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PRESERVE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT

ISSUE: The Patient Protection and Affordable Care Act (PPACA), enacted in March 2010 as Public Law 111-148, requires the development of Medicare hospice payment system reforms along the lines recommended by the Medicare Payment Advisory Commission (MedPAC) in 2009 and again in 2010 (Section 3132(a)). Under the new law, the effective date for collection of data to begin is January 1, 2011, with system reforms in operation no earlier than October 1, 2013.

P.L. 111-148 also includes interim hospice payment changes, including the institution of a productivity adjustment to the annual market basket inflation update beginning in FY2013. In addition, the final reform bill reduces the market basket index by 0.3 points for FY2013 through 2019, but conditions the 0.3 point market basket reductions in each of FY2014 – 2019 on growth in the health insurance-covered population exceeding 5 percent in the previous year.

RECOMMENDATION: Congress should restore the market basket and productivity reductions authorized under P.L. 111-148 and reject any further proposals to cut the hospice market basket update. A study of the need for refinements in the Medicare hospice benefit as recommended by the Government Accountability Office (GAO) and MedPAC should be conducted before any cuts in reimbursement are undertaken. Also, Congress should oppose any reductions in the annual updates until such time as all payment reforms are instituted and then only after the issues are fully examined.

RATIONALE:

- Beginning in FY2010, the Centers for Medicare and Medicaid Services (CMS) begin phasing out by regulatory issuance the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index over seven years. It is estimated that the phase-out, when completed, will reduce hospice payments by 4 percent.
- MedPAC has projected that Medicare hospice financial margins for 2011 (without consideration of costs related to volunteer and bereavement services) will average about 4.2 percent; however, there is some concern that these estimates may not take into full account costs associated with the new face-to-face encounter requirements that went into effect Jan. 1, 2011.
- A study by Duke University showed that patients who died under the care of hospice cost the Medicare program an average of about \$2,300 less compared

with those who did not. In its June 2004 report on the Medicare hospice benefit, the GAO determined that 34 percent of hospices in 2000 and 32 percent in 2001 had higher costs than reimbursements. A cut in the market basket update would impair the ability of hospices to maintain Medicare beneficiary access to care.

- The GAO recommended that CMS should 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. It did not recommend an across-the-board cut in hospice payments. CMS is in the process of collecting such data for analysis.
- MedPAC, at its November 2008 and subsequent meetings discussed potential recommended revisions to the Medicare hospice benefit reimbursement system. There is concern about the costs of short stay patients not being covered in the current reimbursement system. Financial margins for hospices with shorter stay patients are generally significantly lower than those of hospices serving long-stay patients. Paying accurately for all types of patients is important to ensure access to services for all Medicare beneficiaries who want to elect hospice care and to ensure that the program is paying rates that cover providers' costs for all types of patients.



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HOSPICE PHYSICIAN/NURSE PRACTITIONER FACE-TO-FACE ENCOUNTER REQUIREMENT

Background

The Patient Protection and Affordable Care of 2010 (PPACA) conditions Medicare payment for extended-care hospice patients on a face-to-face encounter with a hospice physician or nurse practitioner (PPACA Section 3132(b)). The Centers for Medicare and Medicaid Services (CMS) promulgated a Final Rule on November 2, 2010 that requires the encounter within 30 calendar days of the start of the 3rd or subsequent benefit period (usually after 180 days of hospice care) (75 Fed. Reg. 70372, November 17, 2010). The rule sets out CMS's implementation in a prescribed format for the encounter and documentation thereof.

Concern

The hospice face-to-face encounter requirement applies to patients entering their 3rd or subsequent benefit period on or after January 1, 2011. At this point, CMS has yet to issue interpretative guidelines that are needed to make the rule operational. Further, CMS has yet to clarify a number of the ambiguities in the rule. CMS has not initiated major education or awareness efforts directed to hospice agencies, hospice physicians/nurse practitioners, or Medicare beneficiaries. Of greatest concern, though, are the facts that many small and/or rural hospice programs with limited staff may have great difficulty meeting the requirement given the short time frame, and hospice programs generally may be discouraged from taking actively dying patients with previous hospice care history onto service because the hospice cannot arrange a face-to-face meeting before beginning care. While CMS may plan to issue electronic web site postings and to host an "Open Door" forum in the future, these efforts will be insufficient to bring patients, physicians and hospice administrative personnel to the level of knowledge needed to ensure timely and unimpeded access to needed hospice care within the short time before the rule becomes effective. The rule is complicated and the limited educational plans by CMS cannot possibly bring about the needed understanding of the rule among thousands of Medicare hospices and their administrative staff, hospice physicians and nurse practitioners, and hospice beneficiaries by January 1.

Proposal

1. Implement the rule as planned on January 1, but do so with a transitional period of no less than 6 months wherein CMS will monitor for compliance, provide notice of noncompliance where appropriate, provide continuing education on the requirements, and institute changes in instructions and guidelines where needed. Noncompliant claims would not be denied payment until successful completion of the transition period. Essentially, this approach is a "dry run" on the rule allowing CMS, physicians, patients, and providers to work out any misunderstandings, confusions, or knowledge shortfalls.
2. Require CMS to extend flexibility relative to imposition of the hospice face-to-face requirement in instances where a patient with previous history of hospice care is being admitted in the final stages of a terminal illness and in immediate need of hospice services.
3. Require CMS to initiate a comprehensive educational plan for hospice agencies, their personnel and hospice beneficiaries to ensure a thorough understanding of the requirements.

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Authority

PPACA states that the hospice physician/nurse practitioner encounter requirement applies for patients entering their 3rd or subsequent benefit period “on and after January 1, 2011.” At the same time, the PPACA mandate allows the encounter and its attestation to take place “in accordance with procedures established by the Secretary.” Accordingly, the Secretary has the authority to establish a transitional procedure and take additional steps to ensure appropriate understanding and application of the rule in order to avoid impediments to necessary access to hospice care.