



National Hospice and Palliative Care
Organization



The Honorable Patrick J. Tiberi
Chairman, Health Subcommittee
Committee on Ways & Means
Washington, D.C. 20515

Dear Chairman Tiberi,

On behalf of the National Hospice and Palliative Care Organization (NHPCO), thank you for inviting organizations to comment on ways that Congress, the Administration, and providers can collaborate to provide relief from the regulations and mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries.

NHPCO is the largest membership organization representing the entire spectrum of hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice locations and more than 59,000 hospice professionals in the United States, caring for the vast majority of the nation's hospice patients.

In recent years, hospices have been faced with substantially increased regulatory burdens, based on new regulations and subregulatory guidance, changes required by hospice payment reform, additional quality reporting obligations, and increased audit activity. While some of these changes are positive, hospices report that they are facing many regulatory burdens that take valuable staff time away from patients and are not increasing the quality of care provided. So we very much appreciate your interest in soliciting feedback from providers and taking steps to eliminate or simplify duplicative, excessive, antiquated and contradictory regulatory requirements.

To begin, we commend to your attention several pieces of legislation that have been introduced that would alleviate many of the regulatory or policy challenges hospice providers face.

1. Rural Access to Hospice Act (H.R. 1828)

Despite recent growth in hospice utilization, hospice care is underutilized in rural areas. A March 2015 report from the Medicare Payment Advisory Commission (MedPAC) found that 48.9 percent of Medicare decedents in an urban area utilized hospice in 2014, compared to 32.3 percent of decedents in frontier regions.

One reason for this disparity is a statutory barrier that inhibits access to hospice in rural communities. When patients enroll in hospice, they select a physician or nurse practitioner to serve as their attending physician, typically someone who has knowledge of the patient and their medical conditions. The attending physician collaborates with the hospice in the development of the care plan, and is kept informed of the patient's care. Typically, the attending physician is reimbursed for these services under

Medicare Part B. Unfortunately, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) do not bill Medicare under Part B; they are paid a fixed, all-inclusive payment for all services provided to Medicare beneficiaries. Unfortunately, due to a statutory oversight, the services of a RHC or FQHC physician to serve as a patient's attending during hospice care are not included under this all-inclusive payment.

The Rural Access to Hospice Act (S. 980/H.R. 1828) was introduced by Senator Capito (R-WV) and Senator Shaheen (D-NH) and in the House by Representatives by Congresswoman Jenkins (R-KS) and Congressman Kind (D-WI). This bill will allow RHCs and FQHCs to receive payment for serving as the hospice attending physician. NHPCO and HAN urge all members of Congress to cosponsor this common-sense, non-controversial legislation, and ensure that terminally ill beneficiaries in rural communities can access the hospice benefit.

2. The Medicare Patient Access to Hospice Act (H.R. 1284)

The hospice attending physician is an important member of the hospice interdisciplinary team. The attending physician certifies a patient's terminal prognosis, directs symptom management, prescribes appropriate treatment, and manages the patient's plan of care in collaboration with others. The hospice attending physician can be either the patient's long-standing primary care provider or a hospice physician.

The shortage of primary care providers is creating a concomitant shortage of hospice attending physicians. Moreover, Medicare allows only physicians and nurse practitioners to serve as a patient's hospice attending physician. Physician assistants – who are licensed, certified health care providers who are explicitly trained in the area of primary care – are currently prohibited from serving as the hospice patient's attending physician.

The Medicare Patient Access to Hospice Act (H.R. 1284), introduced in the U.S. House of Representatives by Congresswoman Jenkins (R-KS) and Congressman Thompson (D-CA) allows PAs to serve as the attending physician to hospice patients and perform other functions that are otherwise consistent with their scope of practice. This legislation will remove a barrier in current law that restricts patients' access to the hospice attending physician of their choice.

3. The Hospice Commitment to Accurate and Relevant Encounters (CARE) Act (Draft)

The ACA included a requirement that a hospice physician or nurse practitioner must have a face-to-face encounter with a hospice patient before the end of a 180-day recertification period and again for each 60-day recertification after that date. The hospice community supports the intent of the face-to-face encounter requirement, but has found staffing limitations and timelines to be unduly burdensome.

To address these issues, the Hospice CARE Act would (1) expand the range of professionals who can perform a face-to-face encounter to include physician assistants, (2) modify the reference to the 180th

day recertification to the first 60 day period in order to make the statute consistent with CMS's interpretation, and (3) allow hospices up to seven days after the patient elects hospice to provide a face-to-face encounter in the limited circumstances of a hospice newly admitting a patient who requires a face-to-face encounter because of past hospice experience with a different hospice so that admission isn't delayed. These changes will make sure that patients are not denied timely access to hospice services, and that programs can prioritize quality care while remaining compliant.

Additionally, we submit for your consideration our comments to the Centers for Medicare and Medicaid Services on CMS 1675-P, Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Proposed Rule, which included recommendations in several key categories, summarized below:

1. Hospice Payment Policy Issues

Notice of Election/Notice of Termination or Revocation: Hospice providers have identified a range of issues related to payment for hospice claims, especially around the Notice of Election and Notice of Termination/Revocation (NOE/NOTR) processes. Currently, NOEs require duplicative, manual entry of all beneficiary data. This is administratively burdensome, and increases the potential for keying errors that could delay payment. Further, hospices report a lag between submitting NOEs/NOTRs and that information being available in the Common Working File (CWF).

These administrative burdens and technological barriers create significant challenges for hospices, Part D providers, and other health care providers. When the CWF does not reflect the patient's hospice election, Part D providers, hospitals, or other providers may inadvertently bill for services that are not appropriate.

This lag also creates problems for hospices who are trying to comply with CMS's sequential billing requirement. When the patient revokes or is discharged, or when a patient changes hospices. Because bills must be submitted sequentially, if the first hospice has not submitted a NOTR or final claim, the second hospice is unable to bill. Typically, this causes the second hospice's NOE to be submitted late. The second hospice must have an exception request approved in order to submit claims and receive reimbursement. If there is any change in the hospice election, where the patient revokes, chooses another hospice, or is discharged from the hospice for any discharge reason, sequential billing issues mean that there are circumstances that often require significant time and third parties to settle.

To address these issues, NHPCO recommends that CMS:

- Continue working toward allowing electronic filing of NOEs;
- Ensure that beneficiaries' termination or revocation of their hospice benefit is immediately available in the Common Working File (CWF);

- Make retroactive to October 1, 2014 its December 1, 2016 determination, (announced by CMS in SE1633) to provide exceptions for timely-filed Notices of Election (NOEs) that have inadvertent

errors that cannot be immediately corrected due to Medicare system constraints and allow hospices to receive reimbursement for days of care provided;

- Explore options to eliminate sequential billing for hospice;
- Place a flag in the hospital claims processing system so that hospitals will know, in a timely fashion, when a beneficiary has elected hospice, and;
- Consider other training and process opportunities to improve hospice coordination with Part D providers, Skilled Nursing Facilities, hospitals and other providers.

2. Other Hospice Policy Issues – Staffing and Coding Concerns

Medicare requires that hospices provide “substantially all” core services directly through employees. This includes physician services, nursing services, social work services (which must be either provided by or supervised by an employee with a Master of Social Work (MSW), counseling services – including spiritual, bereavement, and dietary counseling. With workforce shortages in many of these disciplines, however, hospices are often challenged to meet these requirements. NHPCO recommends several changes that would address these staffing concerns, including:

- Eliminate the regulatory interpretation that a dietitian engaged by the hospice must be a W2 employee of the hospice;
- Allow hospices to contract with nurses for the provision of continuous home care (CHC) and require hospice training as a part of the contractual obligation, and;
- Allow continuous home care (CHC) to be provided for a minimum of four hours in a 24 hour period, beginning and ending at midnight.

3. Hospice Audit Issues

Hospice providers report a substantial increase in the number and scope of government audits. Often auditors have a lack of understanding about the hospice benefit and hospice regulations and often cite the hospice for issues that are clearly allowed in the hospice regulations. Examples include audit findings citing the hospice for the following: days of care denied because the hospice patient had no hospitalizations or emergency department visits (not a requirement for hospice); days of care denied because the patient was not homebound (not a requirement for hospice); or the patient lived more than 180 days after admission (not prohibited for hospice), so all care after 180 days was denied. Having to expend time, effort, and money challenging such inappropriate audit findings is frustrating and administratively burdensome. To address this issue, NHPCO recommends that CMS:

- Provide additional training for audit staff on hospice eligibility and hospice regulations;
- Follow the established waiver of liability provisions for audit findings that the patient is not “terminally ill”;
- Ensure that government auditors are subject to, and follow, established audit deadlines in reporting audit findings;
- Ensure that audit entities should provide a meaningful review of medical record documentation and sufficient clinical rationale to support claim denials;

- Ensure that audit contractors follow legal standards for waiver of liability and ensure that CMS' directive to limit review to the initial reasons for review is followed;
- Take steps to ensure that medical review audits are not duplicative require that the Medicaid Integrity Contractors (MICs) be educated about eligibility requirements for Medicaid hospice patients in the states.

4. **Data Collection and Submission Mechanisms Under Consideration**

NHPCO believes that the utilization by hospices of a standardized assessment instrument has the potential to provide data that can be used to inform both quality reporting and payment refinements. The data instrument under development was announced in the FY2018 Hospice Wage Index Final Rule (Federal Register, August 4, 2017). NHPCO also is committed to active participation in the discussions and development of any data collection mechanisms that CMS may be considering. As this work continues, NHPCO urges CMS to ensure that the hospice patient assessment tool (HEART):

- Truly reflects the holistic and comprehensive nature of hospice care (including physical, psychosocial, and spiritual components);
- Recognizes the importance of an individualized approach to care;
- Includes the patient's and family's right to refuse or defer offered services. Care delivered in various settings (including the nursing home, assisted living facility, hospital, hospice facility as well as in the patient's home) is recognized and accommodated;
- Recognizes that assessment must be interdisciplinary and is the foundation of documentation that guides care on an ongoing basis, and;
- Data gathered through assessment must easily and readily be usable for the development and updating of the plan of care.

Thank you, again, for allowing us to share our thoughts and ideas. We look forward to working with you on these issues, and other policy changes that will ensure that all Medicare beneficiaries can access the high quality, compassionate end-of-life care offered by hospice.

Sincerely,



Edo Banach
President and CEO