



September 10, 2010

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Carla M. Braveman  
*Chair*

Donald M. Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
ATTN: CMS-1510-P  
Baltimore, MD 21244-1850

Dear Dr. Berwick:

The Hospice Association of America (HAA), an affiliated organization of the National Association for Home Care & Hospice (NAHC), appreciates the opportunity to comment on proposed regulations issued by the Centers for Medicare & Medicaid Services (CMS) to govern section 3132 of the Affordable Care Act. Section 3132 requires that on or after Jan. 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. Section 3132 also requires that the physician or NP who has the face-to-face encounter make an attestation that the encounter took place.

In a June 17 letter, HAA provided an initial set of recommendations to CMS on the hospice face-to-face requirement. A copy of it is appended for your reference. Since that time we have had the opportunity to review the proposed regulatory changes and analyze their impact on hospice operations. While we are supportive of the goals and motivations that led Congress to enact the new hospice requirement, we are increasingly concerned that the new requirement will create significant challenges for hospice programs of all sizes nationwide, and particularly for small hospice programs in rural areas. These challenges are of sufficient magnitude that they will demand deliberate planning by hospices to ensure they budget their financial, clinical, and operational resources to comply with the new requirement. For these reasons and those provided below, we urge that CMS delay the effective date for the face-to-face requirement

to no earlier than Jan. 1, 2012, or until such time as the Secretary of Health and Human Services and hospice organizations are able to fully address the added responsibilities and operational concerns related to this requirement, and ascertain departmental and hospice provider readiness.

## **ISSUES/RECOMMENDATIONS**

**1. Insufficient Hospice Physician/NP Staffing to Meet the Requirement.** Under current practice, many hospice programs work with the patient's primary care physician and do not assume direct medical care of their patients, thus they do not schedule physician or NP home visits on a regular basis. Instead, continuing eligibility is determined through hospice physician examination of a wide range of clinical findings reported by members of the inter-disciplinary team. A number of hospice programs have expressed apprehension that they will be unable to meet the face-to-face requirement due to insufficient hospice physician/NP availability, limited resources and/or practitioner shortage in the geographic area. Where sufficient clinical resources are available, hospices may need to contract with or hire additional clinicians. If this is the case, this will add a significant administrative and financial burden on hospice programs.

**Recommendations:** In addition to the delay, once readiness has been established by the Secretary, we recommend phasing in the requirement for a face-to-face encounter by applying it first to hospice programs with a high proportion of long-stay patients. CMS should allow the face-to-face requirement to be fulfilled by the patient's attending physician as well as by a hospice physician/NP. CMS should also give special consideration to the additional burden that this requirement will place on rural and underserved areas, and exempt from the requirement geographical areas that are designated Health Professional Shortage Areas.

**2. Prohibitive Costs of the Hospice Face-to-face Encounter Requirement.** As mentioned in our first issue (above), most hospice programs do not currently schedule regular face-to-face encounters between a hospice physician/NP and the patient. Home visits by hospice physicians/NPs can be very costly, particularly for hospices that cover a large geographical area. Hospices that are currently working to incorporate the requirement into their operations report that costs have expanded exponentially as a result.

**Recommendations:** We urge that CMS ensure that the hospice physician/NP face-to-face encounter is billable to Medicare by the hospice program or by the attending physician in cases where he makes the visit. CMS should specify the billing code under which either the hospice program or attending physician must bill for the encounter; this code should include reimbursement of mileage and travel time for a high-level practitioner. In addition, as current payment rates do not reflect the added administrative costs for implementing the face-to-face requirement, CMS should increase hospice rates of payment to reflect the additional cost burdens.

**3. Inadequate CMS Resources to Ensure Accuracy of Previous Hospice Service.** The resource currently available for use by hospices (primarily the Common Working File – CWF) in determining previous history of hospice care by a patient are not

sufficiently up to date to be able to rely on them with absolute accuracy for purposes of establishing the patient's full history of hospice care and current benefit period. Nor can hospices fully rely on reports by patients or family members to document previous hospice service. CMS is contemplating incorporation of hospice data into the redesigned Provider Statistical and Reimbursement Report (PS&R); however, it is unclear when the PS&R might be able to provide better information so that hospices can track previous patient service by another hospice with certainty.

**Recommendations:** Until such time as CMS can ensure that the CWF and/or PS&R hospice data are accurate and timely, a hospice should be responsible for counting only those benefit periods during which the patient was under its care. Alternatively, CMS should provide clear guidance on what would constitute a hospice's "best effort" to secure the patient's full hospice history for establishing the proper benefit period, and provide a "hold harmless" for those programs who have met the "best effort" standard.

#### **4. Challenges Related to Meeting Face-to-face Requirement for Patients**

**Readmitted While Actively Dying.** It is not unusual for a patient who has previously been served by a hospice and revoked election to be readmitted to hospice in the latest stage of his or her terminal diagnosis. Some patients resume care for only a day or two before they die. In cases where resumption of care begins very close to the 180-day benefit period or subsequent benefit periods, a hospice may not be able to provide needed care on a timely basis while at the same time ensuring that a physician/NP encounter takes place prior to the patient crossing benefit periods. If the patient has been on service by a different hospice previously and accurate information related to the patient's care history may not be available through the CWF, difficulties in meeting the face-to-face encounter requirement will be exacerbated.

**Recommendations:** CMS should forgo imposition of the face-to-face requirement in cases where a patient's referring physician and/or hospice staff assess a patient as imminently terminal and must begin treatment immediately to ensure that the patient receives needed services.

**5. Application of Benefit Period Standard for Patients with Sequential Hospice Care/Terminal Diagnoses.** Hospices have also raised an additional concern with respect to counting hospice care for purposes of the benefit period in that there are cases where a patient may have been diagnosed as terminally ill, elected the hospice benefit, and subsequently underwent recovery and left hospice care. There are instances in which these patients return to hospice care at a later date (sometimes years later) and in some cases with a different terminal condition. However, the hospice benefit periods are calculated on full hospice care history rather than based on the terminal diagnosis that justifies care currently being provided.

**Recommendation:** CMS should apply the benefit period calculation requirement to the current terminal diagnosis, as opposed to all service under hospice throughout the patient's care history. Additionally, in cases where a patient has revoked his or her hospice election or has been discharged from hospice services for whatever reason and is off hospice service for a significant period of time, CMS should allow hospice programs to "start the clock" over again for purposes of establishing when the face-to-face requirement must be met.

**6. Potential for Professional/Ethical Conflict.** Under current Medicare law, patients electing hospice maintain eligibility to receive services under the regular Medicare benefit for health concerns not related to the terminal diagnosis. Hospice programs have raised concerns that hospice physicians/NPs may, during their visits 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. 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.

**Recommendation:** CMS should acknowledge the potential for such professional/ethical conflicts and make every effort to avoid establishment of any barriers (either through the hospice conditions of participation 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 face-to-face encounter.

Once again, we appreciate the opportunity to comment on the proposed regulations as put forth by CMS. Please feel free to contact us if we can provide further clarification on any of these points or if we can be of service in any way.

Sincerely,

A handwritten signature in black ink, appearing to read 'Theresa M. Forster', written in a cursive style.

Theresa M. Forster  
Director

Attachment



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Carla M. Braveman  
*Chair*

June 17, 2010

ATTN: Lori L. Anderson  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

**RE: Comments and Recommendations on Implementation of PPACA  
Section 3132(b) Requirement for Hospice Physician/NP Face-to-Face  
Encounter Prior to 180<sup>th</sup> Day Recertification of Eligibility for Services**

Dear Ms. Anderson:

Over recent weeks, the Hospice Association of America, an affiliated organization of the National Association for Home Care & Hospice (NAHC), has sought input from its members on concerns and suggestions for implementation of Section 3132(b) of the Patient Protection and Affordable Care Act (PPACA), which requires that a hospice physician or nurse practitioner (NP) conduct a face-to-face meeting with a hospice patient prior to the 180<sup>th</sup> day recertification (and for each subsequent recertification) to determine continued eligibility for services. We are hopeful that the following comments will assist the Centers for Medicare & Medicaid Services (CMS) as it develops proposed regulations to govern this new legislative requirement. What follows is an effort to synthesize the feedback we have received from numerous providers of hospice services.

**RECOMMENDATION: Phase in the requirement for a face-to-face encounter by applying it to hospices that have a high proportion of long stay patients first, subsequently applying it to all hospices.**

Hospice providers are appreciative of the need for greater accountability in the Medicare program and understand the rationale that served as the impetus for enactment of the face-to-face requirement. We believe that implementation of the requirement that a physician provide a narrative explanation of the clinical findings that support life expectancy of six

months or less and the accompanying attestation will help to ensure greatly improved engagement of the certifying physician(s) in the patient's case and condition. Given that the narrative and attestation requirement to the physician certification and recertification process was only recently implemented (October 1, 2009) and that information is not yet available as to the impact it may be having on hospice utilization, as well as the concerns that many hospices (particularly smaller and rural programs) have about their ability to meet the face-to-face encounter requirement, we strongly recommend that CMS take a stepped approach to implementing the face-to-face requirement, beginning with hospice programs that have higher proportions of long stay patients (as referenced in section 3132(b)(ii)). CMS may also wish to consider, at least initially, imposing the requirement on every other recertification, as was recommended by the expert hospice panel to the Medicare Payment Advisory Commission (MedPAC) in 2008.

**RECOMMENDATION:** The physician/NP encounter should be billable to Medicare by the hospice program if conducted by a practitioner (including an NP) employed or under contract with the hospice; likewise, the encounter should be billable to Medicare by the attending physician if the encounter is conducted by the attending physician. CMS should specify the billing code under which either the hospice program or attending physician must bill for the encounter; this code should include reimbursement of mileage and travel time for a high-level practitioner.

Hospice programs average very low financial margins under the Medicare program. Depending on the specifics of the regulations implementing the face-to-face requirement, most programs anticipate the new requirement will significantly add to the demands on the physician or NP who must conduct the encounter. In some cases hospices will be required to employ or contract with additional practitioners to meet the new rule. Hospices cannot easily absorb the added costs. For this reason, the rule should specify that the hospice program is able to bill for the services of the hospice physician or NP who conducts the encounter.

**RECOMMENDATION:** Provide clear guidance to hospice programs on what elements make up an encounter for purposes of satisfying the requirement, how the requirement will be satisfied in cases of breaks in service, and the way in which patient service days will be calculated for determining appropriate timing of the encounters.

The legislative language under section 3132(b) provides little guidance regarding what is expected of the physician/NP who is conducting the encounter. CMS must clearly delineate the content of the encounter. Additionally, the legislative language on the face to face requirement suggests the encounter must be conducted prior to the 180<sup>th</sup> day recertification (and prior to subsequent recertifications) but raises questions as to how CMS will address instances where a hospice may discharge a patient prior to the patient hitting the 180<sup>th</sup> day recertification and subsequently reenroll the patient. We believe that clear guidance must be provided so that patients in need of continuing services will be protected against discharge by programs that may be attempting to

avoid the face-to-face requirement. Finally, given that hospice patients may experience breaks in service due to a change in their medical status, as recognized by the change to unlimited 60-day benefit periods, guidance is needed on how CMS will calculate the days on service for purposes of when the face-to-face requirement will be required.

**RECOMMENDATION: Allow for the encounter to be conducted by means of telehealth, including telephone, interactions between physician/NP and patient or responsible family member.**

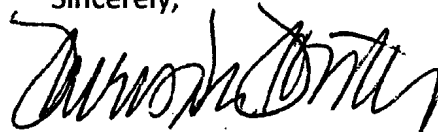
In growing numbers, hospice programs are developing and utilizing telehealth programs as efficient and effective means for monitoring patient status and maintaining active communication. Given concerns regarding the increased burden on physician/NP practitioners and added costs associated with the face-to-face requirement, CMS should allow use of telehealth – including physician/NP consultation with the patient or a responsible family member by telephone – as a means for fulfilling the face-to-face encounter requirement.

**RECOMMENDATION: An encounter with the hospice medical director, a hospice-employed or contracted physician/NP, or the patient's attending physician should satisfy the requirement.**

**Rationale:** The legislative language states “a hospice physician or nurse practitioner” must conduct the face-to-face encounter. It is unclear whether this means that the professional must be under contract or in the employ of the hospice, or if the requirement could be satisfied by an encounter with the patient's attending physician. Hospice programs, particularly smaller or rural programs, have expressed concern that this requirement will substantially add to the workload of their physician medical directors that in many cases are part-time volunteers or contract staff who also have private practices. Similarly, with physician and NP shortages widespread in certain areas of the country, the availability of these professionals to meet the new requirement is uncertain. For this reason, we recommend flexibility as to who is eligible to conduct the encounter.

Many thanks for your consideration of these recommendations. We would be happy to discuss these recommendations or any other issues related to implementation of section 3132(b) with members of the CMS staff. Please feel free to contact me by telephone at 202-547-7424 or by email at [tmf@nahc.org](mailto:tmf@nahc.org) if we can be of further assistance.

Sincerely,



Theresa M. Forster, Director  
Hospice Association of America