National Hospice and Palliative Care Organization

January 21, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
131 Russell Senate Building
Washington, D.C. 20510

The Honorable Mark Warner
Co-Chair, Chronic Care Working Group
475 Russell Senate Building
Washington, D.C. 20510

Re: Response to *Bipartisan Chronic Care Working Group Policy Options Document*
Submitted electronically via chronic_care@finance.senate.gov

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

On behalf of the National Hospice and Palliative Care Organization (NHPCO), thank you for your leadership and efforts on the Chronic Care Working Group. This endeavor is a model of bipartisan, open and deliberative policymaking, and we appreciate the opportunity to share our thoughts and concerns about the proposal to "carve-in" hospice under the Medicare Advantage (MA) program. NHPCO is the largest nonprofit membership organization representing hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice locations that care for the majority of hospice patients in the country. NHPCO is committed to ensuring that all Americans – and their families - can access high-quality, compassionate end-of-life care.

Hospice is a coordinated model for quality, compassionate care for people facing a life-limiting illness. Hospices provide expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes, while also supporting the patient's family.

As you know, hospice has never been a covered benefit under Medicare Advantage (MA). MA enrollees who elect hospice revert to fee-for-service when they elect hospice care, allowing them to access the hospice of their choice without any network limitations, additional costs, or pre-approval from the MA plan. Beneficiaries can continue to receive MA covered benefits (e.g., vision or dental care) through their MA plan and receive care unrelated to their terminal illness under fee-for-service. This allows beneficiaries a wide choice of hospice providers, streamlines administration for hospices, and ensures the integrity and quality of the hospice benefit.

The current arrangement works well for all stakeholders – patients who want a wide selection of providers, MA plans who have little or no expertise in end-of-life care, and hospices who are able to focus on delivering high-quality, seamless care to some of our most vulnerable citizens. There is no evidence that beneficiaries endure any fragmentation or gaps in care; in fact, MA enrollees typically benefit from longer lengths of stay in hospice than individuals in fee-for-service. The medical director of one large national insurer suggested that "The success of [the Aetna Compassionate Care program] . . . has been supported by efficient administration and broad access to local hospice services. **Eliminating the carve-out would diminish patient access, program impact and satisfaction."** In short, the hospice carve-out is working.

Unfortunately, this balanced system would be upended by the Chronic Care Working Group's proposal to "carve-in" hospice under MA. Based on hospices' experience with private commercial insurance and Medicaid managed care, we are gravely concerned that the proposal would negatively impact beneficiaries, hospices, and the Medicare program by:

- Limiting beneficiary access to the hospice of their choice
- Diluting the quality and integrity of the hospice benefit
- Undermining the autonomy of the hospice Medical Director
- Increasing the administrative burden for hospice providers
- Threatening the financial stability of hospice programs

Beneficiary Access

The selection of a hospice program is a deeply personal health care decision. Hospice providers are literally invited into the homes and daily lives of patients and their families, at a time when they are physically, emotionally and spiritually vulnerable. In choosing a hospice provider, patients often take into consideration their faith, their unique personal and family needs, referral to a particular hospice from a friend or family member, the reputation and familiarity of the hospice programs in their community, and other factors. It isn't simply a medical decision. Under the current system, MA enrollees are not bound by limited managed care networks, are not subject to additional costs or co-pays, and do not have to receive pre-approval to access hospice (beyond the existing certification for hospice-eligibility).

If hospice is carved-in to MA, however, beneficiary access could be severely limited. Network adequacy requirements call for plans to contract with a bare-minimum number of providers based on statistical formulas and geography. Small, community-based providers, faith-based providers, and others might be left by the wayside, leaving beneficiaries without access to those programs who might have served their loved ones or family friends. MA plans could also assign additional co-pays, deductibles, or prior-authorizations for both in-network and out-of-network hospice utilization, adding financial and bureaucratic stress and confusion to patients and their families.

And unlike typical MA enrollees, hospice patients do not have the luxury of waiting several months for an open-enrollment period to change plans to elect the hospice of their choice – more than one-third of hospice patients die within a week of electing hospice. More than half of all hospice

patient die within two weeks of electing hospice care. The limited networks with potential pre-authorization requirements of managed care are a bad fit for hospices and patients alike.

Hospice Integrity and Quality

Hospice is a comprehensive, interdisciplinary benefit that meets *all* of the patient's physical, psychological, spiritual and familial needs related to the terminal prognosis. The hospice inter-disciplinary team (IDT) includes physicians, nurses, social workers, chaplains, volunteers, and other professionals as required by the patient and their families. This combination of providers ensures that the *whole* patient is treated – not just his or her physical illness.

In their experience with commercial insurers and Medicaid managed care, many hospice providers have witnessed managed care organizations asking hospice organizations to offer a subset of services, such as pain management or in-home care, but at a reduced fee-for-service rate. While some hospices do offer these scaled-back services for pre-hospice patients, they do so knowing that eligible beneficiaries can ultimately access the full hospice benefit outside of their MA plan.

Based on this experience, however, NHPCO is concerned that a "hospice lite" model may undermine the integrity of the hospice benefit, incentivizing plans to offer only a diluted and less effective set of services. It is easy to imagine a plan paying for pain relief therapies, but shortchanging the spiritual and emotional counseling that it is so important to patients and families at the end of life -- not only for the patient, but their families and loved one too. While this might benefit MA plans' bottom lines, it could have tragic consequences for patients and their families. Patients at the end-of-life deserve more than a diluted set of services.

Further, quality measurement and improvement differ significantly between managed care settings and hospice. Quality improvement in managed care places heavy emphasis on chronic disease management, preventive care, screenings, as well as access and utilization. While hospice quality measurement and improvement is in its infancy, metrics of this nature – with their emphasis on prolonging life – may not be a good fit.

Provider Autonomy and Risk

Currently, hospices are responsible for all treatment and costs related to the patient's terminal prognosis, while still coordinating (but not paying for) care unrelated to the terminal prognosis. For example, a late-stage cancer patient might receive her palliative care, social services, and family supports through hospice, but continue to see her ophthalmologist and get Part D coverage for her glaucoma treatments. In these cases, the hospice medical director makes the determination regarding what is and is not related to the terminal prognosis, and unrelated care is covered under traditional fee-for-service.

We are concerned that MA plans would undermine the autonomy of the hospice medical director, and require hospices to pay for services/care that is unrelated to the terminal diagnosis. Hospices

are not designed to assume risk for these costs; a shift of this nature could threaten the financial sustainability and viability of hospice programs.

Administrative Burden

Hospice programs are extremely efficient operations, running on margins much lower than others in the healthcare continuum when accounting for unreimbursed services like bereavement costs and volunteer coordination. The current MA carve-out allows hospices to focus staff time and resources on delivering high quality patient care. Unfortunately, the proposal to carve-in hospice under MA would significantly increase hospices' administrative burden. Rather than a single claims process, hospices would be required to negotiate, manage and process claims from each MA plans with whom they contract. One hospice posits that an MA carve-in would nearly triple their administrative staff in order to negotiate various contracts, ensure proper authorization and reauthorization procedures, and process claims.

Further, hospice is *already* a managed benefit. Hospices manage patient care related to the terminal condition for a fixed daily rate, just as MA plans manage medical care for their enrollees for a monthly capitation. The MA carve-in would seemingly add another layer of 'managed care' to what is essentially a managed hospice benefit. In doing so, this creates redundancy, complexity, and increased administrative cost for both hospices and MA plans, but adds very little value – either in terms of quality or cost of care – to the consumer or the taxpayer. In fact, an estimate prepared by Avalere Health (attached) suggests that **making this change would cost the Medicare program more than $895 million over ten years.**

Financial Viability

Finally, and most fundamentally, an MA carve-in would likely undermine the financial viability of many hospice programs. It is presumed that under this proposal, MA plans would be able to set their own (likely lower) reimbursement rates for hospice care. This change would come at a time when hospices have already faced multiple Medicare reimbursement reductions, a series of costly regulatory changes, and more recently, a complete overhaul of the Medicare hospice payment system. The cumulative effect of these changes has been a permanent reduction in hospice rates of more than 10 percent.

Additionally, MA plans are notoriously slow to process and reimburse claims – on the commercial side, hospices find it takes plans an average of 120 days to pay claims. The three Medicare Administrative Contractors charged with processing hospice claims currently reimburse within 14 days. This almost tenfold delay in payment would require hospices to have much larger cash reserves or would result in greater interest charges.

We are also concerned that the dilution of the hospice benefit (as outlined above) could result in shorter lengths of stay for MA enrollees who ultimately elect hospice. Not only does this affect patient quality of care, it could also affect the financial viability to care for the 70 percent of fee-for-service patients.

In summary, this slate of changes could force many hospices to close their doors, leaving patients, their families, their employees, and their communities without important end-of-life options.

Alternative Approaches

As the committee moves forward with this effort to improve care for the chronically ill, we urge you not to carve hospice into the Medicare Advantage program. This proposal would impair beneficiaries' access to quality hospice care, increase costs and administrative burdens for hospice programs, and is opposed by many stakeholders, including some of our nation's largest health insurance plans.

Instead, we strongly encourage you to adopt and include provisions of S. 1549, the Care Planning Act, which we believe would strengthen the quality of end-of-life care, and make it more cost-efficient through enhanced resources for patients and families to promote more informed choices and prevent unnecessary and costly medical procedures.
Specifically, the Care Planning Act would offer beneficiaries a team-based advanced care planning benefit that would provide them with the information and resources necessary to adequately plan for advanced and terminal illness. It also proposes the creation of an Advanced Illness Coordination Services demonstration project that would allow us to innovate and build upon the hospice model to provide symptom management, care coordination, and spiritual and psychological support to individuals who have advanced illness, but who are not yet ready or eligible to elect hospice. This legislation is truly a bipartisan, non-controversial measure that would improve access to and quality of care for individuals with advanced and terminal illness.

Additional enhancements to the existing benefit such as creating incentives for increased care coordination between hospices and MA plans would provide MA patients with the right access to hospice at the right time in their disease progression.

NHPCO also applauds CMS's Medicare Care Choices Model that provides a new option for Medicare beneficiaries to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. NHPCO believes these are the types of strategies and innovations that will improve the quality of life and care received by Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures.

If Congress enacts legislation creating a carved-in benefit, safeguards must be in place to protect patient choice and the integrity of the hospice benefit. In addition, **a pilot or demonstration phase**, coupled with a robust evaluation, would allow us to better understand the unique impact this change would have and make modifications to ensure the sustainability of hospice. NHPCO seeks to ensure the following, in the event of a carved-in benefit:

- **Beneficiary Access:** Patients must have access to the hospice of their choice; a carve-in must allow patients the flexibility to go outside of the MA plan network to receive hospice

services from the hospice of their choice, taking into account the specific desires of the patient, such as specialized or faith based providers, without financial penalties.

- **Integrity of the Hospice Benefit:** The program design of the full hospice benefit must remain unchanged and serve as the model of care; MA plans should not be able to diminish the full depth and breadth of services provided by the hospice's interdisciplinary team.
- **Autonomy of the Hospice Medical Director:** The hospice Medical Director should continue to determine whether care is "related" or "unrelated" to the terminal prognosis; MA plans should have the option to appeal these determinations to CMS.
- **Financial Sustainability:** The reimbursement framework of a carve-in must mirror that of the existing Medicare Hospice Benefit; the same per diem rates should be paid for all hospice beneficiaries under Medicare whether they are under fee-for-service or MA or not. Much as Congress requires hospices to reimburse nursing homes based on the customary room and board rate, MA plans should be required to "pass thru" a payment at least equal to the Medicare hospice per diem. Further, MA plans should be required to reimburse hospice providers in a timely manner.
- **Administrative Burden:** Contracts between MA plans and hospices should be standardized nationwide based on guidance from CMS. If MA plans are allowed to impose preauthorization requirements for hospice care, there needs to be uniformity in the processes, forms and documentation requirements.
- **Opt-out: Many MA plans lack the capacity and expertise to effectively manage a carved-in hospice benefit.** MA plans should be able to opt out of including hospice in their MA plan's benefit package. For MA plan members without a carved-in hospice benefit, the original Medicare Hospice Benefit would be available.

Of course, this proposal creates a host of complicated and interrelated issues that need to be addressed before it should move forward. Our comments are intended to at least touch upon the more obvious issues and we welcome the opportunity to continue our discussions with the relevant professionals to more fully explain our concerns.

Thank you for your consideration of these comments, and for your commitment to improving the quality of care provided to our nation's seniors. We look forward to working with you on this effort and other measures to improve the quality and accessibility of hospice and palliative care services.

Sincerely,

Don Schumacher
President/CEO
National Hospice and Palliative Care Organization