CMS-1539-P-10

Submitter : Mr Rebecca Baisch **Date:** 06/29/2007

Organization : Hospice of Eastern Idaho Inc

Category : Hospice

Issue Areas/Comments

Educational Requirements for Nurse Parctitioners

Educational Requirements for Nurse Parctitioners

Regarding the proposed rule to reduce the hospice reimbursement rate to a lesser figure if the care is given farther away from a main office in a CBSA, or indeed any main office: the personnel giving said care are usually hired in, and paid at, the prevailing rate for their home office area. In addition, the farther one goes from the main offices, the higher the transportation costs become, necessitating either a higher compensation level, or payment of mileage to the employee. At the very least, the rates should continue to be based on the costs in effect at the hospice's main office.

Submitter : **Mr. Alan Morgan** **Date: 06/29/2007**

Organization : **National Rural Health Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1539-P-11-Attach-1.DOC

#11

Administrative Office
521 E 63rd Street
Kansas City, Missouri 64110-3329
Telephone: [816] 756.3140
FAX: [816] 756.3144

NATIONAL RURAL HEALTH ASSOCIATION

Government Affairs Office
1600 Prince Street, Suite 100
Alexandria, Virginia 22314-2836
Telephone: [703] 519.7910
FAX: [703] 519.3865

June 29, 2007

Leslie Norwalk, Esq., Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Delivered Via On-Line Form: *http://www.cms.hhs.gov/eRulemaking*

Subject: CMS-1539-P – Medicare Program; Hospice Wage Index for Fiscal Year 2008; "Rural Areas Without Hospital Wage Data"

Dear Administrator Norwalk:

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the impact of the Centers for Medicare and Medicaid Services' above referenced Proposed Rule on the nation's hospice system and the Medicare program. We look forward to working with you on our mutual goals of improving access and quality of health care for all rural Americans, while making sure that the Proposed Rule does not have a negative impact on the unique circumstances of rural hospice providers.

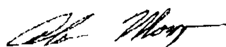
The NRHA is a national nonprofit membership organization with over 15,000 members that provides leadership on rural health issues. The Association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

The NRHA acknowledges CMS' dilemma in adopting a wage index in geographic areas where there are no hospitals located in the market designation and applauds the efforts to find a new methodology that works for the two regions where this applies, Massachusetts and Puerto Rico. We would not argue with the logic and the use of pre-floor, pre-reclassified wage index data for Massachusetts. This seems to be a reasonable way for CMS to approximate the same information that is used to calculate the wage index for an area that lacks the necessary data from hospitals.

However, we ask that CMS not simply take this formula and use it across the nation without further review. In the proposed rule, CMS states that "this policy could be readily applied to other rural areas…should a similar situation arise in the future, we may re-examine this policy." We strongly urge CMS to follow statements made in this regulation and re-examine this policy if it is needed in other situations. Massachusetts is a very different state than most others in the country. The formula that seems to make a lot of sense in that part of the country, may not work in others. CMS, in the Proposed Rule, has already shown the necessary flexibility and good judgment in creating a system that is different for Massachusetts and Puerto Rico. The NRHA is not sure whether similar tweaks may be necessary if other situations present themselves, it is our belief, however, that they should be evaluated if needed.

Thank you for your consideration of these comments. We look forward to continuing our work together to mutual goals of improving access and quality of health care for all rural Americans. If you would like additional information, please contact Maggie Elehwany, Vice President of Government Affairs and Policy, at 703-519-7910.

Sincerely,



Alan Morgan
Chief Executive Officer

CMS-1539-P-12

Submitter : | **Date:** 07/02/2007

Organization : National Association for Home Care & Hospice

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1539-P-12-Attach-1.DOC

#12

National Association for Home Care & Hospice

July 2, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8012
Baltimore, Maryland 21244-1850

Attention: CMS-1539-P Medicare Program: Hospice Wage Index for Fiscal Year 2008, Clarification of Selected Existing Regulations and Policies

The National Association for Home Care & Hospice (NAHC) is the largest national organization in the United States representing hospices and home care agencies and the thousands of caregivers and patients they serve. We appreciate the opportunity to comment on the proposed Hospice Wage Index for Fiscal Year 2008 and Clarification of Selected Existing Medicare Hospice Regulations and Policies. NAHC circulated the proposed Centers for Medicare & Medicaid Services (CMS) changes and clarifications in an E-Newsletter to members and in Caring Magazine which has a distribution of approximately 30,000 (all hospices, home health agencies and hospitals in the United States).

The comments NAHC received from hospices expressed the belief that the changes and clarifications were reasonable and NAHC agrees with this perspective. There were comments that the reimbursement rate for the inpatient respite level of care is very inadequate as has been pointed out in the Government Accountability Office October 2004 Report *Medicare Hospice Care Modifications to Payment Methodology May Be Warranted.* The GAO's analysis of hospice costs and payments concluded that the inpatient respite level of care reimbursement was 53 percent lower than costs in 2000 and 61 percent below costs in 2001. This trend has not changed. When a hospice patient is placed in a facility for the inpatient respite level of care, the hospice continues to provide

visits, drugs, supplies, etc. as needed in addition to paying the facility more than the hospice inpatient respite reimbursement rate. As CMS is serious about making things clear and rational regarding the general inpatient level of care, it should follow that the inpatient respite level of reimbursement be such that it covers the costs involved.

Thank you again for the opportunity to comment.

Sincerely,

Janet E. Neigh

Janet E. Neigh
Vice President for Hospice Programs

CMS-1539-P-13

Submitter : Ms. Mary Ann Starbuck

Date: 07/02/2007

Organization : Southern Tier Hospice and Palliative Care

Category : Hospice

Issue Areas/Comments

Educational Requirements for Nurse Parctitioners

Educational Requirements for Nurse Parctitioners

See Attachment

GENERAL

GENERAL

See Attachment

Payment for Hospice Care Based on Location

Payment for Hospice Care Based on Location

See Attachment

CMS-1539-P-13-Attach-1.DOC

#13

July 2, 2007

Department of Health and Human Services
Attention: CMS-1539-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

Thank you for the opportunity to submit comments on the Proposed Rule CMS-1539-P– FY 2008 Wage Index, published in the Federal Register on May 1, 2007. Please consider our comments concerning the wage index, site of service and caregiver breakdown and general inpatient care.

"Wage Index"

While recognizing that the methodology for preparing the annual wage index is established, it is worthwhile to note the disadvantage placed on rural areas, particularly those adjacent to urban areas with a much higher wage rate. Commuting an hour or more to work is not uncommon in Upstate New York and many rural areas of the country. With the low rural wage index for hospice, many rural hospices find themselves competing for nursing staff and social workers as well as other employees with both hospices and other health care providers in urban areas with much high reimbursement rates, thus the ability to pay higher salaries. Additionally, staff in urban areas often travel fewer miles to visit patients and thus retain more income when fuel prices are as high as they have been so far this year. It is strongly recommended that CMS look at ways to reflect the higher incident of employee cost with hospice in rural areas because the service is provided primarily in patient's homes and, potentially, look at a way to blend rural rates with urban rates in areas where there is clearly a rural staff drain to more urban areas.

"Site of Service"

CMS is urged to remove the following statement from the final regulations: "...hospice providers have been able to inappropriately maximize reimbursement by locating their offices in high-wage areas and delivering services in a lower-wage area. We also believe that hospice providers are also able to inappropriately maximize reimbursement by locating their inpatient services either directly or under contractual arrangements in lower wage areas than their offices." This statement is both inflammatory and demeaning to hospice, and does not appear to be substantiated by fact. Hospices generally contract with all hospitals in an area and the patient chooses the hospital which he or she prefers. Certainly a hospice might have an inpatient unit in a particular hospital, but it is doubtful that a hospice would do this or arrange contracts based on manipulating inpatient reimbursement rates. Furthermore, since urban areas generally have higher rates, most hospice patients and their families would complain if the patient was forced to be receive inpatient services in an area further from home.

Is it not possible that any case CMS has seen of inpatient in a lower rate area is only a reflection of patient choice? Many, if not most hospices, reimburse the contracted hospital almost all of the GIP. Given this, many if not most hospices would not benefit from manipulating the location of inpatient care. If the office is located in a higher wage rate area while most of the care is provided in lower wage rate areas, might this not occur because it is easier to secure staffing in the more populous urban area? Might the urban area be more central to the entire service area and more accessible because of interstates, etc.? STHPC actually suffers in the reverse; our office is in a rural area while most of our inpatient care occurs in the urban area. However, this was the best location for our office and the most central for our staff and patients. It would seem that most hospices would make decision regarding office location for these factors rather than reimbursement.

The statement is unnecessarily harsh, given the fact that the following justification seems adequate: "We believe that the application of the wage index values, for rate adjustments on the geographic area, where the hospice care is furnished provides a reimbursement rate that is a more accurate reflection of the wages paid by the hospice for the staff used to furnish care. We also believe that payment should reflect the location of the services provided and not the location of an office."

If CMS or any fiscal intermediary feels that a particular hospice is manipulating rates, I strongly suggest that CMS or the fiscal intermediary contact this hospice or those hospices directly. First, this may simply be a misperception by CMS or the fiscal intermediary and as noted above. However, if a hospice is truly manipulating patient care in this manner, it is doubtful that this change alone will cause the hospice to cease manipulating reimbursement over patient care. Direct action should be taken rather than smearing all hospices or believing that this singular action will change the overall practice of a particular hospice.

"Care Giver and General Inpatient Care"

This is clearly **NOT** a "clarification." The Medicare policy is stated as it has been interpreted for more than twenty years:

Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting. (Chapter 9 of the Medicare Benefit Policy Manual 40.1.5 - Short-Term Inpatient Care (Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

This has been the written guidance from CMS and fiscal intermediaries over the twenty plus years that Hospice has been a Medicare covered service. To suddenly state that "...some hospices are billing Medicare for "caregiver breakdown" at the higher "general inpatient level, rather than the lower payment for "inpatient respite" or "routine home care" levels of care...." when this is exactly what the Medicare Benefit Policy Manual states should be done, is incomprehensible.

Further, to state that "To receive payment for "general inpatient care" under the Medicare hospice benefit, beneficiaries must require an intensity of care directed towards pain control

and symptom management that cannot be managed in any other setting." when the Medicare benefit policy manual states that caregiver breakdown can justify "general inpatient care" is incorrect. If the justification for short term inpatient care is only pain and symptom management that cannot be provided in another setting, why would the manual and consistent CMS and fiscal intermediary transmittals have referred to "caregiver breakdown" as a justification?

"Caregiver breakdown" should not be billed as "general inpatient care" regardless of where services are provided, unless the intensity-of-care requirement is met." This is contrary to practice for the past twenty plus years. **Caregiver breakdown is and always has been a justification for short term inpatient care; it could not legally be considered a "clarification" to change this after twenty years.**

Perhaps it would be helpful to consider several real life examples of caregiver breakdown. These are situations where the patient was being cared for at home and would not have been considered for inpatient admission, but for the fact that there was caregiver breakdown.

Example A
A young woman is being cared for at home by her husband while receiving hospice services. The patient is routinely receiving break through medication for pain, is bed bound and unable to perform any ADLs without assistance. The hospice volunteer arrives at the home to find the caregiver on the floor unresponsive and the patient screaming. She calls 911 and hospice, and the caregiver is transported to the hospital where he is admitted for an MI. There is neither other family nor friends who can care for the patient so the patient is transferred to the hospital for short term inpatient care. There are no nursing home beds at the time, and the placement process is begun upon admission. What would happen to this patient if she were not admitted for short term inpatient care? This was not a planned respite and there was no way to guarantee that she could be placed within 5 days. She could have revoked hospice in which case she would have been admitted to the hospital, an IV would be placed and Medicare would pay a hefty reimbursement to the hospital. What would that serve? What did happen to this patient? The hospice staff followed both the patient and her caregiver and the patient returned to the home the day following the caregiver's discharge on the seventh day following the MI. Medicare only paid out the hospice short term inpatient rate for six days, much less than the hospital DRG, the patient did not receive expensive and unnecessary treatment in the hospital, and everyone won.

Example B
An elderly man is being cared for at his home by his daughter. While the caregiving is less than ideal at times, the patient and the daughter continue this arrangement with the support of hospice. The caregiver has a fight with two of her siblings who come to the home and complain, but have refused to provide any care. The father supports or appears to support the two non-caregiving

daughters in the disagreement and the caregiver leaves the home calling hospice from the bus station to state she is returning to her home out of state. Hospice calls the home and receives no answer. The hospice nurse immediately goes to the home to find the bed bound patient home alone and unsafe. He is soiled and confused. The patient is cleaned up by the case manager and LPN, while the social worker attempts to contact the daughters. No one is willing to care for the father; neighbors and friends are contacted, but are unable to provide care. There is no male bed available in an area nursing home and the patient is placed in GIP given that he is unsafe home alone – unable to toilet himself, provide needed medications himself, etc. He is admitted for short term inpatient and transferred to a nursing home on day 8 when a male nursing home bed becomes available – thanks to extensive work by the social worker.

In addition to these examples, there have been several cases where given five, six or seven days, hospice has been able to gather family and friends to care for the patient at home. If the patient is able to care for him or herself at home alone, even though accustomed to having a caregiver and potentially more comfortable with a caregiver, this patient would not be admitted for caregiver breakdown. It is only used when the caregiving is essential, there was no way to plan for the circumstance – it is emergent, and there is no other setting. Again, please refer to the exact language from the manual, "Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting." This is the interpretation that hospice and fiscal intermediaries have used consistently. If the patient is unsafe alone, in need of medications that the patient cannot administer alone, and will be alone because of caregiver breakdown, inpatient care is needed. FI's have consistently allowed this on review, generally with the expectation that alternate arrangements are sought immediately and aggressively. However, this is not the same as symptom control for short term inpatient care without caregiver breakdown. . In these circumstances, the hospice patient either develops a new or exacerbated symptom at home that cannot be controlled in the home setting.

To reassure you, STHPC has used respite where the caregiving breakdown was not acute. Staff have cajoled caregivers to hold on while STHPC has arranged a placement or convinced caregivers to try a respite with a firm commitment that they will take the patient home at the end of the respite. STHPC has increased services where that patient could be home alone while the caregiver recuperates from an accident, injury or medical crisis. STHPC has even had instances were family and friends have been able to be pulled together quickly to cover in an emergency. However, this is not always possible. When caregiver breakdown has been used for admission, it has been because there was truly no other alternative to keep the patient safe and comfortable.

It is current and appropriate practice that fiscal intermediaries address inappropriate use of GIP. Hospices who have survived FMR for GIP report that fiscal intermediaries have routinely approved short term inpatient care for caregiver breakdown as described above, as well they should since this is allowable according to the Medicare manual.

Many hospice directors have asked for fiscal intermediary Medical Director clarification of caregiver breakdown in meetings, during phone calls and in specific instances. The clarification has consistently related that caregiver breakdown is a justification for inpatient admission when the situation is emergent, the patient would be unsafe/uncomfortable remaining at home due to lack of caregiving, and there was no other alternative.

It would be inappropriate for CMS to punish patients by removing a long established, needed benefit of the hospice program because CMS perceives some hospices are inappropriately using GIP. This universal blame seems to be a theme of these regulations. Perhaps CMS would benefit from studying the ineffectiveness of "group slap" punishment, particularly when only a few are in need of discipline. Again, if there are hospices misusing the GIP, and caregiver breakdown in particular, this should be addressed with the particular hospices.

"If the individual is no longer able to remain in his or her home, but the required care does not meet the requirements for "general inpatient care", hospices should bill this care as "inpatient respite care", payable for no more than 5 days, until alternative arrangements can be made." While hospices are fortunate to have hospitals and nursing home willing to contract for the hospice respite rate, these contracts indicate respite as a planned admission dependent upon bed availability. Caregiver breakdown is not planned and, often, the patient cannot be placed within 5 days since there has not been planning for placement. Nursing home beds are scarce and nursing homes require a Medicaid application, PRI, etc. to be in place before they will consider admitting a patient. STHPC has excellent relationships with a number of area nursing homes, however, same day placement has never been achieved nor New York State regulations. With a bed available, placement usually takes two to three days at minimum, and a bed is rarely available. STHPC is actually experiencing a decrease in hospice patients within the nursing home because nursing homes throughout New York State are pushing for greatly increased rehabilitation admissions with planned discharges. First, the reimbursement is better and secondly, this seems to be the push from the State. With this, there are fewer beds available and placement is often taking weeks. This is not a major problem for our patients where it is evident that placement will be needed in the future due to compromised caregiving. However, it will increase the need for admissions for caregiver breakdown when it is an emergent situation as described in the examples above.

Is CMS seeing more frequent use of caregiver breakdown? This would seem appropriate since most hospices are experiencing difficulty finding adequate caregiving as patients outlive family and friends, are more isolated from family and friends, and have family and friends who believe someone else should be responsible for providing custodial care for the patient. Hospice staff are more and more frequently assessing a patient as being unsafe, but the patient is making the informed decision to be unsafe and adult protective services when consulted determine there is nothing that can legally be done in the situation, particularly in light of the patient's limited life expectancy and legal guardianship taking longer than six months to obtain. Most hospices would report

that patient's regularly have caregivers who are only slightly more functional than the patient – the most common example being the elderly hospice patient with an elderly spouse as a caregiver and no other support outside of hospice. Is there a likelihood of caregiver breakdown in these circumstances? Certainly, this is possible if not probably. Are hospices routinely trying to have patients and their family prepare for these circumstances by making applications to skilled nursing facilities, etc.? Of course, STHPC staff spends hours each week on these cases. However, hospice cannot force patients or families to do this and resistance is often strong.

"As explained, this is a clarification of current Medicare policy and is not anticipated to create new limitations on access to hospice care." **This is not a "clarification" and it will definitely create new limitations on access to hospice care.** Hospices will not be able to afford to place a patient inpatient and pay the hospital the inpatient rate while receiving the routine home care rate, nor should a hospice be expected to do so when the needed arises from caregiver breakdown. Patients will choose to revoke hospice and the patient and their physician will seek inpatient admission. Medicare will pay the hospital the DRG, hospice will no longer be involved and often inappropriate and costly consults and services will occur with no benefit to the patient. Who will win in this situation? Clearly, no one wins - not Medicare, not the patient and not hospice. Isn't a lose, lose, lose situation the very thing that both government and providers should be seeking to avoid? Hospice has witnessed the erosion of the inpatient benefit to the point that many hospices offer very little inpatient care. **This "clarification" is completely unacceptable. It is a major reduction in the existing hospice benefit with precedence extending over two decades**. Hospice must maintain the ability to admit patients for short term inpatient care when existing caregiving falls apart and the patient will be unsafe or physically uncomfortable (without needed medications, etc.) without caregiving. Hospice will do all it can to avoid these situations and to prepare for caregiving breakdown, particularly if the patient has limited caregiving. Hospice should and will take aggressive action to place the patient in an alternative setting as quickly as possible.

That patient who is bed bound and unable to toilet him or herself, give him or herself medication, etc. is not a respite admission when the patient's caregiver is killed in a car crash returning from the pharmacy to obtain medication for the patient or when the caregiver suffers a stroke while caring for the patient – and there is no other caregiving that can be put in place. Do you understand that the patient will be suffering from the cause of the caregiving breakdown as well as the breakdown in care itself? Is it not difficult for a fully functioning adult to cope when a spouse is killed or suffers a heart attack? Can you imagine what this does to a hospice patient who often blames him or herself for the caregiver's suffering? Hospice will do all it can to avoid these situations and to prepare for caregiving breakdown, particularly if the patient has limited caregiving. **However, hospice MUST remain able to admit a patient for short term inpatient care in these circumstances.**

What has hospice done to make CMS so cynical and angry? STHPC pays out over eleven dollars more for patient care than it receives from Medicare reimbursement. This is not totally uncommon. When we look organizationally at ways to bring the cost of care closer to reimbursement (certainly an objective that Medicare can understand), we look at increasing length of stay(currently the median is in the teens and the average is in the forties) and negotiating favorable contracts, not ways to scam Medicare. If Medicare would work with hospice to increase length of stay to that which was originally intended in both the legislation and regulation, the patient, hospice and Medicare might win.

Hospice is not your enemy. While hospice is growing, and will continue to grow as our population ages, hospice is not simply trying to "take" Medicare dollars. As studies have shown, Hospice actually saves Medicare dollars. More importantly, hospice has a total focus on achieving desired patient outcomes at the lowest cost. This is the only style of practice that will be feasible as the population ages and fewer workers are caring the burden of health care costs. Instead of looking at hospice as a culprit, consider looking at hospice as a partner that could help CMS and the health care system use scarce dollars more wisely.

Make changes in the regulations that are appropriate such as the determining inpatient reimbursement rate by location of care rather than location of the hospice office, but don't degrade hospice by alleging the change is needed because of our misbehavior. Work with hospice on the general inpatient and caregiver guidelines, but don't assume that hospices are purposely working the system and, most importantly, don't make patients suffer in your zeal to correct a perceived (or misperceived) wrong. Again, if you perceive that a hospice or certain hospices are doing something wrong, please investigate it with them. It might be that your perception is incorrect. If you are correct, take appropriate action – with the offending hospice, not with the entire industry. I can assure you that hospice, state associations and national associations would be happy to work with you on educating hospices on compliance with any regulation where CMS sees a pattern of misinterpretation. However, please do not "clarify" a critical benefit of the hospice program out of existence.

Thank you for entertaining these comments. If you have any questions or require additional information, please contact me at 607/962-3100 or mstarbuck@sthospice.org.

Sincerely,

Mary Ann Starbuck
Executive Director

Submitter : **Dr. Geraldine Bednash** **Date: 07/02/2007**

Organization : **American Association of Colleges of Nursing**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

Nomenclature Changes

Nomenclature Changes

See attachment as well as comments below.

Centers for Medicare and Medicaid Services
Attention: CMS-1539-P
To Whom it May Concern:

On behalf of the American Association of Colleges of Nursing (AACN), I would like to thank the Centers for Medicare and Medicaid Services (CMS) for allowing us the opportunity to respond to the Federal Register Notice (42 CFR Part 418; CMS- 1539-P) regarding the proposed hospice rule. We are specifically responding to Section II Provisions of the Proposed Rule; Subsection E Clarification of Selected Existing Medicare Hospice Regulations and Policies; Part 1) Educational Requirements for Nurse Practitioners. AACN represents over 610 schools of nursing and serves as the national voice for America's baccalaureate- and higher-degree nursing education programs. Together, these institutions produce about half of our nation s registered nurses and all of the nurse faculty and researchers.

We are currently engaged in a national effort to establish standards for the education and certification of our nation s advanced practice registered nurses (APRN) comprised of nurse practitioners (NP), certified nurse midwives (CNM), clinical nurse specialists (CNS), and certified registered nurse anesthetists (CRNA). You may be aware that the educational requirements for APRNs are undergoing significant changes in response to a national consensus on the appropriate preparation for specialty nursing practice. Our organization has recommended that all APRNs be prepared for practice through the terminal clinical degree titled the Doctor of Nursing Practice (DNP). This recommendation was developed as a result of a national process of investigation, dialogue, and consensus building. The movement to the DNP is a direct response to the recommendations of both the Institute of Medicine and the National Academy of Science that nursing education should be dramatically reformed to enhance the capacity of APRNs to deliver high quality, safe, effective patient care in the increasingly complex world of health care.

Therefore, AACN would like to address the educational definition for nurse practitioners. Under the section that discusses the Educational Requirements for Nurse Practitioners, CMS proposes that the definition of attending physician at ? 418.3 be cross referenced with the requirements of ? 410.75(b). CMS regulations ? 410-75 and 410-76 state that the eligible NP or CNS must hold a master s degree in a defined clinical area of nursing from an accredited educational institution. We are concerned that a narrow interpretation of this regulation may prevent reimbursement for NPs and CNSs who do not hold a master s degree but have instead acquired a more advanced level of education, the Doctor of Nursing Practice.

Currently, a large number of institutions have initiated DNP programs which will allow the student to move from the baccalaureate degree directly to the DNP, thus they will never receive a master s degree. However, they will clearly have met all the educational requirements for a master s degree in addition to the preparation that will allow them to be granted the DNP. This nation depends heavily on the availability of well educated and high quality NPs and CNSs and without clarification on this issue, access to their services may be hindered.

Given the advancement in nursing education, AACN recommends that in the consideration of this proposed rule change, the definition in ? 410.75(b) be altered to reflect the current and evolving educational requirements for APRNs. Specifically, we suggest that the term master s degree be changed to graduate degree. This would ensure that all APRNs be afforded the same benefits under any CMS regulation.

Thank you again for the opportunity to respond to this notice. Should you have any questions or require additional information, please contact Stacey Pine of my staff at (202) 463-6930.

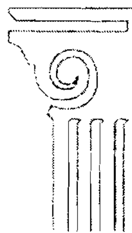
Geraldine Polly Bednash, PhD, RN, FAAN
Executive Director

CMS-1539-P-14-Attach-1.DOC

CMS-1539-P-14-Attach-2.DOC

#14

American Association
of Colleges of Nursing



July 2, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1539-P
P.O. Box 8012
Baltimore, MD 21244-1850

To Whom it May Concern:

On behalf of the American Association of Colleges of Nursing (AACN), I would like to thank the Centers for Medicare and Medicaid Services (CMS) for allowing us the opportunity to respond to the Federal Register Notice (42 CFR Part 418; CMS- 1539-P) regarding the proposed hospice rule. We are specifically responding to Section II *Provisions of the Proposed Rule*; Subsection E *Clarification of Selected Existing Medicare Hospice Regulations and Policies;* Part 1) *Educational Requirements for Nurse Practitioners.* AACN represents over 610 schools of nursing and serves as the national voice for America's baccalaureate- and higher-degree nursing education programs. Together, these institutions produce about half of our nation's registered nurses and all of the nurse faculty and researchers.

We are currently engaged in a national effort to establish standards for the education and certification of our nation's advanced practice registered nurses (APRN) comprised of nurse practitioners (NP), certified nurse midwives (CNM), clinical nurse specialists (CNS), and certified registered nurse anesthetists (CRNA). You may be aware that the educational requirements for APRNs are undergoing significant changes in response to a national consensus on the appropriate preparation for specialty nursing practice. Our organization has recommended that all APRNs be prepared for practice through the terminal clinical degree titled the Doctor of Nursing Practice (DNP). This recommendation was developed as a result of a national process of investigation, dialogue, and consensus building. The movement to the DNP is a direct response to the recommendations of both the Institute of Medicine and the National Academy of Science that nursing education should be dramatically reformed to enhance the capacity of APRNs to deliver high quality, safe, effective patient care in the increasingly complex world of health care.

Therefore, AACN would like to address the educational definition for "nurse practitioners." Under the section that discusses the *Educational Requirements for Nurse Practitioners*, CMS proposes that the definition of "attending physician" at § 418.3 be cross referenced with the requirements of § 410.75(b). CMS regulations § 410-75 and 410-76 state that the eligible NP or CNS must "hold a master's degree in a defined clinical area of nursing from an accredited educational institution." We are concerned that a narrow interpretation of this regulation may prevent reimbursement for NPs and CNSs who do not

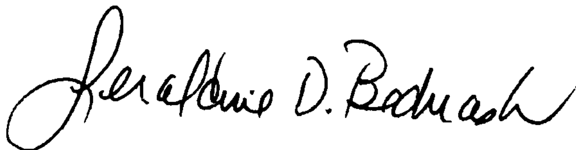
hold a master's degree but have instead acquired a more advanced level of education, the Doctor of Nursing Practice.

Currently, a large number of institutions have initiated DNP programs which will allow the student to move from the baccalaureate degree directly to the DNP, thus they will never receive a master's degree. However, they will clearly have met all the educational requirements for a master's degree in addition to the preparation that will allow them to be granted the DNP. This nation depends heavily on the availability of well educated and high quality NPs and CNSs and without clarification on this issue, access to their services may be hindered.

Given the advancement in nursing education, AACN recommends that in the consideration of this proposed rule change, the definition in § 410.75(b) be altered to reflect the current and evolving educational requirements for APRNs. Specifically, we suggest that the term "master's degree" be changed to "graduate degree." This would ensure that all APRNs be afforded the same benefits under any CMS regulation.

Thank you again for the opportunity to respond to this notice. Should you have any questions or require additional information, please do not hesitate to contact Stacey Pine of my staff at (202) 463-6930.

Sincerely,



Geraldine "Polly" Bednash, PhD, RN, FAAN
Executive Director

Submitter : **Mr Gwen Toney** **Date: 07/02/2007**

Organization : **Ohio Hospice and Palliative Care Organization**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Payment for Hospice Care Based on Location

Payment for Hospice Care Based on Location

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1539-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

July 2, 2007

Re: Comments on [CMS-1539-P] RIN 0938-AO72 (Medicare Program; Hospice Wage Index for Fiscal Year 2008)

Dear Sir or Madame:

The Ohio Hospice and Palliative Care Organization represent hospice and home care agencies in our state and the patients and families they serve. OHPCO is submitting comments on CMS-1539-P Hospice Wage Index for Fiscal Year 2008 for the following section:

2. Care Giver Breakdown and General Inpatient Care

Medicare policy as described in chapter 9 of the Medicare Benefit Policy Manual, states
That skilled nursing care may be required by a patient whose home support has broken down, if this breakdown makes it no longer feasible to furnish needed care in the home setting. If the hospice and the caregiver, working together, are no longer able to provide the necessary skilled nursing care in the individual s home, and if the individual s pain and symptom management can no longer be provided at home, then the individual may be eligible for a short term general inpatient level of care.

Since the inception of the program, the unexpected loss of a caregiver has always fallen under the general inpatient care and providers have been instructed in that payer doctrine for many years. To change these long held principles, would be a detriment to hospice patients when a caregiver loss is experienced resulting in broken home support and a financial burden to hospices not expecting a higher level of patient care. The inpatient respite day dollars will not cover the expected level of patient care now provided as emergency care in the hospital setting.

It is OHPCO opinion that this policy change is another example re-interpretation of Medicare regulations without any change in verbiage and may be designed to reduce expenditures without regard for patient safety and hospice expense.

Suggestion: OHPCO and its members would recommend that the patient care policy not be changed from the current and past interpretation for the expected loss of a caregiver requiring emergency inpatient care. In the hospice conditions of participation, (Sec. 418.302-Payment procedures for hospice care (4) General inpatient care day) a general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. If there is breakdown in caregiver support, then the patient would meet the requirements of the regulation in that chronic symptom management could no longer be managed in the home setting.

Thank you for the accepting this comments. If you have any questions, please contact me at the information below.

Sincerely,

Gwen Toney
VP of Government Affairs
Ohio Hospice and Palliative Care Organization
555 Metro Place North Suite 650
Dublin, OH 43017

614-763-0036
gwen@ohpco.org

Submitter : **Ms. Michael Aureli** **Date: 07/02/2007**

Organization : **Arkansas Hospice, Inc.**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Basing home based care salaries on the hospital wage index is not adequate. While staff who go to a rural hospital to work have a case load each day that is comparable to hospital care in an urban area, home based hospice staff cannot see the case load in a rural setting that can be seen by those who work in urban areas.

Hospice staff in rural areas can only see about 60% of the patients in their own homes that an urban hospice worker can see in the same expanse of time. There is also an extra cost for mileage expense for the rural staff.

Care for rural home based patients in more expense in the cost of staff time and mileage cost. It should be reimbursed at a higher rate.

Perhaps there should be an added componenet in the hospice per diem rate known as the "expansive geography index" used as a 1.5 multipler on the hospice wage index formula for rural counties.

Thanks for listening.

Payment for Hospice Care Based on Location

Payment for Hospice Care Based on Location

If a hospice program cannot take the patient into a hospice inpatient facility at this time of crisis, where can the patient go?

Submitter : **Dr. Aryeh Shander** **Date: 07/03/2007**

Organization : **EHMC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Brian Ellsworth** **Date: 07/03/2007**

Organization : **CT Council for Hospice & Palliative Care**

Category : **Health Care Professional or Association**

Issue Areas/Comments

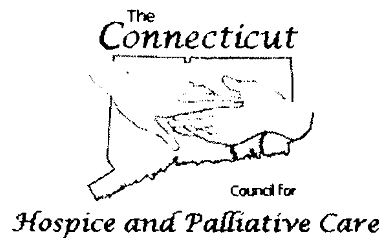
GENERAL

GENERAL

See attachment

CMS-1539-P-18-Attach-1.PDF

#18



July 2, 2007

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1539-P
P.O. Box 8012
Baltimore, MD 21244-1850

Re: CMS-1539-P Medicare Program: Hospice Wage Index for FY 2008; Clarification of Caregiver Breakdown and General Inpatient Care

Dear Sir/Madam,

On behalf of 30 hospices serving over 8,500 patients annually, the Connecticut Council for Hospice & Palliative Care is pleased to submit comments on behalf of our members regarding the clarification of care giver breakdown and general inpatient care which was published in the *Federal Register* on May 3, 2007 in conjunction with the proposed Hospice Wage Index for Fiscal Year 2008.

Caregiver Burnout Clarification – Overall Comments

On its face, the clarification of caregiver burnout appears to be reasonable and differentiates the purpose of the use of General Inpatient rate and the Respite rate. The Council has significant concerns, however, about inadequate reimbursement for Respite care.

The CMS clarification states that the patient must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting. The Council supports that caregiver breakdown should not be billed as General Inpatient Care regardless of where services are provided unless the intensity of care requirement is met, which would be supported in clinical documentation.

Concern about Inadequate Rates for Respite

Please see Attachment A for a breakdown of typical expenses for a Respite Care case in Hartford, CT. Based on this case example, it is apparent that costs for the hospice provider increase significantly when a patient utilizes Respite care, but revenue barely changes. This is not sustainable and creates a barrier to Respite care.

CT Council for Hospice & Palliative Care,
110 Barnes Road, PO Box 90, Wallingford, CT 06492
Phone (203)-265-5923

Inadequate reimbursement can mean that hospice providers have difficulty finding nursing facilities that are willing to provide Respite level of care because the reimbursement is below the Medicaid rate for Room and Board. This can, at times, create an access issue, especially in emergency situations, such as the unexpected death of a caregiver.

Finally, the Council is concerned that CMS is unable to quantify the extent of the use of General Inpatient Care in the event of caregiver breakdown. We question why this clarification is being made without further analysis as to its impact. In fact, CMS believes that only a small percentage of patient days attributed to General Inpatient care would be appropriately re-allocated to inpatient Respite care. If true, we question the basis for this clarification. The calculation of the net impact analysis is based on current reimbursement rates for Respite services, and does not consider that this rate is woefully inadequate. Therefore, the projected cost savings are inaccurate.

Recommendations

- The Council strongly urges CMS to **increase reimbursement for inpatient Respite care** to meet or exceed the applicable Medicaid nursing home rate in order to insure appropriate access to services and adequate reimbursement for hospice providers.

- The Council supports **continued CMS oversight and focus on inappropriate use of General Inpatient level of care for caregiver breakdown**, and suggests **focusing** on those providers nationally with an inordinate amount of GIP billing. The Council recommends that CMS **conduct further analysis** regarding the use of General Inpatient level of care to be able to adequately quantify the impact of this issue on Medicare costs.

- The Council supports **comprehensive documentation of necessity of General Inpatient level of care**. We feel that there are times when this level of care is appropriate for the patient and family's well-being, and should be taken into consideration, with an expectation of thorough documentation to support the need for General Inpatient care based on intensity of care required to meet patient needs.

Thank you for your consideration of these comments.

Sincerely,

Brian Ellsworth, Executive Director
The Connecticut Council for Hospice and Palliative Care

Attachment A
Hartford, CT Area Example of Respite Care under Hospice Medicare Benefit:

The hospice routine rate for Hartford, CT is $146.75. If the patient requires inpatient respite level of care the hospice provider must use a local skilled nursing facility. The nursing facility is unable, per regulation, to charge less than they receive from Medicaid for Room and Board services, which means that the hospice provider must pay approximately $230 per day to the nursing facility.

The work of coordinating the respite care requires more of the hospice provider's staff time--- not less. In addition, a patient requiring respite care is, generally, not ambulatory or has some significant problems with ambulation so the patient must be transported to the facility. This may require a wheelchair transport or a stretcher/ambulance transport depending upon the patient's condition.

While the patient is in the nursing facility, the hospice provider continues to provide at least the same level of staff oversight and care as they were in the home and they are still paying for necessary equipment, medication and supplies as they do on routine level of care.

There are, therefore, no costs that go down for a hospice when a patient goes onto inpatient Respite care. Assuming a 5-day stay, here is an example of costs:

Increased costs from a 5 day Respite stay

$230/day times 5 days =	$1,150
transport to and from SNF	$250 (average)
Increased staff time	$200 (estimate)

Total increased cost of Respite level of care for 5 days = $1,500

Increased reimbursement from a 5 day Respite stay

Daily rate increase from $146.75 to $148.31=	$1.56 per day
$1.56 per day times 5 days =	$7.80

Total increased reimbursement for Respite level of care for 5 days = $7.80

Increased revenue net of increased costs, gain/(loss) = ($1,492.20)