Medicare Program:
Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices

Final Rule

Hospice Provisions from:
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Code of Federal Regulations - Title 42, Parts 409, 418, 424, 484, and 489
November 2, 2010

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Summary
This final rule sets forth an update to the Home Health Prospective Payment System (HH PPS) rates, including: the national standardized 60-day episode rates, the national per-visit rates, the non-routine medical supply (NRS) conversion factors, and the low utilization payment amount (LUPA) add-on payment amounts, under the Medicare prospective payment system for HHAs effective January 1, 2011. This rule also updates the wage index used under the HH PPS and, in accordance with the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), updates the HH PPS outlier policy. In addition, this rule revises the home health agency (HHA) capitalization
requirements. This rule further adds clarifying language to the "skilled services" section. The rule finalizes a 3.79 percent reduction to rates for CY 2011 to account for changes in case-mix, which are unrelated to real changes in patient acuity. Finally, this rule incorporates new legislative requirements regarding face-to-face encounters with providers related to home health and hospice care.

**EFFECTIVE DATE:** These regulations are effective on January 1, 2011.

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II. Provisions of the Proposed Rule and Response to Comments

**H. New Requirements Affecting Hospice Certifications and Recertifications**

Section 3132 of the Affordable Care Act requires hospices to adopt some of MedPAC’s hospice program eligibility recertification recommendations, including a requirement for a hospice physician or nurse practitioner to have a face-to-face visit with patients prior to the 180th-day recertification, and to attest that such a visit took place. The Affordable Care Act was enacted too late in the calendar year for the implementation proposals relating to these new requirements to be included in a Hospice Wage Index Proposed Rule. Therefore, these proposals were included in the Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Proposed Rule. As such, we are responding to comments and issuing our implementation plan in this final rule.

In its March 2009 Report to Congress, MedPAC wrote that additional controls are needed to ensure adequate accountability for the hospice benefit. MedPAC reported that greater physician engagement is needed in the process of certifying and recertifying patients’ eligibility for the Medicare hospice benefit. The Commission reported that measures to ensure accountability would also help ensure that hospice is used to provide the most appropriate care for eligible patients. MedPAC recommended these measures be directed at hospices that tend to enroll very long-stay patients. Specifically, MedPAC recommended that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180-day recertification and each subsequent recertification, and attest that such visits took place. (MedPAC, Report to the Congress: Medicare Payment Policy, Chapter 6, March 2009, \pp. 365 through 371.)
Section 3132(b) of the Affordable Care Act requires hospices to adopt MedPAC’s hospice program eligibility recertification recommendations. Specifically, the Affordable Care Act amends section 1814(a)(7) of the Act to require that on and after January 1, 2011, a hospice physician or nurse practitioner (NP) must have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient prior to the 180-day recertification, and prior to each subsequent recertification. Furthermore, the Affordable Care Act requires that the hospice physician or NP attest that such a visit took place, in accordance with procedures established by the Secretary of the HHS. The Affordable Care Act provision does not amend the statutory requirement that a physician must certify and recertify a patient’s terminal illness. By statute, only a physician (not a NP) may certify a patient’s terminal illness, however, section 3132(b)(2) of the Affordable Care Act allows a NP to furnish a face-to-face encounter; in the case where the NP provides the face-to-face encounter, the NP would then need to provide the clinical findings from that encounter to the physician who is considering recertifying the patient.

This new statutory requirement will better enable hospices to comply with hospice eligibility criteria and to identify and discharge patients who do not meet those criteria.

Hospices which admit a patient who previously received hospice services (from the admitting hospice or from another hospice) must consider the patient’s entire Medicare hospice stay to determine in which benefit period the patient is being served, and whether a face-to-face visit will be required for recertification.

As required by the Affordable Care Act, we made several proposals regarding §418.22(a)(3), (a)(4), (b)(3), (b)(4), and (b)(5) in order to implement this new statutory requirement. We believe that required visits should be fairly close to the recertification date, so that the visit allows a current assessment of the patient’s continued eligibility for hospice services. These visits can be scheduled in advance, particularly for those patients with diagnoses where life expectancy is harder to predict. As such, in §418.22(a)(4), we proposed that hospice physicians or NPs make these visits no more than 15 calendar days prior to the 180-day recertification and subsequent recertifications, and that the visit findings be used by the certifying physician to determine continued eligibility for hospice care. We noted that this 15-day timeframe also aligns the timeframe for recertification visits with the timeframe required for the comprehensive assessment update, as specified in our Conditions of Participation (CoPs) at §418.54(d). This timeframe requirement is also consistent with the timeframe required for the review of the plan of care, as specified in our CoPs at §418.56(d). We wrote that the 15-day timeframe provides a balance between flexibility in scheduling the visit and enabling a relatively current assessment of continued eligibility, while also allowing efficiency in update and review processes, as required by the hospice CoPs.

As noted earlier, the statute requires that the face-to-face encounter be used to determine the patient’s continued eligibility for hospice services. We proposed that the
clinical findings gathered by the NP or by the physician during the face-to-face encounter with the patient be used in the physician narrative to justify why the physician believes that the patient has a life expectancy of 6 months or less. Accordingly, we added this proposed requirement to §418.22(b)(3) as subparagraph(v).

Because the statute also requires the hospice physician or NP to attest that the face-to-face encounter occurred and by statute only a physician may certify the terminal illness, at §418.22(b)(4) we proposed that the face-to-face attestation and signature be either a separate and distinct area on the recertification form, or a separate and distinct addendum to the recertification form, that is easily identifiable and clearly titled. We also proposed that the attestation language be located directly above the physician or NP signature and date line.

The attestation is a statement from the certifying physician or from the NP which attests that he or she had a face-to-face encounter with the patient. If the face-to-face encounter was provided by a NP, the attestation should also include a statement that the clinical findings of that encounter have been provided to the certifying physician for use in determining continued eligibility for hospice care. We proposed that the attestation include the name of the patient visited, the date of the visit, and that it be signed and dated by the NP or physician who made the visit. Hospices are free to use other attestation language, provided that it incorporates these required elements. These elements must be included whether the visit is made by a NP or a physician. We note that it is possible that the certifying hospice physician is the same physician who made the visit.

As previously mentioned, we proposed to revise §418.22 to incorporate these requirements and we proposed to add paragraphs (a)(4) and (b)(4) to implement the requirements for a face-to-face encounter with long-stay hospice patients and the attestation of that face-to-face encounter.

In requiring a timeframe in which the face-to-face encounter must occur, for consistency, we believe it is important to also clarify required timeframes for all certifications and recertifications. Long-standing guidance in our Medicare Benefit Policy Manual’s chapter on hospice benefit policy allows the initial certification to be completed up to 14 days in advance of the election, but does not address the timeframe for advance completion of recertifications (see CMS Pub. No. 100-02, chapter 9, section 20.1). To clarify our policy in the regulations, and to be consistent with the timeframe for the newly legislated face-to-face encounter for recertifications, we proposed that both certifications and recertifications be completed no more than 15 calendar days prior to either the effective date of hospice election (for initial certifications), or the start date of a subsequent benefit period (for recertifications). This proposed timeframe also aligns with the CoP timeframe for updating the comprehensive assessment (§418.56(d)), and with the CoP timeframe for reviewing the plan of care (§418.54(d)). Finally, this proposed 15-day advance certification or
recertification timeframe would also help ensure that the decision to recertify is based on current clinical findings, enabling greater compliance with Medicare eligibility criteria. We believe the new statutory requirements reflect the Congress’ desire for increased compliance with Medicare eligibility and, in order to implement these provisions, we proposed to revise §418.22(a)(3).

Furthermore, longstanding manual guidance stipulates that the physician(s) must sign and date the certification or recertification. However, the HHS Office of Inspector General (OIG) recently found that certifications for some hospice patients failed to meet Federal requirements, including the signature requirement (HHS OIG, “Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements, September 2009”). In keeping with the Congress’ desire for increased compliance with Medicare eligibility criteria, and to achieve consistency with the 180-day recertification attestation requirements, we proposed to add language to the certification requirements in our regulations to clarify that these documents must include the signature(s) of the physician(s) and the date each physician signed the document.

Additionally, with the new statutory requirements for a face-to-face encounter prior to the 180-day recertification, and for every recertification thereafter, it is important for hospices to easily identify which benefit periods require a recertification visit. Hospice patients are allowed two 90-day benefit periods followed by an unlimited number of 60-day benefit periods, so every 60-day benefit period is by definition beyond the 180-day recertification. Because we do not currently require that certifications or recertifications show the dates of the benefit period to which they apply, we proposed to add language to our certification and recertification regulations to make this a requirement for all hospices. While many hospices already include this information, there are some that do not. Having the benefit period dates on the certification would make it easier for the hospice to identify those benefit periods which would require a face-to-face encounter and would ease enforcement of this new statutory requirement.

Section 1814(a)(7)(A) of the Act requires a valid certification or recertification for Medicare coverage. Additionally, section 1814(a)(7)(D) of the Act now also requires a face-to-face encounter with patients who reach the 180th-day recertification. We proposed to revise our regulations to require that the physician’s signature(s), date signed, and the benefit period dates be included on the certification or recertification because we believe this information is necessary to determine if these documents are valid, and to ease the implementation of the new statutory requirements. We believe these requirements are consistent with practices in the hospice industry, and we do not believe these proposals will be burdensome to hospices. As such, we proposed to add §418.22(b)(5) to incorporate these signature and date requirements.
The following is a summary of the comments we received regarding the new requirements affecting hospice certification and recertification proposals.

Comment: Commenters asked for clarification of whether 180 days of hospice care must be provided before the face-to-face encounter was required, or whether the face-to-face was required when a patient enters the 3rd or later benefit periods. Several commenters suggested that we clarify the proposal so that the focus is on benefit periods, which they believe is consistent with the intent of the statute and the regulation, and which is easier to track; these commenters suggested we change the regulatory text to reference election periods rather than days.

In contrast, other commenters suggested we reword the proposal so that an encounter and its accompanying attestation will be required after 180 days of hospice care and every 60 days thereafter. The commenters wrote that basing the encounter timeframe on benefit periods rather than actual days of care would result in some patients requiring visits after only a short time in hospice, which the commenters believe was not in keeping with CMS’ intent to have patients with long lengths of stay assessed for continued eligibility. A commenter suggested that those 180 days must be continuous in order to trigger a face-to-face encounter.

Other commenters wrote that each new hospice admission should begin as day 1 for that hospice. One said that patients with a history of inappropriate admissions to different hospices should not cause the appropriate admissions to hospices to be penalized. Another wrote that although Medicare hospice is not fee-for-service, hospices still assume the risk of enrolling patients with high-cost medical needs based on the expectation that other patients will have lower cost medical needs. This commenter wrote that if a patient has had a previous hospice stay, and those days are counted toward the 180th-day recertification requirement, payment for those days was made to another hospice. The commenter also believes this invalidates an argument that the hospice has “accrued” sufficient funds to cover the additional costs of the required visits. The commenter suggested we not consider a patient’s total hospice history in defining the 180th-day recertification requirement, but only focus on days of care within the specific hospice providing care. The commenter suggested that this would also eliminate problems related to accurately tracking of time spent in hospice.

Another commenter wrote that if a patient had a significant break in hospice service, CMS should restart the time clock for the 180th-day recertification. Several commenters suggested that we consider each new terminal diagnosis to restart the clock as day 1; these commenters were referring to situations where a patient receives hospice care for a terminal diagnosis from which he or she recovers, and later receives hospice care for a different terminal diagnosis.

Other commenters asked for information about how to count the days when a hospice patient becomes eligible for Medicare in the midst of a non-Medicare hospice
stay or when the patient has previously received hospice care outside of the Medicare hospice benefit.

Response: The relevant language in the Affordable Care Act reads, “...a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification...” The Medicare statute, as amended by the Affordable Care Act, does not define the term “180th-day recertification.” For purposes of this provision, the Medicare statute also does not specifically address how the face-to-face encounter requirement should apply in the situation in which a beneficiary completes the first 90-day benefit period and is recertified for a second 90-day benefit period but does not receive 90 days of service in the second benefit period due to (for example) a revocation in the middle of the benefit period.

In interpreting the statutory term “180-day recertification,” we considered the statutory scheme and the existing language used in the statute and in our regulations, all of which is structured around the concept of benefit periods which, by statute, cannot last longer than a maximum number of days (90 days for the first two and 60 days for subsequent benefit periods). The fact that the statute imposes a maximum number of days per period does not mean that an individual must receive hospice services for the maximum number of days before a statutory requirement can be imposed on subsequent benefit periods. For example, for payment to be made to a hospice provider with respect to a beneficiary, section 1814(a)(7) of the Act requires a certification (and recertification) at the beginning of each benefit period, the first two of which can last as long as 90 days each. Previously, we have interpreted these provisions to require a recertification at the beginning of each subsequent benefit period, even if the prior benefit period did not last the maximum number of days due to, among other things, the beneficiary’s revocation under section 1812(d)(2)(B) of the Act. Thus, the regulatory language at §418.22 requires certifications at the beginning of each benefit period rather than requiring certifications after a certain number of days of service was actually provided to a beneficiary.

For the foregoing reasons, we are defining the 180th day recertification to be the recertification which occurs at the start of the 3rd benefit period - that is, the benefit period following the certification for a second, 90-day benefit period, regardless of whether the beneficiary received a full 90 days of service in the second 90-day benefit period. We note that, as one commenter wrote, this method of counting the time will also be easier for hospices to track. We also believe that the statute considers the patient’s total hospice benefit period, rather than starting the clock at day 1 or period 1 for each new hospice or for a different terminal diagnosis. Furthermore, this method of counting benefit periods is consistent with how our systems operate when tracking Medicare hospice beneficiaries.
We agree with the commenter who wrote that hospices assume the risk of enrolling patients with high-cost medical needs based on the expectation that other patients will have lower cost medical needs. As such, we believe that hospices should consider costs of patient care in the aggregate, and not on a per-patient basis. Therefore, we did not argue in the proposed rule that a hospice “accrues” sufficient funds on a per-patient basis to cover the cost of the visit based on a patient having prior days of care with that hospice.

To illustrate this benefit period method of counting, if a hospice patient elected the benefit for the first time on June 1st, completed the 1st 90 day period (on August 30th), began the 2nd 90 day period, but revoked 30 days into the benefit period (on September 29th), and re-elected hospice the following January, the beneficiary would be in his 3rd benefit period. The 3rd benefit period would require a face-to-face visit at admission even though he had not received 180 calendar days of care.

The Medicare hospice benefit periods only apply to Medicare hospice patients, regardless of whether Medicare is the primary or secondary coverage. In other words, non-Medicare stays are not considered when counting benefit periods to determine when a face-to-face encounter must occur. The first Medicare benefit period would begin on the effective date of the first Medicare hospice election.

To clarify the language used about the timing of the requirement, we are modifying our proposal and the regulatory text to refer to the face-to-face encounter as being required prior to the 3rd benefit period recertification and each subsequent recertification.

Comment: Several commenters were concerned that they could not provide a face-to-face encounter within 15 days prior to the 180th-day recertification or each subsequent recertification. One wrote that this timeframe is a barrier to rational geographic batching of visits. They cited difficulties due to shortages of physicians and NPs, particularly in rural areas. Several commenters said they would need to hire additional staff but were concerned about being able to successfully recruit a physician or NP because of shortages, particularly in rural areas. One wrote that there are not enough well-trained hospice practitioners in this country to handle the potential volume of these visits and asked if we were concerned that the influx of providers required to make these visits would “water down” the quality of the assessments, and negatively impact the delivery of care to hospice patients.

Some noted that they have a part-time Medical Director with a busy private practice, who is simply not available to make the visits. One noted that in urban areas, traffic tie-ups add to the time required to make these visits. Others wrote that visits in rural areas require significant travel time, sometimes as long as 4 hours; one added that during these visits, their Medical Director would also be completely unavailable by phone for other patient and staff needs because in some remote areas there is limited cell phone service.
One asked if there was a requirement regarding the location(s) where a required face-to-face visit could occur. Another commenter wrote that the language of the proposed regulation at § 418.22(c)(4) implies that the practitioner must visit the patient at his or her home, rather than allowing the patient to come to the physician or NP. This commenter suggested that we change the regulatory text from “must visit” to “have a face-to-face encounter” as specified by section 3132 of the Affordable Care Act. A commenter noted that in some areas, patients would have to come to the physician, creating a burden on patients and families. Several commenters added that they cannot get frail or dying patients to the physicians because many cannot sit up in a car, and in rural areas, Emergency Medical Services (EMS) may be the only option for transportation.

Another commenter wrote that patients would not be able to afford the ambulance ride to a physician’s office to make the visit; others were concerned that forcing a patient to travel to a physician was an undue hardship on both the patient and the family, would expose the patient to potentially infectious patients in the doctor’s office, and could lead to exacerbation of symptoms such as severe pain or dyspnea.

One commenter suggested we consider the impact of the required visit on the family; another commenter wrote that the required visits would be an added stress to the family as they wait for confirmation from hospice staff that hospice care can continue. Another commenter wrote that if a patient required ambulance transport to a doctor’s office, it would be an unreimbursed expense for the hospice, and asked if Medicare could cover the ambulance ride outside of the hospice per diem payment amount. One commenter said EMS will not cross county lines, yet 21 percent of the hospice’s patients lived in a different county.

Another commenter asked if the hospice could discharge a patient if the patient or family refused the physician visit, or delayed it, and noted that with 15 days, there may not be time for adequate discharge planning. Several noted that some states have minimum discharge requirements, such as Alabama with a minimum 30-day requirement, which make the 15-day timeframe unworkable; one commenter asked how to handle the situation where the recertification visit determines that discharge is needed, but it occurs with less than 30 days to plan, as required by some State laws. This commenter asked that we allow for adequate discharge planning.

A few commenters asked what the hospice should do if the visit cannot be made due to scheduling difficulties, inclement weather, unsafe road conditions, or due to an emergency. Another commenter said that a hospice physician might not have an attending physician’s dictation from the visit in time to make the attestation, and asked for more time to make the visits. One commenter wrote that the time constraints do not fit well with patients’ conditions if their disease trajectories are in rapid decline. A commenter asked what would be the impact on a hospice if the required visit was not made in the allowable timeframe but was earlier or later. This commenter also asked if
this requirement only affected Medicare hospice patients. Many commenters asked for more time to make the visit, suggesting 21 or 30 days.

**Response:** We appreciate commenters' input on the problems in scheduling these face-to-face encounters, and we recognize that rural hospices, in particular, may experience more logistical difficulty due to the shortage of physicians or NPs in some areas. Based on concerns and recommendations from the public comments on potential logistical issues, we are revising our proposed policy to change the visit timeframe from up to 15 days prior to the start of the 180th-day recertification, and each subsequent recertification, to a visit timeframe of up to 30 calendar days prior to the 3rd benefit period recertification, and each subsequent recertification. We believe this additional time will provide hospices with the flexibility they need to meet this Congressional mandate, to provide adequate time for discharge planning when indicated, and to accommodate other logistical issues discussed in the public comments.

We are unclear about the meaning of the comment related to State laws about discharge, and believe it may be outside the scope of this rule. We are only able to focus on the Medicare statute and payment regulations, which require that patients who are no longer eligible for the benefit be discharged. The statute does not allow us to pay for hospice care for patients who are not eligible for the benefit.

The regulations at §418.26(d) require hospices to have a discharge planning process in place “that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.” The word “prospect” in this regulatory text indicates that hospices should be considering whether stable or improving patients might become ineligible in the future, and plan for a possible future discharge.

Hospices are required to follow State laws in addition to federal laws. However, we do not see the recertification requirement and any State discharge requirements as being in conflict.

If a patient or family member refuses to allow the hospice physician or NP to make the required visit, a hospice could consider discharge for cause, as the refusal would impede the hospice’s ability to provide care to the patient. The hospice would need to follow the procedures for discharge for cause, which are given in §418.26.

In response to the comment suggesting that we change the proposed regulatory text at 418.22 (C)(4) from “must visit” to “have a face-to-face encounter” as language of the proposed regulation implies that the practitioner must visit the patient at his or her home, rather than allowing the patient to come to the physician or NP, we are revising the proposed language. We believe that the Affordable Care Act allows hospices the flexibility for patients to have a face-to-face encounter with a hospice physician or nurse practitioner. We are revising the regulatory text at §418.22(a)(4) to now read, “As of January 1, 2011, a hospice physician or hospice nurse practitioner
must have a face-to-face encounter...

We expect that hospices will not require patients to come to the hospice physician or NP for the encounter if doing so would exacerbate symptoms or otherwise jeopardize the patient’s well-being; the hospice Conditions of Participation (CoPs) in §418.100(a) require that hospices provide care that optimizes patient comfort, and is consistent with the patient’s and family’s needs and goals. All patient transport must occur within the context of optimizing patient comfort and meeting the specific needs and goals of patients and their families. If transportation to a hospice physician would not optimize patient comfort and/or meet the goals and needs of the patient and family, the hospice physician or NP would need to travel to the patient. If a hospice patient travelling to the hospice physician or NP required ambulance transportation because of his or her medical condition, the ambulance transportation would be included in the hospice per diem; it could not be billed to patient.

We believe that the face-to-face encounters will not be an added stress to family members if they know they are a routine part of the hospice recertification process, and if the family understands that the visit has the potential to improve the quality of care for their loved one.

In response to the commenter’s concern that the patient’s attending physician’s dictation might not be available to the hospice in the 15 days prior to the recertification, and this would prevent the hospice from meeting the 15-day timeframe that was originally proposed, we believe that the commenter appears to misinterpret the statutory requirement. Pursuant to section 3132 (B) of the Affordable Care Act, a hospice physician or hospice NP must perform the encounter. The definition of hospice physician is addressed later in this section.

In response to the comments asking for clarification about to which the face-to-face encounter requirement applies, we note that it only applies to Medicare hospice patients.

Finally, we proposed clarifying some language in our benefit policy manual and aligning timeframes so that recertifications could not be completed more than 15 days prior to the start of the subsequent benefit period. While the entire recertification cannot be completed more than 15 days prior to the start of the benefit period, we are clarifying that the face-to-face encounter and its accompanying attestation are only parts of the recertification, and therefore can be completed up to 30 calendar days prior to the start of the 3rd benefit period recertification and each subsequent recertification.

**Comment:** Several commenters have asked if the hospice face-to-face encounter is billable, and if so what reimbursement code should be used. A number of commenters wrote that their hospices do not have the resources to accomplish this if the visit is not billable; one wrote that this requirement could have the potential to drive smaller providers out of the market. They wrote that this requirement would be a
financial burden, especially to rural providers, in the face of reductions due to the budget neutrality adjustment factor (BNAF) phase-out and future market basket cuts, declining charitable donations, increased costs, and demands for competitive wages. A few commenters mentioned that hospices will be absorbing more than a 14 percent reduction in their Medicare and Medicaid reimbursement levels over the next 10 years; they wrote that these reductions are especially difficult for the hospice community since hospice programs are disproportionately dependent upon Medicare and Medicaid for reimbursement. These commenters believe the upcoming payment reductions place increasing financial pressure on hospices that seek to deliver quality care and comply with additional administrative and regulatory requirements.

A number of commenters wrote that they could not afford this unfunded mandate. One rural commenter noted that their reimbursement is already lower due to wage index adjustments, and yet the costs of these required visits will fall more heavily on rural providers, with long distances to see patients; this commenter believes the burden to rural hospices was becoming “almost insurmountable.” Commenters also mentioned the administrative costs of coordinating the visits, of changing existing forms and documents, and of increased liability risks, and several believe that these are not included in the current hospice reimbursement. Another noted that hospices would be expected to pay physicians or NPs for their travel time, visit time, and mileage, and would have additional administrative costs while receiving the same per diem payment amount. One commenter said that his hospice would be forced to reduce services to patients to pay for these visits. One commenter wrote that this requirement creates a 2-tiered system where providers are compensated better for patients under the 180-day recertification requirement than for beneficiaries who require a face-to-face encounter.

Several said that they would have to hire someone full-time to make the visits, which would create significant financial hardship without reimbursement; one wrote that those monies would be better spent on providing quality care and on fair wages for employees. A few added that having a physician or NP spend hours traveling to see patients would be a waste of scarce human resources in areas where there are physician or NP shortages. A few mentioned that the net result would be less patient care, and more time spent on paperwork.

 Nearly all commenters suggested some form of reimbursement for the visit, with one commenter writing that all physician visits mandated by payers should be billable separately by the physician directly to the payer for reimbursement. One commenter was concerned that because these required visits are medically unnecessary, there would be no reimbursement for them, yet hospices would still incur costs from making the visits. Another commenter added that many physicians or NPs would order tests such as CAT scans or, lab tests to obtain results that justify recertification of patients, and yet would not receive reimbursement for these tests.
A few commenters suggested that any part of the visit that becomes medically necessary, including those where the doctor changes the plan of care (POC) or makes medication adjustments, should be billable. One commenter asked if a hospice could bill the patient for the face-to-face visit if it was not covered.

One commenter wrote that when the Medicare hospice benefit was originally designed, physician face-to-face visits were viewed as an encounter for additional counseling, education, information, and support. The commenter asked why any physician face-to-face visit would not be billable. Another commenter cited our regulations at §418.304, and asked if the face-to-face visit was considered part of the establishment and updating of the plan of care, or is it outside the services listed, and could be billed separately. If the visits are part of the per diem amount, the commenter encouraged CMS to review the payment rates and increase the per diem to reflect this new, mandated service.

A number of commenters believe that the face-to-face requirement was beyond the administrative services provided by the hospice Medical Director, and outlined in the hospice claims processing manual in section 40.1.1 (see Internet Only Manual, 100-04, chapter 11). Several commenters wrote that since active clinical work and a comprehensive analysis will be required of the physician (as distinguished from simple documentation in the medical record), they believed that a billable visit is appropriate. Another wrote that while the medical decision-making is primarily directed at determining prognosis, in many cases, changes in medication and patient management may also be suggested. A different commenter wrote that the face-to-face encounter requires direct patient care services, including a comprehensive clinical assessment and is comparable to the billing for evaluation and management services provided in other settings and should be reimbursed as such. Another commenter wrote that there is no precedent for a physician to be required by law to provide a thorough medical assessment of a seriously ill patient and be constrained from coding, billing, or seeking usual and customary reimbursement for such care.

For any portion of the visit that is billable, commenters asked how to document that billable portion, including whether to make one note or two. A number of commenters wrote that their anticipated costs for the visits would far exceed any reimbursement, particularly given the travel time and mileage costs. Another also noted that there is currently no physician reimbursement for Medicaid patients visited by the hospice physician.

A few commenters noted that NP services that are equivalent to physician services are not currently billable unless the NP is the patient’s attending physician. One asked if this would change under the proposed rule.

A commenter wrote that the Medicare CoPs speak to the actions of a physician providing medical care to a hospice patient as separate from the role of the Medical Director, and that these services are accounted for differently in the per diem payment rate. This commenter wrote that the roles of these two physicians are distinct, and that
CMS should consider providing adequate reimbursement for the services being required. Another commenter asserted that if Medicare wants quality healthcare, Medicare must allow practitioners to bill for their time.

A few commenters wrote that there was an established precedent in Skilled Nursing facilities that encounters to meet mandated requirements are billable and reimbursed by CMS, beyond the administrative duties of the Medical Director. Given this information, they asked us to clarify if the mandated visit would be billable.

A commenter asked if we plan to track face-to-face encounters with a particular CPT code, and if it should be reported on the claim. Another commenter asked if we are concerned about the distortion of the actual cost associated with providing care to hospice patients if these visits are not captured on the claim. Some commenters asked us to devise a HCPCS code to compensate the hospice physician or NP for the time and mileage for making these visits. Others asked us to develop a billing code that would include mileage costs and travel time, and increase the per diems to reflect the additional administrative costs related to the proposal. One recommended a separately reimbursable fee schedule amount specific to face-to-face encounter visits.

Response: We appreciate the commenters concerns about the financial effects of the face-to-face requirement. However, the billing regulations for hospice do not allow for physician reimbursement for administrative activities of physicians. The certification or recertification of terminal illness is not a clinical document, but instead is a document supporting eligibility for the benefit. In the 1983 Hospice Care Final Rule, certifications of terminal illness were described as “simply determinations as to the patient’s medical prognosis, not the plan of care or the type of treatment actually received” (48 FR 56010). As such, the certification or recertification of terminal illness has been excluded from separate physician reimbursement and has been considered an administrative activity of the hospice physician. The face-to-face requirement is part of the recertification, and therefore is an administrative activity included in the hospice per diem payment rate. In contrast, the SNF bundle specifically excludes the services of physicians and other advanced practiced disciplines including NPs. Therefore, SNF physicians or NPs can bill for mandated encounters, as these visits are not part of the bundled payment.

The hospice face-to-face encounter is an administrative requirement related to certifying the terminal illness mandated by the Affordable Care Act. By itself, it would not be billable, as it is considered administrative, as explained above and in section 40.1.1 of the Claims Processing Manual (Internet Only Manual 100-04, chapter 11): “Payment for physicians’ administrative and general supervisory activities is included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.” Determining continued patient eligibility would fall under the
“general supervisory services” described at §418.304(a)(1), rather than under review and update of plans of care described at §418.304(a)(2).

However, if a physician or nurse practitioner provides reasonable and necessary non-administrative patient care such as symptom management to the patient during the visit (for example, the physician or NP decides that a medication change is warranted), that portion of the visit would be billable. We believe that allowing for this type of billing will not only increase the quality of patient care, but also will help defray the costs to hospices of meeting this requirement. Hospices may not bill patients for face-to-face encounters or for any medically necessary physician services provided during the encounter, as these are hospice services. Billing for medically necessary care provided during the course of a face-to-face encounter should flow through the hospice, as the physician or NP who sees the patient is employed by or where permitted, working under arrangement with the hospice (for example, a contracted physician).

The commenter who wrote that hospices cannot bill for physician services provided by a NP unless the NP is the attending physician is correct. The regulations at §418.304(e) only allow nurse practitioner services to be billed when the nurse practitioner is the patient’s designated attending physician. In order to be billable, this regulation also requires that the NP must provide medically reasonable and necessary services that are physician level services, and not nursing services (that is, in the absence of a nurse practitioner, the services would be provided by a physician and not by a nurse). The regulation also excludes billing for services related to the certification of terminal illness.

The hospice physician or NP that has the face-to-face encounter with the patient should ensure that any clinical findings of the visit(s) are communicated back to the interdisciplinary group (IDG), for use in coordinating the patient’s care. This is particularly true if the physician or NP discovers unmet medical needs during the billable or non-billable portion of the visit, so that the IDG can coordinate with any attending physician. Hospices are not to provide services that are duplicative of what the attending physician is doing and are responsible for coordinating with the attending physician if they provide any reasonable and necessary patient care when having a face-to-face encounter. If there is a billable portion attributable to the visit, hospices must maintain medical documentation that is clear and precise to substantiate the reason for the services that went beyond the face-to-face encounter, and which apply to the billed services; this can be done in one note.

At this time, we do not plan to track these required visits with a special CPT code, or to create any additional HCPCS codes related to these visits. In the coming years, we will be reforming the hospice payment system, and will be analyzing hospice costs and reimbursements to ensure that providers are being paid fairly.

We are unclear about the meaning of the comment that indicated that there is currently no physician reimbursement for Medicaid patients visited by the hospice
physician. However, we note that the Medicare hospice benefit reimburses hospice physicians and attending physicians for reasonable and necessary care provided to hospice patients, whether the patients are dually eligible or not. If the commenter is referring to patients who have Medicaid only, we suggest that the commenter see his or her State Medicaid Manual, particularly sections 4305.05 and 4307, which deal with the Medicaid hospice benefit and with physician services, respectively. The paper-based State Medicaid Manual can be accessed through our Web site, at http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CM021927.

Finally, the hospice face-to-face encounter is only required for recertifications when the patient is in the 3rd benefit period or beyond. By definition, hospice patients are terminally ill, with a prognosis of 6 months or less if, the illness runs its normal course. Therefore, the majority of hospice patients should not require a face-to-face encounter.

Comment: A number of commenters wrote that hospices cannot currently access accurate information in a timely manner to determine the status of previous hospice services. The commenters expressed concern that a hospice might admit a patient without having complete or accurate information about previous hospice services, and therefore not be aware that a face-to-face encounter could be required, resulting in denial of payment. Commenters stressed that without timely, accurate information, it is impossible for hospices to comply with this regulation.

Several asked if the fiscal intermediary standard systems (FISS) was available 24 hours per day, 7 days per week, or if the fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs) could impose down times for maintenance, holidays, weekends, or other reasons, noting that many hospice admissions take place after hours and on weekends, and recommended that we review FISS operating hours to ensure that it is available at all times. A few wrote that FISS cannot be accessed via secure internet site from any computer, but that hospices are required to purchase individual licenses and connection capabilities for each computer. One wrote that if a patient is discharged alive from a hospice more than six months from the inquiry date in the Eligibility Home Health Inquire (ELGH), the ELGH screen fails to reflect the previous hospice election, inaccurately suggesting to the provider that the patient had never elected hospice. One noted that using the look-up systems to determine a patient’s hospice history is cumbersome. This commenter also asked how far back benefit period records are kept within FISS. Several commenters noted that many hospices do not bill in a timely fashion, which places the receiving hospice at risk even if the Common Work File (CWF) or other resources are dutifully checked at time of admission. One commenter asked that we explore options to access the FISS system, and to ensure timeliness and availability of the complete hospice history.

A few commenters asked who would be responsible for monitoring the patient’s time in hospice, to know if a face-to-face encounter was required. The commenters
stated they would not know the patient’s history otherwise. One asked how a hospice would know when the last face-to-face encounters took place on patients who are transferred or who came from out of the area. This commenter also asked if a hospice could rely on a previous face-to-face encounter if the patient is being transferred from another hospice within 60 days of the last face-to-face encounter. Several commenters asked if the Provider Statistical and Reimbursement Report (PS&R) would be able to provide benefit period information.

Some also wrote that hospices should not be held accountable for failure to provide a visit if the data systems were unable to provide them with the accurate and timely information needed, or if the provider miscalculated the certification or recertification dates and/or face-to-face visit requirement because of inaccurate system information. Several asked that we provide clear guidance as to what would constitute a “best effort” to secure a patient’s full hospice history for establishing the proper benefit period, and “hold harmless” those providers who have met the “best effort” standard. One commenter suggested we delay implementation of the face-to-face requirement until there is a CMS system in place that is available 24 hours per day, 7 days per week, and that providers not be responsible for knowing about prior hospice use if the data are not available in FISS. This commenter suggested that FISS operating hours be reviewed and that CMS consider requiring the FI/MAC contractors to have FISS available for longer hours and on nights, weekends, and holidays.

**Response:** Hospices are responsible for verifying which benefit period a patient is in at admission by using the CWF to determine the beneficiary’s benefit period. The CWF is used because the FISS is responsible for the actual processing and payment of claims, and does not track benefit periods. There are several CWF query systems to determine which benefit period a hospice patient is in. Both ELGH and Health Insurance Query for Home Health Agencies (HIQH) give real time data; hospices should be using the CWF queries for the most accurate beneficiary information. If providers are unsure how to use the CWF queries, they should contact their MACs.

Because CWF has 9 host sites, a provider would have to search through up to 9 databases to determine if a patient who moved from another part of the country received prior hospice care; a beneficiary’s records are only in 1 of the 9 databases, so as soon as the beneficiary is located, the search may cease. Although this may be cumbersome, the CWF is required to be available from 6:00 am to 6:00 pm Monday through Friday and 6:00 am to noon on Saturdays, by the time zone of the host site. We strive to have the CWF available beyond these minimum timeframes, but there are some regular downtimes: every Saturday, usually from 4 p.m. to past midnight, Sundays from 7:00 p.m. to 9:00 p.m. (central time), and the third Sunday of every month from 12:00 a.m. to 4:00 a.m. (central time).

The PS&R system cannot currently provide the information needed to determine the current benefit period, and the revised system is still under development.
If CWF is not available, hospices have another option for verifying a patient’s hospice benefit periods, using an inquiry that is usually available 24 hours per day, 7 days per week, 365 days per year: the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS), specifically the 270/271 transaction. Those hospices that file their claims through a clearinghouse, or which have a direct connection to CMS, or whose MAC provides an internet portal, would have access to the HETS system as a data source for their eligibility. The HETS 270/271 inquiry is in real time, but claim information lags up to 24 hours. It is also a national database, therefore there is no need to search multiple host sites. A 270 transaction is a transaction query and a 271 transaction is the response to the user. A 270 transaction query for a patient’s benefit periods will return up to 3 years of data, showing all prior hospice benefit periods. This query system can be used if the CWF system is not available; providers can go to http://www.cms.gov/HETSHelp/ for information on the HETS 270/271 transaction, or they can call 1-866-534-7315. Therefore, hospices have multiple ways of verifying a patient’s prior hospice history to determine which benefit period the patient is in.

If a beneficiary has received hospice care at another provider, commenters are correct that the CWF may not be up-to-date if that previous provider has not billed promptly. We share commenters’ interest that the benefit period information available via the CWF or the 270/271 transaction should be as up-to-date as possible. Hospices have a financial incentive to bill in a timely fashion, and in our claims processing manual, we have encouraged providers to file their Notice of Elections as soon as possible after an election; similarly, we have often encouraged providers during the public CMS Open Door Forum discussions to bill in a timely fashion. In addition to checking our data systems for benefit period information, hospices can also ask the beneficiary (or his or her representative) if he or she has received hospice care previously. In putting forth their “best effort” to identify whether a patient requires a face-to-face encounter, hospices should not rely solely on data systems to determine the benefit period, but should also talk with the patient or representative where possible, and should document the information they find along with the methods used to find the information.

Several commenters suggested that we “hold harmless” those who rely on the CWF response information to determine whether a face-to-face encounter is required. We are unable to provide flexibility as the statutory language in the Act requires a certification or recertification in order for Medicare to cover hospice days of care. If a hospice has not had a required face-to-face encounter, then the recertification would not be complete, and we would be unable to cover the days of care that were under that recertification.

However, we believe that the flexibility afforded to hospices in determining benefit period data eliminates most situations where a hospice does not have accurate benefit period data. Furthermore, we believe that in many cases, the patient or his or her representative will know if hospice care was provided previously. Based on analysis
of our FY 2007 claims data, about 20 percent of all hospice beneficiaries reach benefit period 3 or later, and thus would require a face-to-face evaluation. Of that 20 percent, only a fraction of those beneficiaries might have benefit period data that are not up-to-date in the systems, and which cannot be verified with the patient or representative. In addition, of that fraction, another fraction will show benefit period 1 or 2, rather than period 3 or later, due to having prior hospice care. Therefore, given the historical data, we do not believe that this situation will be common or that there is a need to hold hospices harmless.

The Affordable Care Act requires that a hospice physician or NP have a face-to-face encounter with any patient that it admits in the 3rd or later benefit period; prior face-to-face encounters performed by previous providers cannot be used to substitute for a face-to-face encounter that is required by the current hospice. In a transfer situation, the benefit period does not change, so the originating hospice would have been responsible for any required face-to-face encounter if the patient was in the 3rd or later benefit period. When a patient is in the 3rd or later benefit period transfers to a new hospice, the receiving hospice must recertify the patient, but it does not have to have a face-to-face encounter for that current period if it can verify that the previous hospice provided the visit.

In response to comments asking that we delay the effective date, we note that we are unable to delay implementation of the face-to-face requirement since the statutory language requires that it begins on January 1, 2011.

Comment: Several commenters were concerned about requirements when a patient with a prior hospice stay requires a visit upon admission to a new hospice. This group of commenters along with others also noted that during a time of crisis, the need to admit the patient for pain and symptom control should take precedence over provision of any required face-to-face encounter. Another commenter was concerned that requiring a face-to-face encounter would create barriers to timely access and increase costs in situations where a patient elects hospice, revokes, re-elects, revokes, and re-elects in a short time period. Recertification at this 3rd benefit period would require a face-to-face encounter. One commenter noted that if a visit is required at admission, it may unduly delay needed care or prove impossible prior to death if the patient is actively dying. Several commenters wrote that if a patient requires a face-to-face visit at admission, it will likely result in a break in service until the physician can make the visit; one suggested this may lead to patient and family complaints. This commenter asked whether these complaints should be referred to CMS, since the commenter has no control over this legislative mandate, and added that denial of service is a serious issue, especially if the patient is near death.

Several commenters asked that we waive the face-to-face requirement for patients who, because of prior hospice enrollment, require a face-to-face encounter at admission, but whose death is imminent or who die within a week.
One commenter asked what would be required if a patient transferred near the end of the 2nd 90-day period (for example, at day 175), and the recertification was not completed. The commenter wondered how much time the receiving hospice would have to complete the face-to-face encounter. Another commenter asked if providers could rely on the previous hospice’s face-to-face encounter if the patient was being transferred from another hospice within 60 days of the last face-to-face encounter, and wondered how hospices would know when the last face-to-face encounter took place. A commenter suggested that the initial and comprehensive assessment be communicated to the Medical Director, to replace the need for a face-to-face encounter, when a patient would require one upon admission. When a visit is required upon admission, several commenters suggested timeframes after admission to allow the visit, including 2 days, 5 days, 15 days, and 21 days.

Response: During a time of crisis, the need to admit a patient and provide pain and symptom control is a priority. Since this is a new admission, whether the patient is coming from another provider type, from home, or is transferring from another hospice, we understand that the receiving hospice may not have up to 30 calendar days prior to the start of the benefit period to have a face-to-face encounter. However, the statute requires that the visit occur “prior to the 180th-day recertification and each subsequent recertification...” (emphasis added). We do not have the ability to waive a statutory requirement or to allow the initial and comprehensive assessments to replace the required encounter.

As noted previously, in a transfer the benefit period remains the same. When a patient in the 3rd or later benefit period transfers to a new hospice, the receiving hospice must recertify the patient; however, since the benefit period does not change with a transfer, the receiving hospice does not have to have a face-to-face encounter for that current period if it can verify that the previous hospice provided the visit. According to the hospice COPs at §418.104(e), the sending hospice must forward to the receiving hospice the patient’s clinical record, which includes the certifications and recertifications of terminal illness, if requested. The clinical record can be used to verify whether or not the sending hospice provided any required face-to-face encounters.

Our regulations describe recertification as a process. We currently allow 2 calendar days after a period begins for a hospice to provide either a written or a verbal certification or recertification. If a verbal certification is provided, the written certification, including the narrative, must be completed prior to filing the claim. Therefore, certification or recertification can occur at a point in time, but often occur over a period of time.

In response to the comment asking whether complaints should be referred to CMS, we note that hospices are free to refer complaints to us at CMS or to Congressional representatives. We welcome input, and would consider it when evaluating our policies given the constraints of the statute. We appreciate the
concerns that commenters have raised about providing a visit upon admission, particularly in rural areas. We will be examining this issue to see how it fits with the statutory and regulatory language. In the meantime, we will monitor the program for any unintended consequences.

Comment: A number of commenters requested flexibility in who could make the face-to-face visits, and asked us to clarify our interpretation of “hospice physician or NP”. One asked if there was a distinction between the physician as an employee (who received a W-2 from the hospice), a contract physician (who receives a Form 1099 from the hospice), or a volunteer. Others asked if certification in hospice and palliative care was required, or if full-time, part-time, or per diem status mattered. One commenter wrote that the proposal to require a “hospice physician or nurse practitioner” to perform the face-to-face encounter was materially different from the language in section 3132 of the Affordable Care Act. This commenter suggested that we take an approach consistent with the definition of “physician designee” in §418.3, and allow the patient’s primary care physician, specialist, hospitalist, hospice Medical Director, or other qualified physician to perform the visit, provided that physician is willing to certify eligibility for the benefit and communicate the encounter results to the hospice certifying physician.

Several commenters suggested allowing a Physician’s Assistant (PA) to perform the face-to-face encounter; a few noted that in rural areas, PAs are more common than NPs. Other commenters asked if a hospitalist could perform the visit. A third commenter wrote that if a physician can collaborate with a NP to make the visit, why not also with a registered nurse (RN). One commenter said that the requirement that a physician make the visit was an insult to both the RN case manager and to the patient, and suggested that the RN case manager is capable of making the visit. The commenter added that the proposed rule sends the message that an RN case manager is good enough when it merely involves a human being’s needs, but when it comes to reimbursement / money, a physician is required. Another commenter wrote that the Scope of Practice and Nurse Practice Acts for all Registered Nurses specifically allows for physical assessment and expects pathophysiology expertise. The commenter also added that RNs are as equally qualified as a NP to perform these assessments and report findings to the hospice Medical Director to establish eligibility.

Another commenter raised concerns about using a contracted physician to make the visit; this physician may be trained and may have reviewed the chart, but it would likely be the first time this doctor has seen the patient. The commenter wrote that based on the nurse’s notes, the patient has a steady decline, but if the physician sees the patient on a good day, the physician may not believe that the patient is eligible for hospice care, and may recommend discharge. The commenter believes and highly respects the qualifications of physicians, in this case the trained nurse, certified in
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hospice and palliative care, has been seeing the patient multiple times per week, and is a better judge of the patient’s eligibility. Several commenters asked if NPs could sign the certification or recertifications. A few commenters asked that we allow medical residents or fellows to provide the face-to-face visits if they are rotating through a hospice or in a setting where hospice patients reside. One commenter asked if hospices can contract with physicians to only provide the face-to-face encounters, and what employment requirements would those physicians need to meet. Another commenter asked if a hospice could have volunteer physicians make the visit or contract with another hospice, to have their physician or NP make the visit.

A few commenters recommended that a hospice be allowed to contract with a NP for the purpose of making required face-to-face visits, rather than requiring a W-2 employment relationship only. A commenter also asked that we clarify that NPs providing the face-to-face visit must meet Medicare’s general qualifications for a NP and must be licensed by the State in which they are practicing, but that they do not have to have a particular specialty certification or credentials in order to be considered a “hospice nurse practitioner” for purposes of providing the face-to-face visits. A few commenters asked if the NP must be the patient’s designated attending in order to make the required visit. One asked if hospices could contract with a NP even though the hospice did not have a contract with the physician supervising the NP. The commenter added that in her area, there were competing hospitals, which could create a conflict of interest if the hospice Medical Director was associated with one hospital and the contracted NP with a competing hospital. Another commenter asked that we clarify how supervision will work for contracted NPs whose role is to make the face-to-face visits.

Other commenters suggested that advanced practice nurses such as Clinical Nurse Specialists (CNS) could make the visit and that allowing them to do so would decrease the burden of the visits in areas where there are shortages of physicians or NPs, enabling them to meet the requirement. One noted that CNS can become certified in hospice and palliative care.

A number of commenters suggested allowing the patient’s attending physician to perform the required visits. These commenters noted that in many rural areas, the hospice physicians do not assume direct medical care of the hospice patients, but instead determine continued eligibility through review of clinical findings reported by the members of the IDG. The commenters wrote that the attending physicians are involved in these hospice patients’ care, have a history with the patient, and may be geographically closer to the patient. In advocating for allowing attending physicians to make these required visits, one commenter noted that because of historical knowledge and perspective, the attending physician’s medical opinion should be deemed relevant and critical to the delivery of hospice care, and indeed his or her signature is required on the initial certification. One commenter stated that the proposed
regulation fails to recognize the ongoing relationship between an attending physician and the patient, by excluding attending physicians from the encounter. Another wrote that attending physicians would make better use of resources and be more in line with the emphasis placed on attending physician involvement in the 2008 Medicare CoPs for hospices. A different commenter wrote that allowing the attending physician to make visits would be in keeping with Medicare’s Home model. A few asked if hospices could contract with the patient’s attending physician to make the visit, and if so, would the billing be through the hospice or through Part B. One suggested that such billing should flow through the hospice.

A commenter suggested that for hospice patients residing in a facility, the facility physician should be allowed to perform these face-to-face visits and report them to the physician who will sign the plan of care; the commenter added that this would promote coordination of care between the facility and hospice.

A few commenters noted that in some rural areas, the only available physicians are employed by Rural Health Clinics (RHCs) or Federally-Qualified Health Centers (FQHCs). Federal requirements applicable to both of these provider types create barriers to hospices wishing to work with them. One commenter stated that Medicare has recommended that RHC physicians treat hospice patients after business hours in a separate space other than the RHC, billing under Part B, which further inhibits health care provider accessibility. Another commenter asked for additional conversations with us to discuss this issue.

A commenter stated that if a “hospice physician” is interpreted to mean a doctor who is employed by or under contract with a hospice, or the patient’s attending physician, hospices will begin making contracts with doctors to pay a fee for eligibility certifications whenever the hospice staff physicians are unable to have the encounter. The commenter believed that the potential for abuse is obvious, with payment given for favorable eligibility determinations.

Response: The statutory language in the Affordable Care Act limits the disciplines of those who can provide a hospice face-to-face encounter to a hospice physician or NP. A few commenters asked why RNs could not meet the requirement, particularly since they are involved in the patient’s ongoing care. This statutory provision was based upon a recommendation made by MedPAC. In its 2009 Report to Congress, MedPAC reported that a panel of hospice experts agreed that more physician accountability was needed in the certification and recertification process. They wrote that the panel discussed a tension that can exist between the physician and non-physician hospice staff which can lead to inappropriate recertification in some cases. MedPAC’s panelists believed that physicians sometimes deferred too much authority for making eligibility decisions to nonphysician staff. They added that by virtue of their day-to-day contact with patients, these staff members may form emotional attachments with patients that can color their view and their charting of a patient’s continued eligibility for hospice.
A commenter was concerned about a scenario where a contracted physician who is unfamiliar with the patient might see the patient on a day when the patient is doing well, clinically, and thus recommend for discharge when the patient is in fact eligible. The determination of eligibility involves considering the terminal illness, related conditions, co-morbidities, functional status, clinical indicators, laboratory results, etc. We believe the potential for a truly eligible terminally ill patient being found ineligible because he or she was doing well clinically, on the day of the encounter, is unlikely. Even so, the decision to discharge the patient is not made simply by the contracted physician, but involves the members of the IDG and the patient’s attending physician. Hospices should already have policies and procedures in place for handling a situation where there is disagreement about continuing eligibility.

PAs and CNSs are not authorized by the Affordable Care Act to perform the face-to-face visit. Moreover, section 1814(a)(7) of the Act explicitly prohibits NPs from certifying or recertifying hospice patients, and limits this function to physicians only. Therefore, we cannot adopt a policy to allow NPs to certify or recertify patients without change in the statute.

Hospices cannot routinely contract with NPs, because NPs fall under nursing, which is a core service. The only situations under which a hospice could contract with a NP would be under extraordinary circumstances or if the NP service is highly specialized. Extraordinary circumstances generally would be a short-term temporary event that was unanticipated, and would not include face-to-face encounters, which are administrative in nature and which are usually planned. Examples of allowable extraordinary circumstances might include, but are not limited to, unanticipated periods of high patient loads (such as an unexpectedly large number of patients requiring continuous care simultaneously), staffing shortages due to illness, receiving patients evacuated from a disaster such as a hurricane or a wildfire, or temporary travel of a patient outside the hospice’s service area. Hospices may qualify for an “extraordinary circumstance” exemption when they believe that the nursing shortage has affected their ability to directly hire sufficient numbers of nurses. For details on this waiver, please see the letter from CMS’ Survey and Certification group found at http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter10_31.pdf.
Hospices can employ NPs on a full-time, part-time, or per diem basis if needed to have face-to-face encounters. As long as the NP is receiving a W-2 form from the hospice, or is volunteering for the hospice, the NP is considered to be employed by the hospice.

Commenters asked about other physicians who could be considered “hospice physicians” who could be used to meet the face-to-face requirement, including attending physicians. We believe that to be a “hospice physician”, a physician must be either employed by or working under arrangement with a hospice (i.e., contracted). Section 418.3 defines a hospice employee as someone who is receiving a W-2 form from the hospice or who is a volunteer. We agree with commenters that the attending physician has had a history with the patient, has signed the initial certification, and has typically remained involved in the patient’s care while the patient is under the hospice benefit. We do not wish to diminish this physician’s role; however, the regulations have considered services of attending physicians to be outside of the hospice benefit (which is one reason why their services are billed to Part B rather than through the hospice to Part A), and therefore we cannot include the attending physician as a “hospice physician.” By limiting “hospice physician” to those physicians who are employed by or working under contract with a hospice, we also increase accountability, as the hospice is in control over its employees and contracted physicians, but not over an outside attending physician who might have the encounter. Furthermore, as part of the effort to increase accountability, we are clarifying that the hospice physician who has the face-to-face encounter must be the same physician who is composing the narrative and signing the certification. Given that the hospice is ultimately responsible for the certification, part of which is the face-to-face attestation, the hospice needs control over the timing of the staff visit, and over the preparation and review of visit documentation, which is used for the narrative and to inform the decision whether to recertify or not.

Other commenters suggested that non-hospice physicians other than attending physicians should be able to make the visit (for example, hospitalists, specialists, primary care physicians, etc.). In addition to not meeting the statutory criteria of being a “hospice physician,” we agree with the commenter who wrote that allowing physicians who are not involved with the patient’s overall care to have the visit could lead to abuse, where an unscrupulous doctor might continue to support eligibility of ineligible patients for a fee. Additionally, we do not believe that allowing any physician to have the required face-to-face encounter would be appropriate because determining eligibility for hospice care requires knowledge of the patient’s complete medical situation, including the terminal illness, related conditions, and other co-morbidities. Medical residents or fellows who are rotating through a hospice may provide the required face-to-face encounter if they are employed by the hospice or are working under contract with the hospice, and if they will be composing the narrative and signing the recertification.
Physicians or NPs who volunteer for a hospice are considered employees, and could make the required visits. No payment is made for physician or NP services furnished voluntarily. However, some physicians and NPs may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if the hospice is obligated to pay the physician or NP for the services.

We allow hospices to contract with another hospice to serve their patients, and would allow a hospice to arrange with another hospice to use its physicians to have the required face-to-face encounter. Likewise, hospices can contract with physicians for the purpose of having face-to-face encounters with their patients, but as previously noted, the contracted physician must then be the same physician who composes the narrative and signs the certification. Hospice physicians and NPs can be full-time, part-time, or work on a per diem. Hospice physicians and NPs are not required to have certification in hospice and palliative care.

NPs providing the face-to-face visit must meet Medicare’s general qualifications for a NP and must be licensed as NPs by the State in which they are practicing. Physicians must meet the existing requirements for physicians in section 1861(r) of the Act. They must meet all State and local requirements as required in §418.116. Finally, they must meet the licensed professional requirements at §418.62.

If physicians employed by RHCs or FQHCs are also employed by or working under arrangement with a hospice, they could have the required face-to-face encounter, however they must follow statutory and regulatory requirements in doing so.

In summary, we are defining “hospice physician” as a physician employed by the hospice or working under arrangement with, or under contract with, the hospice. A hospice NP would be a NP employed by the hospice.

Comment: Several commenters asked if the encounter could be done using telephone or video technology, and still meet regulatory requirements. A few suggested that a nurse could be present to do the physical examination under the direct supervision of the physician, who could still see the patient and interact with him or her. Commenters suggested such an approach would be less burdensome and less costly, accomplish the same objectives, and open the door for critical but cost effective physician care to under-served or rural areas. Commenters were concerned about lack of human resources to accomplish the visit, particularly in rural areas, where driving distances can be great, increasing the cost of visits, and where there can be shortages of physicians or NPs. A commenter wrote that allowing telehealth would be consistent with the objectives of health care reform, and would offset travel time and travel costs. A few commenters noted that if telehealth were available, it would not help them due to lack of proper communication infrastructure in some remote areas; others noted that they would be willing to invest in telehealth to counterbalance the cost of sending a physician on home visits.
Response: We appreciate the commenters’ concerns about meeting the face-to-face requirements in rural areas, and their suggestions to consider telehealth. However, section 1834(m) of the Act does not include hospices as an originating site for telehealth. Therefore, hospice patients would have to go to an originating site for the face-to-face encounter. In our analysis of claims data, we found that only 2.9 percent of patients who would require a face-to-face encounter are in rural areas. Given this small volume of patients, we believe that not having telehealth does not hamper hospices’ ability to meet the Affordable Care Act requirements; however, we will continue to monitor this for any unintended consequences.

Comment: A commenter wrote that in her hospice, the Medical Director would perform the face-to-face encounter and write the physician narrative. This commenter and others asked if the narrative and the face-to-face attestation could be combined; one asked if the visit note could serve in place of the narrative when the attending performs both functions. Several commenters suggested the face-to-face requirements were partially duplicative of the narrative. One notes that physicians are used to judging a patient’s condition based on records. Other commenters asked for clarification of the differences between the face-to-face attestation and the physician narrative, and about the format, wording, and location of the attestation, and about how notes for the face-to-face encounter should be entered in the chart; a few asked for consistent guidelines for the narrative and the face-to-face Attestation. One commenter asked if the same physician is responsible for both the visit and the narrative, could the recertification visit documentation form be combined with the recertification of terminal illness brief narrative form with both attestations so that the physician does not have to dictate two separate notes and sign two separate forms.

A few commenters asked if the certification narrative and the face-to-face may be performed by more than one individual, or if hospice physicians could cover for each other. A commenter asked why a NP would provide an attestation of the face-to-face in addition to the physician. One commenter wrote that the face-to-face attestation should be a separate and distinct section of the narrative, and that providers should use an addendum form for the face-to-face attestation if the NP or a different physician from the certifying physician has the encounter. Another commenter asked if the NP could prepare the narrative and have the physician sign off on it. A few asked if electronic signatures were permitted for the attestation, narrative, and/or certification or if the face-to-face attestation could be dictated. One asked if a medically necessary visit is made within the same timeframe (proposed at 15 days), could the visit documentation serve as the narrative requirement, or would a separate narrative note be necessary. This commenter also asked whether it was a problem if the date of the visit did not coincide with the date of the attestation.
A commenter asked that the attestation also include the National Provider Identifier (NPI) of the physician or NP making the visit, to increase accountability. Another commenter asked us to clarify what goes directly above the certification signature – the narrative or the face-to-face attestation. Other commenters asked that the narrative attestation be placed above the physician’s signature attesting that he/she composed the narrative based on his/her review of the medical record, or, if applicable, his or her examination of the patient. Another commenter asked for guidance regarding the validity of the narrative if a clerical mistake is made in recording benefit period dates or certification dates. This same commenter noted that if his hospice uses contracted physicians or NPs to make the required face-to-face visits, these practitioners will be less familiar with the patient’s history and disease progression, and stated that the narrative has the potential to be more informative about the patient’s eligibility than the visit.

Another commenter asked if separate documentation would be required for any billable services provided during the visit, or could the narrative serve as the documentation. This commenter also asked what the documentation requirements for this visit would be. Several asked if there would need to be separate notes for the face-to-face encounter versus any billable portion of the visit.

A commenter wrote that attesting that an encounter has occurred and that documentation has been relayed does not confirm that the information was utilized in confirming eligibility. This commenter believes that the responsibility for verifying that all eligibility requirements have been met should remain with the certifying physician and be included in a single attestation.

A few commenters wrote that the additional attestation required for the face-to-face encounter creates an additional paperwork burden, and creates issues with forms, transcribing, timely documentation, and software updates. One commenter wrote that the final implementation date should be delayed to allow time for providers to update electronic and paper forms. A different commenter believed that it was burdensome, redundant, and unnecessary to require a physician or NP to attest in writing to having had a face-to-face encounter, and reiterated that the responsibility for verifying that the patient meets all eligibility criteria should remain with the physician and be included in a single attestation.

Response: The face-to-face requirement was added to the requirements for physician recertifications. Those requirements are described in detail in our regulations at §418.22. In brief, currently hospices provide a signed certification or recertification which:

- States that the patient is terminally ill, with a prognosis of 6 months or less if the illness runs its normal course;
- Includes a written narrative either immediately prior to the physician’s signature, or as a signed addendum. The narrative includes a statement under the
physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his or her examination of the patient; and,

- Is accompanied by clinical information or other documentation supporting the diagnosis.

The Affordable Care Act added a fourth component to the certification, with the face-to-face encounter and its attestation that the visit occurred. We proposed that the face-to-face attestation and signature be either a separate and distinct area on the recertification form, or a separate and distinct addendum to the recertification form, that is easily identifiable and clearly titled. We also proposed that the attestation language be located directly above the physician or NP attestation signature and date line.

Like the physician narrative, the face-to-face requirement is designed to increase physician accountability in the certification process, and to ensure that beneficiaries are eligible for the hospice benefit. While the purposes of the narrative and the face-to-face visit are similar, we do not believe that the two are duplicative of each other. There is value in having a physician see a patient, rather than just reviewing medical records about that patient, in determining continued eligibility.

The face-to-face attestation is a statement from the certifying physician or the NP which attests that he or she had a face-to-face encounter with the patient; if a NP had the encounter, the attestation should also state that the clinical findings of that encounter have been provided to the certifying physician for use in determining continued eligibility for hospice care. Unlike the narrative, the face-to-face attestation does not detail the clinical findings of the visit, but simply attests that the visit occurred.

The regulations describing the narrative require that it be composed by the certifying physician, therefore a NP could not prepare it. We agree with the commenter who suggested that including the NPI of the individual who visited the patient increases accountability and we will consider including the NPI the face-to-face attestation in the future. We do not want to prescribe language that hospices should use in preparing the face-to-face attestation, provided the attestation includes the elements we have described.

The face-to-face attestation statement includes the date of the visit, and the signature of the physician or NP who made the visit, along with the date signed.

The date of the face-to-face encounter does not have to match the date that the attestation was signed; however, both dates should be included.

Several commenters asked if the narrative could be combined with the face-to-face attestation. The face-to-face encounter can be conducted by either a hospice physician who completes the certification, or a NP, and the face-to-face attestation must be signed by the person who conducted the visit. The narrative must be composed by the certifying physician, who by signing, attests that he or she composed it based on his or her review of the medical records and on examination of the patient.
We are clarifying that if a physician is the clinician who has the face-to-face encounter, then the same physician should compose the narrative and sign the recertification.

The hospice has the option of putting both the face-to-face attestation and the narrative, with its accompanying attestation and signature, on the same page of the recertification. We would require that the format be such that the face-to-face attestation appears separate and distinct from the narrative and its attestation; hospices are free to decide how to separate the sections (that is, through spacing, through lines, etc.). We agree that for consistency, the narrative and its accompanying attestation should be above the physician’s signature, and the face-to-face attestation should be above its accompanying signature, and are changing the regulatory text to reflect this. If the narrative and its attestation and the face-to-face attestation are included as part of the certification (rather than as an addendum), we suggest, but do not require, the order of the content to appear as follows: the face-to-face attestation (if applicable), followed by the physician narrative, followed by a narrative attestation, followed by the physician signature. We believe this order is logical as it allows the narrative attestation signature to be the same as the certification or recertification signature for those hospices which include the face-to-face attestation and narrative as part of the main certification document.

Hospices also have the option of placing the face-to-face attestation, the physician’s or NP’s signature, the narrative, and its attestation and signature, on a single page as an addendum to the main certification or recertification. They may also have the face-to-face attestation and narrative on separate pages as addenda to the certification and recertification documents. Finally, hospices may also include either the face-to-face attestation or the narrative in the main certification document, and have the other as an addendum. We are seeking to give hospices greater flexibility in how they include this information as part of their recertifications.

In summary, the narrative and face-to-face attestation may be included in the main certification document, but should be separate sections. They may also be on a single page as part of the main certification or recertification document, or as an addendum. The face-to-face attestation is completed by the person who visited the patient: either a hospice physician or a NP. If a NP saw the patient and completed the face-to-face attestation, the physician should not also complete the face-to-face attestation, because the physician did not make the visit. However, a certifying physician would still have to compose the narrative, using clinical findings from any face-to-face visit, and sign the narrative attestation.

We agree that attesting that an encounter has occurred and that documentation has been relayed does not confirm that the information was utilized in confirming eligibility. That is why we require hospice physicians to use the information from the face-to-face encounter in composing the narrative. We cannot combine the
narrative and the face-to-face attestations into a single attestation because the statute allows NPs to perform face-to-face visits, but NPs cannot compose or sign the narrative. The face-to-face encounter must be documented in accordance with hospice policy using currently accepted standards of practice. The documentation from the face-to-face encounter is part of the clinical record, and should be used in composing the written narrative. It is not necessary for the physician or NP to make separate notes for any billable services provided, as long as the visit documentation clearly supports any billable services that were provided. Visit notes are not a substitute for a physician narrative, which is a brief explanation of the clinical findings that supports continuing eligibility for the hospice benefit; the narrative draws on information from a variety of sources, and not just from notes of any face-to-face encounter which occurs.

While the mandated face-to-face attestation does create additional paperwork for hospices, we believe that we have provided sufficient flexibility for providers to meet the requirement. We appreciate hospices’ concerns about required software changes and the timing required to make those changes. As noted earlier and again later in this final rule, our timeframe was driven by the required implementation date set by the Affordable Care Act, which was enacted in late March 2010. The statute requires implementation as of January 1, 2011; thus, it does not provide flexibility with respect to the date of implementation.

Electronic signatures are permitted on hospice certifications and recertifications; the narrative and the face-to-face attestation are parts of the certification or recertification, and therefore may also be signed electronically. If a physician forgets to date the certification, our longstanding policy described in our benefit policy manual in section 20.1 (Internet only manual 100-02, chapter 9) states, “If the physician forgets to date the certification, a notarized statement or some other acceptable documentation can be obtained to verify when the certification was obtained.” The certification or recertification applies to the benefit period dates noted on the document, therefore, if those dates are recorded incorrectly, the hospice could potentially have days of service denied for coverage during a medical review.

**Comment:** A few commenters asked how the recertification visits relate to the local coverage determinations (LCDs). One commenter wrote that her hospice already completes guidelines from the LCDs for recertification, but much of this information requires prior knowledge of the patient condition to determine deterioration. The commenter noted that if the expectation is that the physician will be verifying the patient’s condition based on the LCDs, this should be clear. The commenter was concerned about the situation where a physician or NP visits the patient, documents clear and valid reasons for recertification, but subsequent review determines the patient is not eligible based simply on lack of certain measures of decline. A few commenters asked us to provide clear guidance on what the face-to-face encounter
should include (that is, elements that make up an encounter) for purposes of satisfying the requirement.

One commenter asked how a hospice should handle a situation where the physician determines the patient is no longer hospice eligible and discharges him, but the Quality Improvement Organization (QIO) finds the patient is hospice appropriate. The commenter wrote that it could not admit the patient in good conscience and asked for guidance.

Another commenter stated that he hoped that CMS is funding research to improve LCDs, saying that there is no formula for predicting “six months or less”, especially for non-cancer diagnoses.

Response: In general, the face-to-face encounter for recertification requires that the same clinical standards be met as for the initial certification. The face-to-face encounter enables the clinician to assess the signs and symptoms in relation to the patient's terminal illness to determine whether the patient meets the clinical standards for recertification. When assessing the patient for hospice recertification, the medical records in addition to the face-to-face examination are utilized to provide a rationale for recertification. The clinical findings should include evidence from the three following categories:

1. Decline in clinical status guidelines (for example, decline in systolic blood pressure to below 90 or progressive postural hypotension);
2. Non disease-specific base guidelines (that is, decline in functional status) as demonstrated by Karnofsky Performance Status or Palliative Performance Score and dependence in two or more activities of daily living; and
3. Co-morbidities.

For more information about the criteria, please see local coverage determinations (L13653, L25678, or L29881). These LCDs are on the CMS Web site in the Medicare Coverage Database at http://www.cms.gov/mcd/overview.asp. They are also on the local contractors' web pages.

Predicting life expectancy is not an exact science. We are not currently funding research related to LCDs; research that could inform LCDs is completed through a number of venues, including academic institutions, the private sector, and some government agencies. In determining life expectancy for conditions with less predictable trajectories, hospice physicians are also free to use any disease-specific scores or scales that can help them in predicting life expectancy. Some providers already do so, and have reported that it improves the accuracy of their prognoses.

If a patient improves or stabilizes sufficiently over time while in hospice, such that he/she no longer has a prognosis of 6 months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit. Such patients can be reenrolled for a new benefit period when a decline in their clinical status is such that their life
expectancy is again 6 months or less. Conversely, patients in the terminal stage of their illness, who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than 6 months, remain eligible for hospice care.

A patient’s condition may temporarily improve with hospice care. When improvement is evident in documentation such as physician orders, medications, hospital records, doctor’s records, other health records, test reports, etc, contractors consider the length-of-stay and the length of sustained improvement.

There should be clear evidence of the status of the patient’s conditions and the clinical factors that caused the patient to be not eligible or to be recertified as terminally ill. If the patient is recertified, the medical records should reflect the length of time the symptoms have been evident, evidence of progressive deterioration or sudden deterioration, and increase in frequency and intensity of hospice services and medications.

If a patient appeals a pending discharge to the QIO, the QIO decision is binding; a hospice could not discharge a patient as ineligible if the QIO deems that patient to be eligible. The provider is required to continue to provide services for the patient. In the QIO response, the QIO should advise the provider as to why it disagrees with the hospice, which should help the provider to re-evaluate the discharge decision. If at another point in time the hospice believes that the patient is no longer hospice eligible, the provider should give timely notice to the patient of its decision to discharge. The patient could again appeal to the QIO, and the hospice and patient would await a new determination from the QIO based on the situation at that time.

Comment: A number of commenters were concerned that the required face-to-face encounter would create access problems for patients, would delay care and thereby lead to unnecessary patient suffering, or would reduce the quality of patient care. One commenter wrote that doctors may be less willing to refer patients to hospice if required to have these encounters, while others were concerned that patients would be discharged; several suggested that the face-to-face requirement could lead to overall Medicare costs increasing as these patients use emergency rooms and inpatient services at end-of-life rather than hospice. Several commenters were concerned that those who were actively dying would have care delayed if they required a visit upon admission due to previous hospice stays, as the hospice may have to wait to get a hospice physician or NP to see the patient.

Some commenters wrote that access to hospice services may be limited for patients who live in outlying areas, because of the travel time required to make the visits. Another commenter wrote that lack of transport to bring rural patients to a physician would lead to denying access to care for many elderly or bedbound patients unable to have a timely face-to-face visit. A few commenters suggested they may have to reduce their service areas to meet the requirement, which would jeopardize
access to hospice services for beneficiaries in outlying areas. Another commenter believed that with staff shortages, meeting the face-to-face requirement would require the hospice to pull practitioners from patients who need the care and expertise of a physician or a NP to make required visits. The commenter believed this would reduce services and lower the quality of care that patients receive. A few commenters wrote that the requirement could lead to patient discharge, with one noting that the subsequent hospice would then have to incur the cost of the required visit. One commenter wrote that discharging patients could lead to ethical dilemmas or charges of patient abandonment. A few commenters suggested that the result of this mandate would be increased cost to the health care system if long-stay patients are discharged from hospice care.

One commenter asked what options would be available to a hospice, or to the patients, if agencies in medically underserved areas are unable to locate physicians or NPs who are able and willing to make the required face-to-face visits. A few commenters said that volunteer Medical Directors used by rural providers cannot make these visits, which would force the hospice to discharge patients. Another commenter said that with the maturation of the baby boomer generation, demand for hospice services would be rising, at the same time that fewer qualified physicians are pursuing careers in gerontology or palliative care, and believes that this would intensify the current situation. Another commenter wrote that it is in his agency’s best interest to have physicians certified in hospice and palliative care to make the visits, but that recent requirements for an internship mean these physicians will be in shorter supply, and therefore, more costly to hospices.

A few commenters were concerned that hospice programs may not be able to manage this burden, and their closure would affect vitally important access to hospice services. One wrote that the data collected by the Community Hospice Partnership, a national coalition researching the economic sustainability of not-for-profit hospices, estimates that the cumulative reductions in reimbursement would lead to closure of 65 percent of Wisconsin’s rural hospices by 2014. The commenter added that this proposed face-to-face requirement was not considered in the analysis, meaning rural Wisconsin providers would be more severely affected.

Response: We appreciate the commenters’ concern about the timeliness and quality of patient care and about patient access to hospice services. We believe that this provision was included in the Affordable Care Act to ensure the continued eligibility of hospice patients, who are supposed to have a life expectancy of 6 months or less. MedPAC, the OIG, and CMS have concerns about the appropriateness of some long-stay patients, who may have been admitted to hospice care too early in the course of their illness. The hospice face-to-face encounter is only required for recertifications when the patient is in the 3rd benefit period or beyond, which is after 6 months of hospice care for those who complete each benefit period. As mentioned previously,
we found that only 2.9 percent of all Medicare hospice beneficiaries were in the 3rd or later benefit period and in rural areas, where physician or NP shortages are greatest. Therefore, only a small percentage of all Medicare hospice patients will both require these encounters and will be in a rural area where physician is more of a concern.

With that perspective, we believe that physicians will not hesitate to refer appropriate patients to hospice. We clarify, for the commenter, that it is the responsibility of the hospice to ensure that the face-to-face encounter occurs. We do not allow outside attending physicians to have the face-to-face encounter, and the hospice is responsible for either providing the encounter itself or for arranging for the encounter. Therefore, we do not believe that physicians will reduce referrals inappropriately, leading to unnecessary suffering and increased Medicare costs for patients at end-of-life. As noted in a previous comment, a patient may require a visit at admission and be actively dying. In this situation, a hospice physician or NP might see the patient anyway, given the circumstances cited; hospices are supposed to provide physician services to their patients when needed during a time of crisis. Our data suggest that only 1.1 percent of hospice beneficiaries live in rural areas and require a face-to-face encounter at admission. Therefore, we believe this is an infrequent situation, which will not lead to delays in care or in the admission of the patient.

While we appreciate the additional training and experience of those physicians who specialize in gerontology or in palliative care, we do not require a hospice physician or NP to be certified in those specialties. Volunteer physicians are considered hospice employees, and are permitted to have face-to-face encounters with patients. As previously noted, we also are allowing hospices to bill for any medically reasonable and necessary patient care provided by a hospice physician, or by a hospice NP who is also the patient’s attending physician, in the course of a face-to-face visit. Therefore, hospices will receive some financial relief for the costs of having these required visits, and should not experience the financial burden some commenters described.

As noted previously, we have also doubled the time allowed for making a required visit to 30 calendar days prior to the recertification date to better enable hospices to meet this requirement. Given the additional time for having face-to-face encounters, we do not believe that hospices will need to discharge patients due to lack of time to complete the face-to-face encounters, which could result in increases in non-hospice healthcare costs or which may raise ethical issues. Similarly, if a hospice physician or attending NP cannot travel to the patient for the required visit due to distance, time, or other reasons, and the hospice is encountering a shortage of physicians or NPs such that it cannot find any to hire or any physicians to contract with, the hospice can have the patient come to the physician or NP for the face-to-face encounter, provided the hospice meets the requirements in the CoPs regarding patient safety and comfort. Having the patient come to the physician or NP, when appropriate, can also be considered if a hospice is concerned that using its staff to make required face-to-face visits would reduce services or lead to lower quality patient
care. We believe that requiring a face-to-face encounter with a hospice physician or nurse practitioner will lead to increased quality of care for hospice patients, rather than decreasing quality of care.

We are unable to comment on the data collected by the Community Hospice Partnership, or their findings, as we do not have those data, the study methods, or findings, however, the reimbursement allowed to hospices for providing reasonable and necessary patient care in the course of a required face-to-face encounter should provide financial relief to providers.

**Comment:** Several comments suggested alternative approaches to the face-to-face encounter to ensure continued hospice eligibility. One commenter suggested that hospices can better manage their patients by performing an automatic chart review for long-stay patients, and include better prognostication information on their recertifications. This commenter also wrote that her hospice is researching using validated prognostication tools which are disease specific, and which can be done by a RN just as effectively as by a physician. A different commenter wrote that his hospice uses a detailed review process for patients not showing decline, and is therefore already performing what the proposed rule is trying to accomplish. This commenter suggested that we initially enforce the face-to-face requirements for all hospices but allow those providers that have a lower rate of long-stay patients to “opt out” in the future. The commenter believes this would force hospices to focus on admission practices and not place an undue burden on responsible providers. Another commenter wrote that his hospice’s Discharge Management process is redundant in relation to the face-to-face requirement, and asked that we eliminate it. Another suggested that we require a separate comprehensive assessment for long-stay patients.

One commenter wrote that it seemed like her hospice was being punished because a lack of Federal oversight has allowed some hospice programs to go astray. Several commenters understand the need to combat fraud and abuse; one also suggested that uncontrolled growth in the number of providers, vulnerabilities in the payment systems, and a diminished commitment to integrity by some newer providers was at the core of the problem, and led to ill-conceived regulatory changes. These commenters suggested that better enforcement of existing regulations, closer inspection of documentation through ADRs/medical review, review by recovery audit contractors, comprehensive error rate testing audits, Medicaid program integrity audits, zone program integrity audits, OIG investigations, more frequent surveys, and/or other interagency efforts to combat Medicare fraud would be a better approach. One commenter suggested that if we are concerned about the growth of hospice, we should implement a moratorium on new hospice providers for 5 years, where no new hospices could enter a market unless an existing hospice in that same area closes. A few commenters wrote that they believe the cap reimbursement mechanism is the best
control of utilization rather than “Monday morning quarterbacking prognosis” or seeking confirmation of prognosis by a visit by a physician or other practitioner.

A few suggested we delay or suspend implementation (often suggesting a delay until January or February 2012), or eliminate the requirement altogether. One commenter asked that if we decide to delay implementation, we notify the industry immediately, rather than waiting for publication of the final rule, so that hospices could effectively plan their staffing and hiring. Another noted that hospices have not been allowed adequate time in practice to determine the increased level of physician involvement to meet this requirement. One wrote that we should eliminate the face-to-face visit prior to readmission, if the two physicians agree to the certification of terminal illness. Another commenter suggested we only require a face-to-face encounter if the Medical Director has not made a visit within the recertification period for other medical issues.

Several suggested that we only require the face-to-face for hospices that have a higher than average length of stay, or that we apply the requirement to patients with stays greater than 240 days. Other commenters suggested we waive the requirement for hospices that tend not to enroll very long-stay patients, or for small and rural hospices with less than a 25-50 person daily census, or for all rural hospices. Another commenter suggested we exempt patients and providers in Health Professional Shortage Areas from the requirement. One commenter suggested that we only apply this mandate to continuous service greater than 180 days with no break in service. A few suggested we require the visit at 180-days but only at every other or every third recertification thereafter, or every 180 days thereafter; another suggested we not require the visit at the benefit periods after 180 days until the total effects of the mandate have been evaluated. Some suggested a phased or stepped approach to implementation, such as applying it to hospices with a high proportion of long-stay patients first. Another suggested 100 percent review of patient stays over 180 days in providers with an unusually high percentage of “long-stay” patients. This commenter wrote that this would be a welcome edit targeted at problem providers.

The same commenter also suggested that the face-to-face encounter be crafted around the provider and not the patient, with the encounter required prior to the 180th day of care within a provider, rather than over the patient’s entire hospice history, with subsequent visits required again at each 180-day interval within that provider. This commenter suggested that if the patient transfers or is later admitted to another hospice, the 180 day count would start over. To avoid having unscrupulous providers that own other provider numbers in the same geographic area make patient transfers designed to dodge the visit requirement, the commenter suggested we could have a 100 percent review of long stay providers, using an edit of chain-related providers.
Another commenter suggested that if there was greater than a 3 or 6-month hiatus between hospice admissions, the mandate should not apply to the total hospice stay, but instead would start with the subsequent hospice admission.

Other commenters suggested that the hospice Medical Director could meet the requirement with a phone consultation with the patient while a hospice nurse was seeing the patient, at the time of the recertification visit. Another commenter believes that since the patient is reviewed by the hospice team at least every 14 days, a physician is already certifying his/her belief that the patient is indeed eligible. Others wrote that hospice nurses are trained in recognizing and documenting the appropriateness of patients, and are familiar with the patients’ history. These commenters stated the requirement was an unnecessary burden on hospices since nurses are adequately handling this now, and could communicate with the physician regarding the continued need for care and recertification.

Some commenters were concerned that the impact of the narrative requirement from the August 6, 2009 FY 2010 hospice wage index final rule (74 FR 39384) was not yet known, and were concerned about the effect of the face-to-face requirement on rural providers. One suggested we conduct studies first to determine the effectiveness of the narrative before requiring the face-to-face encounter. Others suggested that we waive the requirement in areas of documented physician shortages, and others suggested that we waive the requirement for patients that require a face-to-face encounter at admission and who die within a week or who are imminently terminal.

Response: We agree with the commenter who suggested that providers can improve their patient management by performing automatic chart reviews or other review processes for long-stay patients. We also encourage hospices to consider using validated prognostication tools, when available, to inform the larger process of estimating life expectancy.

We agree that preventing fraud and abuse is important; Medicare and other agencies continue in their efforts to identify providers who are abusing the hospice benefit. We also agree that the hospice aggregate cap is an effective means of controlling inappropriate utilization. We believe that while both fraud and abuse prevention and the aggregate cap are helpful in preventing inappropriately long stays, they are not the only means to do so. The face-to-face requirement should reduce inappropriately long stays as physician accountability in the recertification process increases. In the effort to prevent fraud and abuse, the aggregate cap and the face-to-face encounter are complementary approaches to dealing with abuses in the hospice benefit.

A few commenters suggested targeted medical reviews, and the Affordable Care Act also requires medical reviews of certain long-stay cases.
State governments, not the Federal government, control whether to place a moratorium on new providers, so that comment is outside of our purview.

In its 2009 Report to Congress, MedPAC reported that a panel of hospice experts agreed that more physician accountability was needed in the certification and recertification process (Medicare Payment Advisory Commission, Report to Congress: Medicare Payment Policy, Chapter 6, March 2009, pg 365, available at http://www.medpac.gov/documents/Mar09_EntireReport.pdf). The panelists’ comments were part of the impetus for MedPAC’s recommending the face-to-face encounter that the Congress enacted in the Affordable Care Act. Requiring another comprehensive assessment for long-stay patients would shift the burden of gathering information to ensure eligibility from physicians back to RNs and other staff, which would defeat the purpose of the MedPAC recommendation and would not follow the statutory language. Allowing a physician to speak by phone with the nurse while he or she is present with the patient is not a face-to-face encounter as required by the law.

Section 3132 (b)(2) states that the face-to-face encounter is effective beginning on January 1, 2011. The statute is clear and we have no discretion to delay, phase-in, or suspend implementation, regardless of the type of hospice (e.g., rural, those with small censuses, those in areas of physician shortages) or for any other reason (other than a change in law). Nor can we apply the mandate to select situations, such as to patients with more than 180 days of continuous service, to patients who haven’t seen the medical director for another reason within the recertification period. We also cannot allow some providers to “opt-out” of the requirement after a period of time, nor can we limit the requirement to those hospices with a higher percentage of long-stay patients, or to those patients where two physicians agree to the recertification. We cannot craft the timeframe for the face-to-face encounter around the provider, as the statutory language is explicit in requiring it at certain benefit periods. Benefit periods are counted based upon a patient’s total Medicare hospice history, rather than a patient’s hospice history with a given provider. We cannot deviate from the statutory language which specifies when the face-to-face encounter must occur (“prior to the 180th-day recertification and each subsequent recertification”). We will continue to monitor the data for any unintended consequences from the physician narrative or from the hospice face-to-face requirement.

Comment: A few commenters asked if hospices would be expected to perform a face-to-face encounter in December 2010 for patients who will require a face-to-face encounter during January 2011. One asked that we “grandfather” in patients whose recertification would require a face-to-face visit in January 2011. Others asked that the requirement only be effective for patients admitted to hospice on or after January 1, 2011 rather than including patients who were admitted prior to January 1, 2011, and whose stays crossed into 2011. One commenter wrote that this would allow
hospices to marshal the necessary personnel and training resources, to create systems, and to minimize disruption in patient care.

**Response:** In implementing the hospice face-to-face requirement, we must follow the relevant statutory language in the Affordable Care Act, which says, “a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification…”.

The language does not require hospices to have a face-to-face encounter with existing patients who entered the 3rd or later benefit period in 2010, and were recertified in 2010. It does require that patients who enter the 3rd or later benefit period in 2011 have the face-to-face encounter; the statutory language does not give us flexibility to “grandfather” in existing patients. We also believe that by extending the timeframe for the face-to-face encounter from 15 to 30 calendar days, hospices will have the flexibility to meet this requirement for patients who will enter the 3rd or later benefit periods in 2011.

**Comment:** A commenter stated that she is not aware of any data indicating that a physician who sees a patient in a face-to-face encounter once in a 6-month period is better able to prognosticate than a skilled hospice nurse who has seen the patient serially over a 6-month timeframe. The commenter added that unless the physician’s one time face-to-face assessment results in a more accurate prognosis, this requirement is of very questionable value in the efforts to improve the process. Another commenter wrote that the additional burden from the visit does not support a face-to-face encounter; one wrote that those who provide care ethically and in compliance with regulations would have an additional paperwork burden, but this will not effectively eliminate the unethical providers. Another commenter wrote that it would be extremely cumbersome to develop processes in-house with electronic records and software to meet the face-to-face requirements. One commenter wrote that the proposal goes beyond the mandates of the Affordable Care Act in proposing additional layers of payment cuts on top of the disproportionate cuts already scheduled for hospice. Another commenter said that it is not always feasible, practical, or efficient to require face-to-face encounters as proposed. A commenter believed that the attestation and narrative requirement already created a burden greater than the benefit for physicians, patients, and agencies, and that this additional face-to-face requirement would serve as a further barrier to care in areas where patients are already underserved, an economic hardship for small nonprofit providers, and would ultimately result in decreased quality of care for patients and increased costs to Medicare through unnecessary testing, procedures, hospitalizations, and readmissions. A commenter wrote that this face-to-face encounter requirement would lead to decreased utilization of hospice services, decreases lengths of stay if hospices...
discharge patients too soon, which may diminish the purpose of hospice and mute its services. Other commenters wrote that requiring a face-to-face visit by a physician or NP adds a layer of complexity not only to the hospice, but also to the patient’s routine, due to travel, location, and additional paperwork without any compensatory benefit. One commenter wrote that this new requirement does little to truly benefit the patient or to protect the hospice benefit from abuse. Another wrote that patients in small rural communities would be inconvenienced because of the fraudulent behavior of large for-profit hospices.

Response: We appreciate the commenters’ thoughts on the value of the face-to-face encounter. We are taking a long-term view of the encounter, and expect that it will increase physician accountability, lead to discharge of ineligible beneficiaries thereby reducing some lengths of stay, and improve the quality of patient care. While we value the hospice nurse’s experience with the patient, and his or her assessment of the patient’s prognosis, we believe that face-to-face encounters with hospice physicians or NPs can only improve upon that process.

We do not believe this requirement will decrease hospice utilization by eligible patients. We also do not claim that by itself, this requirement will eliminate all abuse of the hospice benefit. As noted previously in this section, this mandate complements other efforts related to protecting the hospice benefit from fraud and abuse.

This requirement does not cut payments, nor do we believe it is overly burdensome. We have provided financial relief for the cost of the visits by allowing billing of reasonable and necessary patient care by the hospice physician or hospice attending NP that occurs during a required face-to-face encounter. We have also provided additional flexibility in the timing of visits, to assist rural providers. We believe these changes help ensure that this requirement does not serve as a barrier to care in underserved areas, and will monitor for any unintended consequences.

While changes in certification requirements may lead to additional paperwork or to software changes, we do not believe that these will be burdensome or overwhelming; rather they are a routine cost of doing business. We have also provided hospices with great flexibility in how they include the face-to-face attestation as part of their recertification documents. We agree that the allowable timeframe for making changes to software or to electronic records is short, and have addressed these concerns later in this section.

We believe that in the long-term, it will strengthen the hospice benefit by returning it to the benefit the Congress intended, for patients who are terminally ill with 6 months or less to live. We are concerned that the hospice benefit is being used by some providers to care for chronically ill patients rather than terminally ill patients, or to serve as a long-term care benefit. We believe that this face-to-face requirement may help to ensure the continued viability of Medicare’s hospice benefit for those at end-of-life.
Comment: A number of commenters wrote to support the intent of the rule to certify only those hospice patients who remain eligible for the hospice benefit or to increase physician accountability, though a few mentioned that those who abuse the benefit would find a way to circumvent the requirement or that the proposed rule was too stringent. One wrote that it is a wise way to counter the growing use of hospice services by those who are chronically ill, rather than terminally ill. Another commenter values the sort of practice, which was proposed as it ties the persons of the treatment team with the patient and with the family. A few commenters also supported our proposal that a certification or recertification could be completed 15 days prior to the start of the benefit period. A commenter from a non-profit hospice wrote that the Congress' and CMS’ faith in the value of physician certification to halt abuse was reasonable, and was important for the nonprofit hospice community to support.

Response: We thank the commenters for their support.

Comment: A commenter was concerned that the timing of the proposed rule, with the open comment period until September 14th and a final rule not due out until late October or mid-November, puts a considerable burden on providers and their patient management software companies. The commenter wrote that software changes would need to be made based on the proposed rule, and that her software company could not beta test its changes because there is not enough time to do so, and to get the software out in November. The commenter added that any changes CMS makes between the proposed and final rules are difficult to accommodate, but obviously necessary. The commenter believes that in the future it would be more reasonable for CMS to publish proposed rules with adequate time for comments, review, and a final rule to be published several months before the effective date, so that software companies and their clients would have adequate time to prepare for the changes. The commenter added that due to the number of unresolved issues with the face-to-face proposal, the regulation effective date may be delayed which would also impact the timing of hiring of additional staff. A few commenters wrote that the timeframe, from publication of the final rule to its effective date, means that hospices have little time to meet with current physician staff to determine if they can manage the required visits, and to hire and train additional physicians and NPs if needed; several asked for more time to hire and train additional staff.

Response: The hospice face-to-face requirement was included in the Affordable Care Act, which was enacted on March 23, 2010. Conforming amendments were added to that law on March 30, 2010. We typically publish hospice payment-related proposed rules in April and final rules in late July or early August. Because of the internal process to publish a proposed rule by the end of March and the date the Affordable Care Act was enacted, we published the proposed rule on April 8, 2010.
Care Act was signed into law, it was too late to include the provisions related to the face-to-face requirement in a hospice proposed rule. The most appropriate rulemaking publication we could use was the HH proposed and final rules. In addition, the HH payment rules have an effective date of January 1st while the hospice payment rules are effective on October 1st.

When we propose and finalize changes to policies, we try to do so with a timeframe that provides adequate time and flexibility to providers, contractors, and software vendors, to implement final rule requirements. In this case, the timing of the enactment of the Affordable Care Act led us to propose the requirements later than usual; the effective date of the face-to-face requirement is mandated in the statute, and we cannot change it. However, the timing of the proposed rule allowed for a 60 day public comment period and the final rule will be effective on January 1, 2011.

Comment: Some commenters asked if they were expected to report the required face-to-face visit on their claims. One wrote that if hospices are expected to report the visit, they should be paid for it. A commenter asked whether hospices should report the NP’s NPI number on the claim or the NPI number of the physician supervising the NP. Several commenters asked if any special codes should be included on claims when the face-to-face visit is combined with a patient care visit, or when the face-to-face visit occurs during a medically necessary physician visit.

Response: We are not requiring any visit reporting for the required face-to-face encounter on hospice claims. This is consistent with our policy of not currently requiring reporting of other administrative activities on hospice claims. Hospice claims currently show the NPI of the attending physician (who may be a NP) and the certifying physician, at the claim level rather than showing the NPI of a practitioner at the line-item level. If hospice physicians or attending NPs provide billable services (as described previously in this section) during the course of the visit, those are to be billed on the claim following usual physician billing procedures, using revenue code 0657 and the appropriate CPT codes. If billable NP attending physician services are included on the claim, the claim should also include a GV modifier, since NP services are paid at 85 percent of services provided by physicians. The NP’s NPI number would only be reported on the claim if the hospice NP is also the patient’s attending physician.

Comment: A commenter wrote that hospice programs have raised concerns that hospice physicians or NPs may, during their visit to gather clinical findings to meet the face-to-face encounter requirement, be expected, by the patient or family members, to treat the patient for issues that are not related to the terminal diagnosis. The commenter noted that this is a particular concern in cases where the patient is not under the direct medical care of the hospice Medical Director but under the care of his or her primary care physician. The commenter suggested that CMS should
acknowledge the potential for such professional/ethical conflicts and make every effort to avoid establishment of any barriers (either through hospice CoPs or coverage requirements) that would prevent the physician or NP from providing adequate notice or explanation to a patient or responsible family member regarding the purpose of the hospice face-to-face encounter.

**Response:** The hospice physician is responsible for providing care for the terminal illness and related conditions, and for caring for any unmet medical needs that the patient’s attending physician (if any) has not addressed. If both the hospice physician and the attending physician are involved in the patient’s care, the patient is taught who to consider “primary” and contact first. The hospice is to collaborate with the patient’s attending physician (if any) in obtaining the initial certification, in performing the comprehensive assessment and any updates to that assessment, in developing the written plan of care, in discharging the patient, etc. Therefore, there should already be a working relationship with the patient’s attending physician; in having a required face-to-face encounter, the physician or NP should coordinate with the attending physician in providing any care to the patient. Because the required face-to-face encounter is usually an expected event, the hospice has time for such coordination. If the hospice physician or attending NP provides reasonable and necessary patient care while making a required face-to-face visit, the hospice may bill for those non-administrative physician services, as described previously in this final rule.

**Comment:** A commenter wrote that CMS has provided no clarity regarding the hospice’s exposure should the face-to-face requirement not be met.

**Response:** The face-to-face requirement is part of the hospice recertification process. Having a valid recertification is a statutory requirement for coverage and payment. We would have grounds to demand and recoup payments for claims that were paid based on an invalid recertification due to not satisfying the face-to-face requirement.

**Comment:** A commenter recommended that CMS continue to accept the hospice date stamp on POCs returned to the agency by physicians who forget or fail to date their signature on this document.

**Response:** At this time, there is nothing to preclude a hospice from using a date stamp if a physician fails to date his or her signature on the POC.

**Comment:** One commenter wrote that including the benefit period dates on the certification and recertification forms imposes a clerical task in physician charting. The
commenter asked why this was proposed if the face-to-face encounter requirement is based upon actual days of care.

Response: As noted previously, the face-to-face encounter is based upon benefit periods and not on actual days of care. Therefore, it is helpful to show benefit periods on the certification. As we wrote in the proposed rule, having the benefit period dates on the certification makes it easier for the hospice to identify those benefit periods which require a face-to-face encounter, and will ease enforcement of this new statutory requirement. Additionally, including the benefit period dates on certifications or recertifications simplifies the medical review process. The physician does not have to be the one to fill in the benefit period dates, but he or she should know what period of time the document covers.

Comment: A commenter wrote that this rule was proposed as intended to be applied to hospices that routinely skew the length of stay averages with long lengths of stay and exceed the hospice caps. The commenter added that it is now applicable to every certified hospice regardless of appropriate lengths of stay or not.

Response: Our proposal is entirely based on section 3132(b) of the Affordable Care Act. The Affordable Care Act did not limit the face-to-face requirement to certain hospices, but required it of all certified hospices.

Comment: A commenter wrote that if CMS plans to reimburse the face-to-face visits, long term care (LTC) facilities should not be involved in hospice billing as the proposed rule is clearly focused on hospice operations, not those of the LTC that contracts with the hospice so patients may receive hospice services. The commenter asked that if CMS anticipates any increased responsibilities of LTC providers, that his organization be included in any stakeholder discussions. Finally, the commenter asked that we clarify that the role of LTC providers will not change under this new regulation.

Response: These requirements affect hospices only and do not affect or change the responsibilities of LTC providers that serve hospice patients who reside in their facilities.

Comment: A commenter asked if the new requirement for physician or NP face-to-face encounters replaces current RN assessments of hospice patients.

Response: This new requirement does not affect the roles and responsibilities of hospice nurses. Hospice nurses should continue to care for and assess patients in accordance with the CoPs. They should continue to provide care for the palliation and management of the terminal illness and related conditions.
Comment: A commenter asked if the new face-to-face requirement allowed the Medical Director to certify hospice patients. Several commenters urged that electronic signatures be accepted for certifications and recertifications or on the attestations. Another commenter asked if having a different diagnosis at admission would affect the face-to-face requirement.

Response: Hospice Medical Directors have always been able to certify or recertify hospice patients. Additionally, electronic signatures on certifications and recertifications continue to be allowed; the narrative and the face-to-face attestation are parts of the certification, and therefore both can be signed electronically. The new face-to-face requirement does not affect either of these policies. The face-to-face encounter is required based upon being in the 3rd or later benefit period, considering the entire hospice history, regardless of diagnosis.

Comment: A commenter wrote that if the face-to-face encounter must occur within 2 weeks of the start-of-care date, and be documented, the industry could not afford this. This commenter noted also that hospices have little or no influence over physician behavior to comply with the additional scheduling and documentation requirements of this proposed rule.

Response: We believe this comment is related to the HH face-to-face requirement, but it was unclear from the language used, so we will respond from a hospice perspective. The hospice face-to-face certification is not required at start-of-care unless, when considering the patient’s entire hospice history, the start-of-care coincides with the recertification at the 3rd or later benefit period. If a hospice employs or contracts with a physician, it has influence regarding physician compliance with these requirements.

Comment: A commenter wrote that a recent Duke University study showed that patients who died under the care of hospice cost the Medicare program an average of $2,300 less than those who did not. This commenter believes that the current reimbursement model no longer fits with the evolution of the hospice benefit since 1983. The commenter also believes that this maturation of hospice necessitates a full scale review and evaluation of the current reimbursement model. The commenter added that changes to the benefit and payment system should preserve access to the hospice benefit, quality care, and reasonable reimbursement rates to maintain a viable and stable delivery system. The commenter also wrote that hospice patients should not have to forgo curative care that might lengthen their lives and enhance their quality of life. This commenter also wrote that the Congress should prevent CMS from implementing payment rate cuts in hospice until the Secretary is able to justify that the
cuts do not negatively impact patients and access to care. The commenter suggested that the Congress prevent us from implementing the payment rate to ensure the full market basket update for the hospice benefit, and that they preserve the BNAF; commenters suggested a rural add-on payment to ensure access for rural patients and to compensate for the financial burden of the face-to-face visits.

A few commenters who opposed the elimination of the BNAF wrote that we moved the hospice wage index away from one which was agreed upon years ago; one asked that we suspend the phase-out until a better approach for wage index adjustment is developed. Another commenter believes the hospice wage patterns do not mirror those of hospitals. This commenter wrote that hospices compete in the same labor market as hospitals, which are allowed to reclassify. The commenter urged us to develop a voluntary pilot project to test a hospice specific wage index, and hopes that we will slow the phase-out. A few commenters also urged that we maintain the aggregate hospice cap, as it protects against abuse of the benefit. One supported our efforts to improve the calculation and enforcement of the cap, provided those efforts do not take away from payment reform. A different commenter suggested we have standards for data submitted on cost reports and not use data from agencies that submit reports that are missing required information.

Response: Some of these comments are outside the scope of this rule so we will not respond to them in this final rule. However, we will respond to those comments related to the Affordable Care Act. Section 3132(a) of the Affordable Care Act requires that we begin reforming the hospice payment system no earlier than October 1, 2013. We have been collecting additional data from hospices for several years now, in preparation for payment reform. Any reformed payment model that we propose would preserve access to hospice care, encourage quality care, and would fairly pay providers. Section 3140 of the Affordable Care Act requires that we conduct a concurrent care demonstration project where hospice services will be provided without the beneficiary having to forgo curative care. The results of this 3-year demonstration project will help inform future decisions about any changes to the hospice benefit. In the Affordable Care Act, the Congress also reduced the market basket update for hospice, but those reductions will not occur until 2013, and therefore are not included in the FY 2011 payment rates. We do not have the statutory authority to provide a rural add-on to hospices. The BNAF phase-out was finalized in the August 6, 2009 final rule, and is outside the scope of this rule. Likewise, the hospice wage index, cost reports, and cap are outside the scope of this rule, and therefore we cannot comment, though we appreciate the commenter’s support regarding the hospice aggregate cap.

In summary, as a result of the comments we received on the proposed rule, we are finalizing the proposals made in the proposed rule with the following changes:
We are changing the regulatory text at § 418.22(a)(4) to clarify that we are counting a beneficiary’s time across all hospices based upon benefit periods rather than on actual days of hospice care. Therefore, a face-to-face encounter will be required prior to the 3rd benefit period recertification and each recertification thereafter.

We are clarifying in the regulatory text at § 418.22(a)(4) that the hospice physician or nurse practitioner is not required to go to the patient for the face-to-face encounter, but that the patient is allowed to travel to the hospice physician or nurse practitioner when medically appropriate.

We are changing the regulatory text at § 418.22(a)(4) so that hospice physicians or nurse practitioners will have up to 30 calendar days prior to the 3rd benefit period recertification, and up to 30 calendar days prior to each recertification thereafter, to have the face-to-face encounter.

We are changing the regulatory text at § 418.22(b)(3)(iii) so that the narrative attestation is directly above physician’s signature, rather than directly below it.

We clarified that hospices may bill for reasonable and necessary care provided to the patient by a hospice physician in the course of having a required face-to-face encounter with a patient.

III. Collection of Information Requirements

D. ICRs Regarding the Requirements for Hospice

Certification Changes As described previously in this final rule, as of January 1, 2011 the Affordable Care Act requires physicians or NPs to attest that they determined continued hospice eligibility through a face-to-face encounter with all hospice patients prior to the 3rd benefit period recertification and at every subsequent recertification. We will require the physician or NP to sign and date an attestation statement that he or she had a face-to-face encounter with the patient, and include the date of that visit. This attestation would be a separate and distinct part of the physician recertification, or an addendum to the physician recertification.

The burden associated with this attestation requirement is the time for each hospice to develop simple attestation language to attach as an addendum or include as part of the recertification document, and the time for the physician or NP to include the patient name, the date that the patient was visited, the visiting physician or NP signature, and the date signed. As of February 2010, there were 3,429 hospices with claims filed in FY 2009. We estimate it would take each hospice 15 minutes of administrative time to develop and review the attestation language, and 15 minutes of clerical time to revise their existing recertification form or to create an addendum. The estimated total one-time burden for developing the attestation form would be 1,714 hours.
The burden for completing the attestation form is estimated at 30 seconds for each recertification at 180 days or beyond. We used the distribution of lengths of stay from hospice claims data to estimate the percentage of patients who required recertification at 180 days, and at subsequent 60-day benefit periods. We estimated that there would be 457,382 recertifications at 180 days or beyond, each of which requires an attestation. We assume that 90 percent of the visits were performed by physicians and 10 percent by nurse practitioners, based on our analysis of FY 2009 physician and NP hospice billing data, with 30 seconds time allowed to sign and date the attestation statement, and to write in the name of the patient and the date of the visit, resulting in an estimated total burden to complete the attestation form of 3,811 hours for CY 2011. In the FY 2010 hospice rule (74 FR 39384), we finalized a requirement that the recertifying physician include a brief narrative explanation of the clinical findings which support continued hospice eligibility. Effective January 1, 2011, regulation text changes to require this narrative to describe why the clinical findings of the face-to-face encounter, occurring at the 180-day recertification and all subsequent recertifications, continue to support hospice eligibility. However, these regulation changes are for clarification. The narrative requirement finalized in FY 2010 requires that the narrative include why the clinical findings of any physician/NP/patient encounter support continued hospice eligibility. Therefore, the only documentation burden associated with this requirement is the signed and dated attestation that the encounter occurred.

In addition, commenters asked that we change the regulatory language at §418.22(b)(3)(iii) to require the physician’s signature to follow the narrative attestation statement, rather than to be above it on the form. The commenters believed that the signature should “close the loop”, and that this placement would be consistent with the face-to-face attestation requirements. We agree with the commenters, and are finalizing this as a change in the regulation. We do not believe that moving the signature underneath the narrative attestation (rather than leaving it above it) creates any additional burden to hospices. The estimate of administrative burden to create the face-to-face attestation includes enough administrative time for form revision to cover moving the narrative attestation signature line.

We reiterate that our longstanding policy has been that physicians must sign and date the certification and any recertifications. Therefore, our making this requirement explicit in the regulation poses no additional burden to hospices. We also clarified the timeframe which the certifications and recertifications cover by requiring physicians to include the dates of the benefit period to which the certification or recertification applies. We believe this is already standard practice at nearly all hospices, but are addressing it in regulation. Using the distribution of lengths of stay from 2007 and 2008 claims data, we estimate that there would be 1,733,663 initial certifications and recertifications during the course of a year. We estimate that it would take a physician 30 seconds at most to include the benefit period dates. We estimate that the time to
require physicians to include the benefit period dates on the certification or recertification would be 30 seconds per certification or recertification, for a total burden of 14,447 hours for CY 2011. Table 17 summarizes the burden estimate associated with these requirements.

Table 17: Estimated Annual Recordkeeping Burden

<table>
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<tr>
<th>OMB#</th>
<th>Requirements</th>
<th>Units</th>
<th>Responses</th>
<th>Hr. Burden</th>
<th>Total</th>
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<td>0938-1067</td>
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<td>0.0083333</td>
<td>14,477</td>
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</table>

Details of our burden estimates are available in the PRA package approved under OMB# 0938-1067. We are revising this currently approved package to incorporate these requirements.

We received one comment about the burden estimate of the hospice face-to-face attestation, and one about an addition to the face-to-face attestation.

**Comment:** A commenter wrote that the administrative burden calculated by CMS did not include the staff time required to track down these face-to-face encounters. The administrative cost that was calculated is not included in the reimbursement for hospices.

**Response:** The above mentioned burden estimate only reflects the burden associated with any additional required documentation. In this case, the additional required documentation is the attestation of the face-to-face encounter. Our burden estimate includes the administrative time to develop an attestation form as well as the time that we believe would be required to revise the hospice’s existing certification or recertification forms, if necessary. The requirement as stated in §418.22 pertains to additional documentation only, that is, documentation requirements subsequent to the face-to-face encounter; therefore, the estimate above does not include any burden associated with the administrative coordination and conduct of face-to-face encounters or tracking the encounters.

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**42 CFR Part 418**

**Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.**

**Part 418 - Hospice Care**

3. The authority citation for part 418 continues to read as follows:

**Authority:** Secs 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).
Subpart B--Eligibility, Election and Duration of Benefits

4. Section 418.22 is amended by--
   A. Revising paragraphs (a)(3) and (b)(3)(iii).
   B. Adding paragraphs (a)(4), (b)(3)(v), (b)(4), and (b)(5).

The revisions and additions read as follows:

§418.22 Certification of terminal illness.

(a) ***

(3) **Exceptions. (i) If the hospice cannot obtain the written certification within 2
calendar days, after a period begins, it must obtain an oral certification
within 2 calendar days and the written certification before it submits a claim
for payment.

(ii) Certifications may be completed no more than 15 calendar days prior to the
effective date of election.

(iii) Recertifications may be completed no more than 15 calendar days prior to
the start of the subsequent benefit period.

(4) Face-to-face encounter. As of January 1, 2011, a hospice physician or
hospice nurse practitioner must have a face-to-face encounter with each
hospice patient, whose total stay across all hospices is anticipated to reach
the 3rd benefit period, no more than 30 calendar days prior to the 3rd benefit
period recertification, and must have a face-to-face encounter with that
patient no more than 30 calendar days prior to every recertification
thereafter, to gather clinical findings to determine continued eligibility for
hospice care.

(b) ***

(3) ***

(iii) The narrative shall include a statement directly above the physician signature
attesting that by signing, the physician confirms that he/she composed the
narrative based on his/her review of the patient's medical record or, if
applicable, his/her examination of the patient.

****

(v) The narrative associated with the 3rd benefit period recertification and every
subsequent recertification must include an explanation of why the clinical
findings of the face-to-face encounter support a life expectancy of 6 months
or less.

(4) The physician or nurse practitioner who performs the face-to-face encounter
with the patient described in (a)(4), must attest in writing that he or she had a
face-to-face encounter with the patient, including the date of that visit. The
attestation of the nurse practitioner shall state that the clinical findings of that
visit were provided to the certifying physician, for use in determining whether
the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. (5) All certifications and recertifications must be signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies.