MEDPAC Medicare Payment Advisory Commission

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June 17, 2009

Charlene Frizzera, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1420-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: File code CMS-1420-P

Dear Ms. Frizzera:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled *Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2010; Proposed Rule.* We appreciate your staff's ongoing work to administer and improve the payment system for Medicare hospice services, particularly given the competing demands on the agency.

As you know, the Commission made a number of recommendations concerning the hospice benefit in our March 2009 Report to Congress. Our recommendations concerning hospice have been motivated by several observations. The Commission's analyses have found that Medicare's hospice payment system contains incentives that make very long stays in hospice profitable for the provider, which may have led to inappropriate utilization of the benefit among some hospices. We have also found that there is a need for more administrative and other controls to check the incentives for long stays in hospice and that CMS needs more data to effectively manage the benefit. Our recommendations sought to reform the payment system, ensure greater accountability within the hospice benefit, and improve data collection and accuracy. We appreciate the consideration that CMS gave these recommendations in the proposed rule. Our comments below focus on the discussion of these issues in the proposed rule.

Physician narrative in certifications and recertifications

The rule proposes to adopt a MedPAC recommendation to require that physicians who certify or recertify hospice patients as terminally ill include a brief narrative explanation of the clinical findings that support a life expectancy of six months or less. As you know, the Commission's recommendation was informed by discussions of an expert panel of hospice medical directors and executives we convened in the fall of 2008. Panelists indicated that some hospices are providing care to Medicare beneficiaries who do not meet the terminal illness requirement, which they attributed, in part, to a lack of physician engagement in the certification and recertification process. We believe that the proposed requirement for a physician narrative would be a valuable step to encourage greater physician engagement and accountability in the certification and recertification process. Such a requirement would help ensure that the physician certifying or recertifying a Medicare patient's hospice eligibility had reviewed the patient's medical record and could synthesize briefly the clinical rationale for their determination that the patient has a life expectancy of six months or less.

The proposed rule states that the narrative should be written or typed on the certification form, and not an attachment because an attachment could be easily prepared by someone other than the physician. We support these efforts to ensure that the narrative is developed by the physician performing the certification or recertification. Along these lines, we suggest that to ensure that the narrative reflects the patient's individual clinical circumstances, CMS should indicate that neither check boxes nor standard language would be permitted to satisfy the requirement. Additionally, we urge CMS to clarify in the regulatory text that this narrative *must* be composed by the physician performing the certification or recertification, and not other hospice personnel. The certification form containing the narrative should include under the physician's signature a statement indicating that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record (and, if applicable, examination of the patient).

Recertification Visits

The proposed rule does not make a proposal, but does seek comment, on a MedPAC recommendation to require a physician or advanced practice nurse to visit the hospice patient prior to the 180 day recertification, and every subsequent recertification thereafter. We believe such visits would help to inform physicians' determinations about patients' continued eligibility for hospice when they recertify patients who approach or have surpassed the presumptive eligibility period (180 days). We note that a few members of our hospice expert panel, including one from a rural area, indicated that it was

common practice at their hospice for a physician to visit patients whose stays approach 180 days to assess continued eligibility.

The proposed rule sought comment on a few specific issues regarding a potential recertification visit requirement, including whether nurse practitioners who perform recertification visits should *not* be involved in the hospice patient's day-to-day care to ensure objectivity. We agree that it would be important for information provided in recertification visits to be objective. The Commission recommended that nurse practitioners be allowed to perform recertification visits (although only a physician is allowed to sign the recertification) to provide additional options for rural areas where travel distances may be long. We believe that any requirement concerning nurse practitioner recertification visits should balance the need for objective information with rural feasibility considerations. One approach that could be considered would be to allow a nurse practitioner who is involved in the patient's day-to-day care to perform some recertification visits, but not the first recertification visit and not consecutive recertification visits.

The proposed rule also indicated that there are different possible approaches for establishing the timeframe for recertification visits, mentioning the "2-week period centered around the recertification date" as one possibility. The Commission believes that the recertification visits should occur over a reasonable timeframe *before* the recertification date. If the visit was to occur after the recertification date, it could create a disincentive for hospices to discharge a patient since it would result in a lack of payment for days of care already provided beyond the recertification date.

Hospice payment reform

The proposed rule seeks comment on the MedPAC recommendation to move away from Medicare's current flat per diem payment system to one under which per diem payments for an episode of care begin at a relatively higher rate but then decline as the length of the episode increases, with an additional payment at the end of the episode to reflect hospices' higher level of effort near the time of a patient's death. While such changes would require Congressional action, we appreciate CMS's efforts to seek comments on this approach.

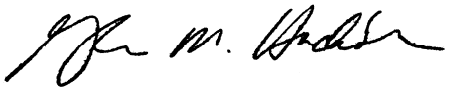
As we have noted previously, the current flat per diem payment system creates incentives for long lengths of hospice stay. We believe the payment system reforms we have recommended would better reflect changes in hospices' level of effort in providing care throughout the hospice episode. In so doing, we believe this approach would promote hospice stays of a length consistent with hospice as an end-of-life benefit (reducing the number of extremely long stays) and will provide incentives for hospices to more closely monitor patients' admissions and continued eligibility for hospice.

Hospice data collection

The Commission would like to acknowledge the update provided in the proposed rule on CMS's ongoing efforts to improve the data available on Medicare hospice claims and costs reports. As you know, the Commission has been a proponent of additional hospice data collection. For example, as indicated in our March 2009 Report to Congress, we believe it would be valuable to include additional data on the Medicare hospice cost reports (such as Medicare payments by the four categories of hospice care, additional sources of revenue such as charitable contributions, and days of care for Medicare non-dual eligibles, Medicaid non-dual eligibles, and Medicare/Medicaid dual eligibles) and to institute stronger cost report edits and additional audit criteria. We also believe that increasing the data reported on hospice claims, particularly additional information on the duration and type of visit, would be beneficial. We look forward to the enhanced claims and cost report data that the agency is working to put in place, as we believe additional data will be important to policy makers in their efforts to further strengthen the Medicare hospice benefit.

MedPAC appreciates the opportunity to comment on the rule. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman