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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1420-P
PO Box 8012
Baltimore, MD 21244-8012

To Whom It May Concern:

The Center for Medicare Advocacy (Center) appreciates this opportunity to comment on the proposed rules published in the Federal Register on Friday, April 24th. The Center is a private, non-profit organization that provides education and legal assistance to advance fair access to Medicare and health care.

A. Proposed Change to the Physician Certification and Recertification Process, § 418.22

The Centers for Medicare & Medicaid Services (CMS) proposed adding a new paragraph to 42 CFR § 418.22 requiring that physicians that certify or recertify hospice patients as being terminally ill include a brief narrative explanation of the clinical findings that support a life expectancy of six months or less. This proposed rule will help accomplish the goal of increased physician engagement in the certification and recertification process. Furthermore, it will provide a succinct statement of the case which will assist providers and beneficiaries in the event that cases later need to be appealed for coverage.

B. Proposed Update of Covered Services, § 418.200

CMS proposed revising § 418.202(f) to state that medical supplies covered by the Medicare hospice benefit include only those that are part of the plan of care and that are for the palliation or management of the terminal illness or related conditions. This is

helpful language but it begs the more difficult question of determining what care is related to the terminal illness or related condition. In order to avoid arbitrary or capricious results, hospices should be required to have written policies describing their processes for determining whether care is related to the terminal illness or related condition.

C. Proposed Clarification of Payment Procedure for Hospice Care, § 418.302

CMS proposed revising § 418.302(f)(2) to clarify that only inpatient days in which General Inpatient care or respite care is provided and billed are counted as inpatient days when computing the inpatient cap. This language will be a helpful clarification.

D. Hospice Aggregate Cap Calculation

Since its inception, the Medicare regulations have included a cap limiting the average annual payment per patient a hospice can receive. If a hospice provider's total payments divided by its total number of beneficiaries exceed the cap amount, then the provider must repay the excess to the program. As written in the regulation, this cap is not a spending limit on each individual beneficiary but is applied to the hospice provider. CMS proposed methods to incorporate efficiencies in the cap calculation process using more sophisticated databases and data systems. According to CMS this will enable hospices to "more quickly review their admissions practices, and make necessary changes to ensure that all their patients meet the eligibility requirements for hospice care."

Prior to drawing this conclusion, one must remember that when the cap was first implemented, the hospice benefit was constructed to limit hospice coverage to six months of Medicare covered care. However, in 1998, the regulations were changed so that access to hospice is not limited to six months. Beneficiaries are now eligible for an unlimited number of 60 day certification periods as long as they continue to have a "life expectancy of 6 months or less if the terminal illness runs its normal course."

When hospice care was first covered by Medicare, no hospices exceeded the cap. Since the hospice benefit has been expanded to cover care for beneficiaries who are terminally ill, regardless of how long they live with the terminal illness, some hospices are now exceeding the hospice cap. Specifically, 8% of hospices exceeded the cap in 2005. Those hospices that exceed their aggregate cap must pay the excess back to Medicare. This is a significant sanction. To avoid future penalties, hospices may inappropriately discharge beneficiaries who live beyond six months. Alternatively, to avoid the cap sanction, hospices may choose not to admit patients with "less predictable trajectories" until the last days of their illness.

The cap needs to be modernized. This is because it currently encourages hospices to look at their financial bottom line rather than the medical condition of their individual patients. The various methods of modernization suggested by CMS will only exacerbate this problem. Instead CMS should consider methods that will ensure that hospice admissions

and decisions regarding ongoing care will not be assessed on cap calculations and fear of future liability, but rather solely on the medical condition of the individual patient.

E. Hospice Payment Reform

CMS states that the national average length of stay for patients in hospice has risen from 48 days in 1998 to 73 days in 2006. This is not alarming given that the benefit is available for those who have a life expectancy of 180 days or less if the illness runs its normal course. CMS notes (apparently based on data from 2005) that hospices in the 90th percentile have average lengths of stay of 212 days. This could be alarming, but it seems reasonable to assume that this group must be the same small percentage (8%) that exceeded the hospice cap in 2005. MedPAC identifies these hospices as largely for-profits, with smaller patient loads, and freestanding facilities.

Based on this information, MedPAC concluded that the current flat per diem system improperly influences hospice length of stay for *some* hospice providers. To remedy the problem, MedPAC proposed a U shaped curve for all providers. With this structure, hospices would be paid more during admission and during the last days of a beneficiary's life, but less during the middle period. Given that most hospice patients are only getting 73 days of care, it is rash to change the whole payment structure, because 8% of hospices (largely small and for-profit) are potentially abusing the system.

If MedPAC's U shaped payment curve is implemented it will have the overall effect of decreasing access to hospice care. Hospices will decide they cannot afford to take care of those who may live for longer periods of times. This category of beneficiary includes those dying with diagnoses such as Alzheimer's disease, chronic obstructive pulmonary disease, and congestive heart failure.

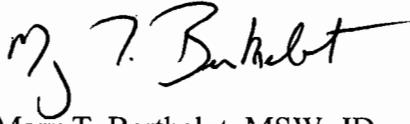
A better solution for addressing concerns regarding fraud and abuse is increased survey activity by local government agencies. Currently CMS recommends surveys only every 8 years. This is not enough. Increased survey activity will ensure that Medicare's dying beneficiaries and their families are actually receiving all the care promised by the benefit. Moreover, it will not have the unintended consequence of inappropriately limiting access to care.

F. Update on Additional Hospice Data Collection

CMS has proposed collecting more information on hospice claims. The collection of this information will be beneficial to CMS and to the hospice community. It will help CMS understand and quantify the value of hospice care both in terms of quality of care and cost savings for the healthcare system at large.

For further comment, I can be reached at 860-456-7790.

Sincerely,

A handwritten signature in cursive script, appearing to read "Mary T. Berthelot". The signature is written in dark ink and is positioned above the printed name.

Mary T. Berthelot, MSW, JD
Attorney at Law