# CY 2020 Medicare Physician Fee Schedule Proposed Rule

- Full Proposed rule (PDF)

*Excerpt below begins on p. 234 of the PDF linked above (shown as p. 40724 in the document)*

## HOSPICE

### A. BACKGROUND

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of a terminally ill individual, and warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define "palliative care" as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (42 CFR 418.3). The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. The hospice interdisciplinary group works with the patient, family, caregivers, and the patient's attending physician (if any) to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families and caregivers about changes in their condition. The care plan will shift over time to meet the changing needs of the patient, family, and caregiver(s) as the patient approaches the end of life.

The regulations for Medicare and Medicaid participating hospices are set forth at 42 CFR part 418. Section 418.3 defines the term "attending physician" as being a doctor of medicine or osteopathy, an NP, or a PA in accordance with the statutory definition of an attending physician at section 1861(dd)(3)(B) of the Act. Section 51006 of the Bipartisan Budget Act of 2018 revised the statute to add PAs to the statutory definition of the hospice attending physician for services furnished on or after January 1, 2019. As a result, PAs were added to the definition of a hospice attending physician as part of the "Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting

Requirements" final rule which was published in the August 6, 2018 **Federal Register** (83 FR 38622, 38634) (hereinafter referred to as the "FY 2019 Hospice final rule").

The role of the patient's attending physician, if the patient has one, is to provide a longitudinal perspective on the patient's course of illness, care preferences, psychosocial dynamics, and generally assist in assuring continuity of care as the patient moves from the traditional curative care model to hospice's palliative care model. The attending physician is not meant to be a person offered by, selected by, or appointed by the hospice when the patient elects to receive hospice care. Section 418.64(a) of the hospice regulations requires the hospice to provide physician services to meet the patient's hospice-related needs and all other care needs to the extent that those needs are not met by the patient's attending physician. Thus, if a patient does not have an attending physician relationship prior to electing hospice care, or if the patient's attending physician chooses to not participate in the patient's care after the patient elects to receive hospice care, then the hospice is already well-suited to provide physician care to meet all of the patient's needs as part of the Medicare hospice benefit. If the patient has an attending physician relationship prior to electing hospice care and that attending physician chooses to continue to be involved in the patient's care during the period of time when hospice care is provided, the role of the attending physician is to consult with the hospice interdisciplinary group (also known as the interdisciplinary team) as described in § 418.56, and to furnish care for conditions determined by the hospice interdisciplinary group to be unrelated to the terminal prognosis. The hospice interdisciplinary group must include the following members of the hospice's staff: A physician; a nurse; a social worker; and a counselor. The interdisciplinary group may also include other members based on the specific services that the patient receives, such as hospice aides and speech language pathologists. The hospice interdisciplinary group, as a whole, in consultation with the patient's attending physician (if any), the patient, and the patient's family and caregivers, are responsible for determining the course of the patient's hospice care and establishing the individualized plan of care for the patient that is used to guide the delivery of holistic hospice services and interventions, both medical and non-medical in nature.

### B. PROPOSED PROVISIONS

In the role of a consultant to the hospice interdisciplinary group, the hospice patient's chosen attending physician may, at times, write orders for services and medications as they

relate to treating conditions determined to be unrelated to the patient's terminal prognosis. The law allows for circumstances in which services needed by a hospice beneficiary would be completely unrelated to the terminal prognosis, but we believe that this situation would be the rare exception rather than the norm. Section 418.56(e) requires hospices to coordinate care with other providers who are also furnishing care to the hospice patient, including the patient's attending physician who is providing care for conditions determined by the hospice interdisciplinary group to be unrelated to the patient's terminal prognosis. As part of this coordination of care, it is possible that hospices may receive orders from the attending physician for drugs that are unrelated to the patient's terminal prognosis.

The FY 2019 Hospice final rule amended the regulatory definition of attending physician, as required by the statute, to include physician assistant. Following publication of the FY 2019 Hospice final rule, stakeholders raised concerns regarding the requirements of § 418.106(b). As currently written, hospices may not accept orders for drugs from attending physicians who are PAs because § 418.106(b) specifies that hospices may accept drug orders from physicians and NPs only. This regulatory requirement may impede proper care coordination between hospices and attending physicians who are PAs, and we believe that it should be revised.

Therefore, we propose to revise § 418.106(b)(1) to permit a hospice to accept drug orders from a physician, NP, or PA. We propose that the PA must be an individual acting within his or her state scope of practice requirements and hospice policy. We also propose that the PA must be the patient's attending physician, and that he or she may not have an employment or contractual arrangement with the hospice. The role of physicians and NPs as hospice employees and contractors is clearly defined in the hospice CoPs; however, the CoPs do not address the role of PAs. Therefore, we believe that it is necessary to limit the hospice CoPs to accepting only those orders from PAs that are generated outside of the hospice's operations.

The role of a PA is not defined in the hospice CoPs because the statute does not include PA services as being part of the Medicare hospice benefit. As such, there are no provisions in the hospice CoPs to address specific PA issues such as personnel requirements, descriptions of whether such services would be considered core or non-core, or provisions to address issues of co-signatures. To more fully understand the current and future role of NPPs, including

PAs, in hospice care and the hospice CoPs, we request public comment on the following questions:

- What is the role of a NPP in delivering safe and effective hospice care to patients? What duties should they perform? What is their role within the hospice interdisciplinary group and how is it distinct from the role of the physician, nurse, social work, and counseling members of the group?
- Nursing services are a required core service within the Hospice benefit, as provided in section 1861(dd)(B)(i) of the Act, which resulted in the defined role for NPs in the Hospice COPs. Should other NPPs also be considered core services on par with NP services? If not, how should other NPP services be classified?
- In light of diverse existing state supervision requirements, how should NPP services be supervised? Should this responsibility be part of the role of the hospice medical director or other physicians employed by or under contract with the hospice? What constitutes adequate supervision, particularly when the NPP and supervising physician are located in different offices, such as hospice multiple locations?
- What requirements and time frames currently exist at the state level for physician co-signatures of NPP orders? Are these existing requirements appropriate for the hospice clinical record? If not, what requirements are appropriate for the hospice clinical record?
- What are the essential personnel requirements for PAs and other NPPs?