and destruction according to the recommendations of the FDA and EPA. There is also typically a documented witness to the destruction and there is a provision for family members of the decedent to refuse the destruction, but this is a rare occurrence. The purpose of this practice is to prevent the diversion of controlled substances. CMS has recognized the long-standing practice in regulations at CFR 418.106. Specifically, the regulations state:

### **§418.106(e)(2) Disposing.**

**(i) Safe use and disposal of controlled drugs in the patient’s home. The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient’s home. At the time when controlled drugs are first ordered the hospice must:**

**§418.106(e)(2)(A) - Provide a copy of the hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family;**

**§418.106(e)(2)(B) - Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; and**

**§418.106(e)(2)(C) - Document in the patient’s clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.**

While these federal regulations do not specifically require the hospice to actually dispose of/destroy the medications, there are some state laws that do require this. These state laws often do not expressly give authority to the hospice staff to “possess” the medications for destruction. Hence, there is confusion at the state level and hospice level regarding what, exactly, hospice staff can and should do with unused/unwanted medications in the home setting. Hospices in states with laws that require they destroy the medications are concerned that complying with state law will cause them to be out of compliance with the Controlled Substances Disposal Act. The DEA encourages home hospice and other homecare providers to assist their patients, and their patients’ families, in disposing of pharmaceutical controlled substances in accordance with applicable regulations. However, assistance by the hospice provider may involve “possession”. Additionally, the Controlled Substances Disposal Act addresses long term care facilities (LTCF) but does not address hospice inpatient units.

**RECOMMENDATIONS:** The DEA should provide clarification of the role hospices should and are able to play in preventing the diversion of controlled substances for those patients under their care in personal residences and in hospice inpatient facilities. CMS should consider the clarified role in light of CFR 418.106 and provide guidance accordingly.

**RATIONALE:** Clarification of the hospice’s role is necessary in order for hospices to be in compliance with both state and federal rules and regulations. Clarification is also necessary for state DEA offices and state legislators to ensure state laws are not in direct conflict with the Act.

## **ENSURE APPROPRIATE DEVELOPMENT OF PERFORMANCE-BASED PAYMENT FOR MEDICARE HOSPICE SERVICES**

**ISSUE:** The latest advance in health care payment policy revolves around tying providers' health care payments to the quality or effectiveness of care they provide, based on patient-related outcomes. Value-based or "Pay for performance" (P4P) systems acknowledge financial remuneration as one of the strongest incentives available; they can be designed to reward providers based on use of certain processes of care, outcomes of care, or patient satisfaction. Incentives to provide high quality health care can be crafted in a variety of ways – for example, payers could impose a "withhold" of a certain amount on each payment until such time as performance can be assessed and the payer determines which providers will receive the incentive payments based on their performance. P4P can also take the form of a penalty for not reaching a required level of performance. P4P has been used in the private sector for some time and has more recently gained the attention of federal policymakers.

As part of the Affordable Care Act, Congress included several provisions that advanced development and implementation of value-based purchasing programs for a variety of provider types under Medicare, including hospice. Relative to hospice, under section 10326 of the Health Care and Education Reconciliation Act of 2010, Congress requires that no later than Jan. 1, 2016, the Secretary of Health and Human Services must establish a pilot program to test value-based purchasing under hospice care, but to date this pilot has not been implemented.

There are several key considerations in development of any value-based performance program, including determination of what measures should be used, what scoring rules will be applied to those measures, the size of the incentive pool, whether the incentive payments are derived from a payment "withholds" or some other source, and the manner in which performance will be linked to the incentive payments. It is advisable that selected measures are ones with which participating providers are familiar, that they represent key factors related to the desired outcomes in hospice, and that the measures are properly risk-adjusted and adequately validated to ensure that they measure what they seek to measure. Of equal importance is ensuring that the measures and the payment structure do not result in negative, unintended consequences -- for example, if a payment withhold approach is utilized, the withhold should not be so large that it affects adequate provider cash flow and, consequently, the ability to supply needed care to patients on service.

The Centers for Medicare & Medicaid Services (CMS) has worked diligently to develop quality reporting programs for a number of Medicare provider types; quality and outcomes-based measurement programs are at varying levels of development. The Hospice Quality Reporting Program (HQRP) is still at a relatively early stage in its evolution: hospices began reporting Hospice Item Set (HIS) data in July 2014, and CMS will begin to examine the validity of the HIS data during the third quarter of 2015. During the second quarter of 2015, hospices began full-time participation (with involvement of an approved vendor) in the hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, which was designed to measure and assess the experiences of patients who died while receiving hospice care, as well as the experiences of their informal primary caregivers. It is anticipated that CMS will introduce public reporting of hospice quality measures within the next few years (after existing or future

measures are appropriately validated).

**RECOMMENDATION:** CMS must give highest priority to ensuring that selected measures are relevant, have gone through the proper validation process and are familiar to hospice providers. Incentives should be geared toward positive reinforcement rather than penalizing providers. Given that the HQRP is currently in an early stage of development and additional data that hospices were required to begin putting on claims in 2014 are still relatively new and problematic for some hospices, the hospice value-based purchasing pilot should rely on volunteer participants, but ensure that it is tested on a variety of hospices relative to size, type, geographical location and patient makeup. Full analysis of the pilot program and its impact on patients and providers must be conducted. As hospice quality measure development continues, future demonstration or pilot programs in value-based purchasing may be appropriate prior to launch of a nationwide value-based purchasing program for hospice.

**RATIONALE:** CMS has been methodical and thorough in its development of the HQRP, but the program is still in its infancy. Development of a pilot program in value-based purchasing for hospice requires equal deliberation and consideration. Value-based purchasing, with its focus on desired outcomes, has the potential to revolutionize health care delivery but must be based on a solid foundation of appropriate measure development, testing, and provider education.