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REGULATORY BLUEPRINT
FOR ACTION

Hospice Association of America
2009 Regulatory Blueprint for Action

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INTRODUCTION

The Regulatory Blueprint for Action identifies important regulatory issues for hospice providers. It gives a summary of each issue, including background information, recommendations, and rationale for the recommendations. This document provides a guide to the hospice industry's position on the issues addressed. The items identified as the top priorities are listed first in the Blueprint.

In order to identify the regulatory issues that are important to hospice providers throughout the country, the Hospice Association of America (HAA) engages in a variety of activities. Member comments gathered from telephone calls, e-mail, written correspondence and personal contact are analyzed. The current industry trends and government actions are evaluated. The HAA Advisory Board of Directors, the Forum of State Associations, the Regulatory Affairs Subcommittee and the NAHC Board of Directors participate in development of positions for the annual Regulatory Blueprint for Action. HAA publishes a list of major issues annually and asks members to score each issue from the most to least important. The results are tabulated and industry priorities identified.

The Blueprint serves as HAA's regulatory plan for action for the current year. Issues that are identified as most important by members become the priorities. However, HAA also recognizes that priorities may shift during the course of any year as a result of federal regulatory action or policy changes.

REINSTATE THE BUDGET NEUTRALITY ADJUSTMENT FACTOR IN THE MEDICARE HOSPICE WAGE INDEX

ISSUE: President Bush's proposed 2009 budget included a regulatory proposal that would permanently eliminate the budget neutrality adjustment factor for the hospice wage index resulting in about a 4 percent cut in the hospice reimbursement rates each year. The anticipated savings would be \$2.29 billion over five years. The Centers for Medicare & Medicaid Services (CMS) issued a Notice of Proposed Rulemaking (NPRM) calling for comments followed by issuance of a final rule. CMS essentially ignored the comments and began a three-year phase out of the BNAF, effective November 1, 2008. As a result of passage of the American Recovery and Reinvestment Act of 2009 which postponed elimination of the BNAF until October 1, 2009, CMS must now reinstate the BNAF back to October 1, 2008.

RECOMMENDATION: CMS should permanently reinstate the budget neutrality adjustment factor in the Medicare Hospice Benefit wage index annual update.

RATIONALE: In 1994, as a result of disparity in wages from one geographical location to another, CMS established a committee to negotiate a wage index methodology that could be accepted by the industry and the government. The National Association for Home Care & Hospice participated in the Hospice Wage Index Negotiated Rulemaking Committee along with representatives of CMS and other hospice stakeholders. On April 13, 1995, the Hospice Wage Index Negotiated Rulemaking Committee signed an agreement for the methodology to be used for updating the hospice wage index which is now in place. At that time, CMS agreed to continue the same budget neutrality adjustment factor that was put into place when the benefit was created in 1983. Given that the agreement was entered into in good faith by all parties, action in this area should only be considered as part of a broader effort to refashion the hospice benefit.

The elimination of the BNAF creates a serious risk of loss of access to hospice care. MedPAC reports that the average hospice margin was 3.4 percent in 2005. Elimination of the BNAF decreases hospice reimbursement by 4 percent. There is no reliable data available to indicate whether the majority of hospices would be able to sustain such an overwhelming cut in reimbursement rates. There is a very real danger of putting community hospices out of business resulting in a lack of access to the hospice benefit, particularly in rural areas.

A June 2004 report by the Government Accountability Office (GAO) determined that 34 percent of hospices in 2000 and 32 percent in 2001 had higher costs than reimbursement. The GAO recommended that CMS collect comprehensive, patient-specific data on the utilization and cost of hospice visits and services to determine whether the hospice payment categories and methodology require modification. CMS is in the process of collecting such data. However, the existing data indicates that hospices can not sustain a 4% cut in Medicare payment rates.

The Medicare budget also will suffer through the loss of hospice care. A recent Duke University study showed that patients who died under the care of hospice cost the Medicare program an average of about \$2,300 less compared with those that did not.

WORK WITH HOSPICE INDUSTRY TO EVALUATE REVISION OF THE MEDICARE HOSPICE BENEFIT REIMBURSEMENT SYSTEM

ISSUE: The Medicare Hospice Benefit (MHB) was created in 1982 to care for terminally ill cancer patients. Currently, Hospice patients with a cancer diagnosis represent only about 43 percent of those being served by hospices. The median length of stay remains at about two weeks and about 30 percent of hospice patients are on the benefit for less than a week. There is growth in the number of long stay patients such as those with neurodegenerative conditions such as dementia, end-stage Alzheimer's disease, Parkinson's disease and cardiovascular disease. Although costs for pharmaceutical and pharmacotherapy for symptom control and pain management have increased dramatically, the reimbursement system has not changed since its inception. The Centers for Medicare & Medicaid Services (CMS) is in the process of gathering hospice data with the intent of determining whether the MHB reimbursement system should be changed. The Medicare Payment Advisory Commission (MedPAC) has recommended that the hospice benefit reimbursement system be revised to reflect the services being provided based on data collected and analyzed by CMS by 2013.

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

RATIONALE: CMS is currently working on what they call Phase III of collecting hospice services data in an effort to make hospices more accountable for providing required services and meeting all the patient's needs related to the terminal illness. To ensure that an accurate and rich data bank is created, it is imperative that CMS collect the necessary data to accurately reflect the full scope of services currently provided by hospices. This is critical to subsequent data analysis to determine whether a revised hospice reimbursement system is appropriate and what it should be.

RESPOND TO NEW HOSPICE CONDITIONS OF PARTICIPATION (CoP) ISSUES

ISSUE: The new hospice conditions of participation (CoP) were released in June of 2008 with an effective date of December 2, 2008. They had not been updated since the inception of the hospice benefit in 1983. The new CoPs are outcome oriented and require surveyors to make more judgment calls than the prior CoPs. Surveyors were trained on the new CoPs in November and future training is planned. The final new Interpretive Guidelines were released on January 2, 2009 and included changes made as a result of questions asked in the November surveyor training. The Centers for Medicare & Medicaid Services (CMS) has agreed to work with the National Association for Home Care & Hospice (NAHC) to resolve any problems that may arise under new CoP interpretations.

RECOMMENDATION: CMS should work with NAHC and the hospice industry to resolve any problems that hospices experience under the new CoPs.

RATIONALE: At the time the original CoP were written, little was known about efficient and effective management of hospice agencies. Hospices have been operating under the original CoPs for 25 years. Hospices have adapted their care provided to meet the needs of patients and families served. Hospices are now required to meet the new CoPs which contain specific new requirements for needs assessments and hospice wide quality of care initiatives. Hospices must adapt to many new demands at the same time that surveyors are working with new regulatory requirements.

ABOLISH PAYMENT DELAYS CAUSED BY SEQUENTIAL BILLING POLICY FOR HOSPICE

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

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

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

ENSURE ACCESS TO DRUGS NECESSARY FOR PAIN CONTROL

ISSUE: Inadequate pain management has been identified by experts in the field as a national public health issue. Terminally ill patients may require very high doses of pain medication to achieve effective pain control. Physicians and other health professionals often do not have adequate knowledge about pain control, and/or have fears of laws related to controlled substances. Exacerbating the problem is the Drug Enforcement Agency's (DEA) reaction to Oregon's assisted-suicide law. The FDA has warned that physicians who prescribe lethal doses of narcotics under Oregon's Death with Dignity Act would be in violation of federal drug laws.

RECOMMENDATION: CMS and the FDA should declare inadequate pain management a national public health issue with goals to:

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

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

ENCOURAGE ACCOUNTABILITY FOR HOSPICE UTILIZATION

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

RECOMMENDATION:

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

RATIONALE: Variation in utilization points not to abuse as much as it does to physician concerns about giving a prognosis of six months or less for terminally ill patients and the differences in health care practices. Development of uniform protocols and the education of providers are the keys to compliance with eligibility criteria and the control of inappropriate utilization.

ENSURE TIMELY UPDATE OF LOCAL COVERAGE DETERMINATIONS FOR HOSPICE ELIGIBILITY

ISSUE: The current hospice local coverage determinations (LCD) promulgated by CMS limit the policies to a set of medical variables and clinical signs and symptoms that are used to predict a prognosis of six months or less for terminally ill Medicare beneficiaries. Claims reviewers using the LCDs are given no instructions or guidance to take into account the physician's clinical judgment and the psychosocial dimensions of the illness for determination of coverage decisions.

RECOMMENDATIONS:

CMS should perform annual reviews of all LCDs and revise the policies based on available research and other pertinent findings relevant to the determination of a prognosis of six months or less. Assure the ICD-9-CM codes are current.

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

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

BASE SURVEY FREQUENCY ON PERFORMANCE OF MEDICARE HOSPICE BENEFIT PROVIDERS

ISSUE: Only 1% of Medicare hospice providers are surveyed each year. There is no legislative requirement for the frequency of surveys for providers of the Medicare Hospice Benefit (MHB). CMS' failure to require that hospice providers be surveyed on a regular basis can result in lack of compliance with regulations and poor quality of care. CMS currently has hospice providers on an eight-year cycle for surveys but that sometimes extends to 10 years in some parts of the country.

RECOMMENDATION: Limited resources available for hospice surveys should be used to target quality issues by adopting the following survey frequency guidelines:

1. New Medicare hospice agencies should be surveyed annually for at least the first two years of certification.
2. Agencies with condition level deficiencies should be surveyed at least annually until they are deficiency free.
3. Complaint surveys should be conducted following significant complaints. If deficiencies are found, annual surveys should be conducted until the hospice is deficiency free.
4. All hospices should be surveyed, at a minimum, every three years.

RATIONALE: When the MHB was created by the Congress, in order to assure quality of care and implement the benefit, CMS was given the responsibility of creating regulations to be followed by providers of hospice services. As the next step of this responsibility, there need to be regular surveys to ensure compliance with these regulations. Recipients of the MHB should be afforded the same protections provided to recipients of other Medicare benefits.

REINSTATE PRESUMPTIVE STATUS FOR HOSPICE WAIVER OF LIABILITY

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

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

RATIONALE: The waiver presumption acts to protect providers who render services to Medicare beneficiaries in good faith, believing that they will be covered. The cushion for error is crucial in the Medicare Hospice Benefit due to the physician’s inherent difficulty in determining that a patient will likely die within six months if the disease runs its normal course. This is particularly true for non-cancer diagnoses. Claims are susceptible to vagaries of interpretation by the fiscal intermediary (FI).

Certifying terminal illness is an inexact science and extremely difficult for the physician, patient and family. An FI determination that a patient is not terminally ill is also devastating.

STUDY HOSPICE REIMBURSEMENT FOR DUALY ELIGIBLE PATIENTS RESIDING IN NURSING FACILITIES

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

The contractual relationship between hospice programs and nursing homes has been under the scrutiny of Health and Human Services Office of the Inspector General (OIG). In a recent report, Hospice Patients in Nursing Homes, OIG made recommendations to eliminate or reduce the Medicare or Medicaid payments for hospice patients living in nursing homes.

RECOMMENDATION: CMS should not reduce payment to the hospice unless data collected and analyzed demonstrates duplicate payment for dually eligible patients residing in nursing facilities.

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

DEVELOP QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT PROGRAM FOR HOSPICE

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

RECOMMENDATION: CMS should develop a quality assessment performance improvement (QAPI) program that has: a) reliable and valid indicators, b) outcome measures limited to those that most accurately predict quality, c) a method for risk adjustment, d) a standard assessment, e) a simple system with clinical utility, f) a mechanism enabling CMS to validate agency data, and g) an ongoing evaluation of the entire system. CMS should include the National Association for Home Care & Hospice's (NAHC) adapted Edmonton System Assessment System (ESAS) as one of the data collection tools to be tested. CMS should also recommend use of NAHC's Patient Satisfaction Survey and Family Satisfaction Survey for hospice use as part of their ongoing QAPI programs based on patient outcomes.

Further, CMS should reinstate its second quality initiative to establish standards of care for providers of the Medicare Hospice Benefit and authorize necessary funding.

RATIONALE: The ideal QAPI program is based on what happens to the patients. In addition, research and demonstration projects are not factored into the current per diem reimbursement structure. The proposed quality system will have a tendency to involve massive data collection unless purposely controlled. Every effort must be made to keep data collection and the paperwork burden to a minimum so resources can be used for patient care rather than paperwork.

OPPOSE EFFORTS TO REQUIRE PHYSICIAN CERTIFICATION FORMS TO INCLUDE A FALSE CLAIMS WARNING

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

RECOMMENDATION: Refrain from including a warning statement concerning penalties for false claims on physician certification and recertification forms for terminal prognosis. Develop educational information about the requirement of a six month prognosis and make resources available to determine a prognosis. Encourage the use of interdisciplinary clinical judgment and appropriate documentation.

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

The science of prognostication is in its infancy and physicians must use whatever tools are available, including medical guidelines developed by the industry, local coverage decisions developed by the fiscal intermediaries, and their own best clinical judgment. Physicians tend to be cautious about certifying terminally ill patients for hospice care, about 30 percent of patients are on the benefit for a week or less and the median length of stay remains at about two weeks. Placing a warning or other statement on the certification of terminal illness could further deter physicians from enrolling appropriate patients, thus denying access to this compassionate, humane, patient-and family-centered care at the end of their lives.

CLARIFY HMO HOSPICE SERVICES TO MEDICARE BENEFICIARIES

ISSUE: Hospice providers and terminally-ill Medicare beneficiaries receive confusing and misleading information from HMOs regarding the Medicare hospice benefit. Often the HMOs themselves are not fully informed about their role vis-a-vis Medicare-certified hospices and HMO enrollees who wish to access hospice care. One of the problems is that information about hospice is scattered throughout the Medicare HMO manual. Another problem is that hospice providers and Medicare beneficiaries are ill-informed about the interface between Medicare, HMOs, and hospices.

For example, an HMO/Medicare beneficiary can enroll in any Medicare-certified hospice, not just one that participates in the HMO plan. The hospice, not the HMO, is responsible for managing the patient's hospice plan of care across all levels and sites of care. The Medicare-certified hospice bills Medicare, not the HMO, for the Medicare patient's hospice care. Medicare pays the HMO on a fee-for-service or reduced capitation basis for services not related to the terminal illness.

RECOMMENDATION: CMS should issue clarified policy guidelines regarding the Medicare hospice benefit and HMO enrollment. CMS should also issue an explanation of rights to the hospice benefit for Medicare beneficiaries and require Medicare HMOs to disseminate it to all enrollees.

RATIONALE: Accurate information disseminated by CMS would help to educate beneficiaries, hospices, and HMOs about their rights and responsibilities and would increase access to the Medicare hospice benefit.

COMPENSATE PHYSICIANS FOR HOSPICE CERTIFICATION

ISSUE: One of the primary requirements for Medicare beneficiaries to access the Medicare Hospice Benefit (MHB) is certification by the patient's attending physician and the Hospice medical director that the patient has a limited life expectancy of six months or less if the disease runs its normal course. The length of stay on the Medicare Hospice Benefit (MHB) is still too short. At the request of Congress, the Government Accountability Office (GAO) conducted a study on the MHB that was released in 2000. Another Report was issued in December 2007, "End-of-Life Care: Key Components Provided by Programs in Four States." They concluded that the most significant influence on patient use of hospice is the physician. "Physicians initiate most referrals to hospice, and they may continue to care for their patients after enrollment as part of the hospice team. Because patients and their families rely heavily on physician recommendations for treatment, including recommendations for end-of-life care, physicians are an influential factor in a patient's entry into hospice." The most recent CMS data shows that the median length of stay remains at about two weeks and 30 percent of hospice patients were on the benefit for less than a week.

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

RECOMMENDATION: CMS should create a new HCPCS code to compensate physicians for patient certification of eligibility for the Medicare Hospice Benefit.

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

ASSURE SNF/NF MEDICARE BENEFICIARY RESIDENT'S RIGHT TO CHOOSE HOSPICE PROVIDER

ISSUE: In 1989, Public Law 101-239 mandated the ability of terminally ill Medicare beneficiaries residing in skilled nursing facilities/nursing facilities (SNF/NFs) to access services under the Medicare Hospice Benefit. As SNF/NF residents become aware of the MHB, more of them are seeking hospice services. However, the SNF/NF has the right to deny hospice services to their residents or at a minimum choose the hospice the SNF/NF will allow to provide the services.

Currently, a terminally ill SNF/NF resident may only access the Medicare Hospice Benefit if the SNF/NF will allow this to occur. If the facility agrees to permit a hospice to provide services for the SNF/NF resident, the Hospice and SNF/NF must have a written agreement that specifies the coordinated services each provider will perform.

RECOMMENDATION: CMS should require that eligible Medicare beneficiaries residing in SNF/NFs have the right to receive hospice services from a Medicare-certified hospice of their choice.

RATIONALE: A Brown University Medical School study funded by the Agency of Healthcare Research and Quality, US Department of Health and Human Services, was released in August 2006. The study, "Hospice Enrollment and Evaluation of its Causal Effect on Hospitalization of Dying Nursing Home Patients" showed that nursing-home residents in hospice care have about half the chance of being admitted to a hospital in their last 30 days of life compared to peers who don't receive hospice care, such hospitalizations can result in large and unwarranted Medicare expenditures.

