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January 26, 2016

Honorable Orrin Hatch  
Chairman, Senate Finance Committee  
United States Senate  
Washington, D.C. 20510

Honorable Ron Wyden  
Ranking Member, Senate Finance  
Committee, United States Senate  
Washington, D.C. 20510

Honorable Johnny Isakson  
Co-Chair, Chronic Care Working Group  
United States Senate  
Washington, D.C. 20510

Honorable Mark R. Warner  
Co-Chair, Chronic Care Working Group  
United States Senate  
Washington, D.C. 20510

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

The Hospice Association of America (HAA) is an affiliate of the National Association for Home Care & Hospice (NAHC), the nation's largest trade association representing home health, hospice, and home care providers and their caregiving staff, as well as the patients and families they serve. HAA represent all types of hospice providers, including chain organizations, freestanding not-for-profit hospices, for-profit entities, and provider-based hospices. We appreciate the opportunity to comment on elements of the Chronic Care Working Group's Policy Options document that address issues that relate to effective management of advanced illness and palliative and hospice care.

The comments provided below will also be supplied as part of NAHC's submission to the Working Group; however, as the comments contain extensive input on issues related to hospice and end-of-life care, we are also submitting them separately from the Hospice Association of America. As noted below, we look forward to continuing discussions with you and other members of the committee as the deliberative process continues on these very important issues.

## **Advancing Team Based Care: Providing Medicare Advantage Enrollees with Hospice Benefits**

Under the Policy Options Document category of Advancing Team Based Care, the Bipartisan Chronic Care Working Group has indicated it is considering requiring Medicare Advantage (MA) plans to offer the hospice benefit provided under traditional Medicare as part of the MA benefit package. Currently, when a patient is diagnosed as terminally ill and decides to elect hospice care, responsibility for Medicare-covered services reverts to the fee-for-service program. The MA plan remains responsible for supplemental benefits and any drugs that would still be covered under Part D (if drug coverage is included in the MA plan). The Policy Options document indicates that this change is under consideration because “current coverage options lead to either a disruption in care or fragmented care delivery”.

A primary goal of the Working Group’s efforts is to improve care for individuals managing chronic illness, and to improve outcomes for vulnerable Medicare beneficiaries living with multiple chronic health conditions. In some cases the line between living with multiple chronic health conditions and approaching the end of life can be a subtle one, so we appreciate the Working Group’s interest in incorporating for public comment some stakeholders’ recommendation that hospice benefits be brought under the MA benefit package. We also appreciate the opportunity to provide our comment on the proposal, and look forward to continued dialogue with the Working Group on this and other important end of life issues as your deliberative process continues.

As a hospice association affiliated with NAHC, which represents both hospices and home health agencies, we have had numerous discussions through the years with home health providers and have in-depth knowledge of some of the challenges associated with providing appropriate, effective, and high quality health care in the home as a contractor of some MA plans. Our comments reflect this experience as well as issues related to the unique Medicare benefit that is hospice care, and our concerns over the negative impact this change would have on hospice beneficiaries, hospice programs, and the Medicare hospice benefit.

### **MA/Structural Issues**

We acknowledge that there are some private plans that have done an exemplary job in developing innovative and effective palliative and end-of-life care programs. These programs are the product of significant investment and effort on the part of the plans and involvement of experts in the field of hospice and palliative care; these plans are to be commended for their important work. The vast majority of MA plans do not provide care directly, nor do they invest significant resources required to closely coordinate and monitor quality of care. They have no experience with the complexities of end-of-life care for the Medicare population. For the most part, these plans contract with a sufficient number of providers to meet established standards for access to care. While the plans are required to offer an “actuarially equivalent” package of Medicare services to their enrollees, they have the freedom to make alternative determinations relative to beneficiary cost sharing and to act as gatekeepers relative to care access.

As the Medicare hospice benefit is a home-based, bundled package of services, some of the issues that have arisen under home health serve as a cautionary note to consideration of bringing hospice under the MA benefit package. Under fee-for-service, home health benefits are offered on an episodic basis (60 days per episode) to homebound individuals requiring skilled, intermittent care. Most MA plans, however, do not offer home health benefits on an episodic basis – rather, they contract with providers on a per-visit basis and permit only a small number of pre-approved visits at a time. As a result, the home health agency must await approval and go through the process of having to communicate with the MA case manager (sometimes a prolonged period of time). Additionally, administrative costs are increased for home health agencies since they include costs for negotiating contracts, securing prior authorization for services, and -- once care has been provided -- efforts to collect payment from the plans (which can be considerable). Some of these “hurdles” create fragmentation of services and beneficiary confusion as providers wait for approval of additional visits or of a change in the plan of care.

It should be noted that the hospice benefit is much more complex than the home health benefit in terms of what is contained in the bundle of services, and certain services must be provided under explicit rules (for example, requirements related to providing core services directly). Hospices are required to provide services that are not reimbursed by Medicare (such as volunteer and bereavement services) as well as an additional array of services (such as massage and music therapies) than are required by Medicare because these services have proven therapeutic value. This is not a structure or array of services that MA plans are likely to recognize or consider as they contract with hospice service providers.

It should also be noted that while hospice care is paid on a per diem basis (depending on the level of care provided) under fee-for-service Medicare, additional services (such as hospice physician services) are paid separately by Medicare but included in total expenditures for purposes of the hospice aggregate cap calculation. Under the hospice Conditions of Participation (CoPs), the hospice physician must provide medical services in all cases when the patient’s attending physician is unavailable to provide them. It is unclear how requirements like this one – which are unique to hospice care – would be handled by MA plans.

While the Centers for Medicare & Medicaid Services (CMS) and others have made considerable advances with the Hospice Quality Reporting Program (HQRP) in recent years, hospices quality measures are not yet publicly reported. As a result there is no single, reliable publicly-available means for comparing the quality of or satisfaction with an individual hospice provider’s care. This gives MA plans little to go on when judging which hospice provider(s) to contract with for services other than low bids by hospice providers. The Medicare Payment Advisory Commission (MedPAC) and others have found that lower cost hospices as a general rule are those that admit patients for significantly longer lengths of stay – an area of particular concern to policymakers and one that significant efforts are focused on curbing. Yet these are the hospice providers who will be most able to offer low bids to MA plans.

## **Beneficiary Issues**

We acknowledge that the coverage rules that are applicable when a MA enrollee elects hospice care are somewhat more complex than would otherwise be the case if hospice were provided as part of the MA benefit package. However, the benefits that would be gained by streamlining the process are more than negated by the additional challenges that would be faced by beneficiaries in the final stages of life and their informal caregivers. Descriptions of some of those challenges follow.

**Beneficiary Choice:** Given the current provider contracting approach of most MA plans relative to choice of provider of services, it is anticipated that MA plans would contract with a single or very limited number of hospice providers, giving a beneficiary or family little or no choice of hospice provider. As a general rule, the current population of individuals entering Medicare is healthier than was the case in previous generations and has a greater familiarity with private plan approaches to care coverage. For these young-old individuals, a MA plan may be a very attractive option. The biggest considerations for a Medicare beneficiary in selecting a private plan will focus on current needs – wellness, preventive and curative care; supplemental benefits provided at limited or no charge; and prescription drug coverage (if offered as part of the plan). Most relatively healthy beneficiaries would not make a private plan decision based on their anticipation of end-of-life care needs. Issues change considerably when a beneficiary is faced with a terminal prognosis of six months or less.

The choice to transition to end-of-life care -- and the provider that will supply that care – are deeply personal ones. Choice of an end-of-life care provider is most often based on the recommendations and experience of family members, the beneficiary's priest or spiritual adviser, or other trusted sources. Under an MA plan, a beneficiary no longer retains choice of provider for end of life care – that right is essentially waived when entering an MA plan.

Under the hospice benefit, a beneficiary has the right to change hospice providers once in a benefit period. If a patient has already changed hospice providers but wishes to change hospice providers again, the beneficiary may revoke hospice care and begin a new hospice benefit period under the care of a third hospice provider, with no loss of care. It is unclear how this current right of provider choice would be preserved under MA – and whether MA plans would have sufficient options among hospice providers in an area to ensure this right to its enrolled patients.

Additional choice concerns arise relative to patients that reside in nursing facilities (NFs). In NFs where hospice care is available, it is based on the facility's choice of hospice providers with which to contract. In cases where a NF patient is on MA, there is no guarantee that the NF and MA-contracted hospice provider(s) will be the same – in fact, there is a very high probability that they will not have agreements with the same hospice(s). Under such contracting limitations, a MA-enrolled patient requiring NF care may not have an option to access hospice care, even if it is offered in his/her facility.

**Cost Sharing.** While some limited beneficiary cost sharing is permitted under the hospice benefit, most hospice providers do not charge copayments for services. MA plans have the freedom to charge

beneficiaries different coinsurances from those charged under fee-for-service as long as the package of benefits is actuarially equivalent to what is offered under fee-for-service. This could result in significantly increased beneficiary/family liability relative to hospice services.

**Benefits, Coverage, and Continuity of Care.** Under hospice, providers are paid on a per diem basis with the expectation that they will supply all care that is reasonable and necessary for the palliation and management of care related to the terminal diagnosis and any conditions determined to be related to the terminal diagnosis. This constellation of diagnoses is what the hospice physician considers as part of his determination that a patient has a six-month prognosis if the patient's disease runs a normal course. It is widely recognized that prognosis is not an exact science and that each patient must be assessed comprehensively to make a clear determination of what conditions are expected to lead to his ultimate demise, as well as to establish responsibility for care and develop an effective treatment plan. This is a hallmark of the hospice benefit. Hospices must assess a patient's needs each time there is a change in his condition, but no less frequently than every 15 days. Hospices must be prepared to change the treatment plan in very short order based on the patient's need. Many MA plans' contracting practices and requirements for prior approval of care or a change in service will create serious conflicts for hospice providers as they may result in delays in (or denials of) the provision of care that is needed by dying individuals.

With great frequency MA plans separately authorize distinct portions of Medicare benefits otherwise offered as a bundle under fee-for-service. This practice, applied in hospice, will lead to conflicts that will arise between the patient's hospice physician/interdisciplinary team and the MA plan over the comprehensive plan of care and appropriateness/approval of distinct services, in addition to delays in approval for services. These threaten the autonomy of the hospice team but also have the potential to impact timeliness and quality of care, as well as overall effectiveness of the hospice benefit.

As noted previously, the vast majority of hospices provide the hospice benefit as structured under fee-for-service (including some services that are not reimbursed by Medicare) as well as an array of additional services neither explicitly covered nor reimbursed by Medicare but that have proven therapeutic for patients in the final stages of life. These are services that hospices currently finance through their financial margins under fee for service as well as through other means – such as through donations or profits from fundraising enterprises such as thrift stores. MA plans may not consider the full scope of benefits that current hospice beneficiaries receive when they contract with providers; as a result, hospices that contract with MA plans may no longer be able to provide this full range of benefits. Consequently, the full benefit of hospice care may no longer be accessible to MA-enrolled terminally ill individuals and their caregivers.

The hospice benefit is the only benefit under Medicare that requires a beneficiary to waive his or her right to a set of services (in this case, curative services related to the terminal illness or related conditions). Beneficiaries DO retain the right, under statute, to access Medicare benefits for curative services targeted at conditions that are not related to the terminal illness. Determinations of relatedness (and unrelatedness) are complex and require intense familiarity with terminal illness

processes and the combined impact of multiple advanced illnesses. Disagreements between MA plans and hospice providers over a patient's right to curative care for non-related conditions will invariably arise; when they do, service delays will diminish patients' comfort and well-being, and could hasten death.

### **Hospice Provider/Benefit Integrity Issues**

In addition to concerns about the challenges associated with integrating the MA structure with the hospice benefit and about the impact this change will have on hospice beneficiaries, this proposed change will also have a significant impact on hospice providers and the integrity of the hospice benefit generally. Many of these issues – MA plan redefinition of the hospice benefit package, the autonomy and authority of the inter-disciplinary team, delays in access to care, disagreement over determinations as to which conditions are related versus unrelated to the conditions that make up the patient's prognosis, the terms under which benefits are provided, additional administrative costs related to contracting and prior authorization of services, to name a few – will also severely impact hospice providers.

In recent years hospice care has undergone a wave of change that has not been experienced since the benefit was initially created. Many of these changes have been implemented with the intent of maintaining the integrity of the hospice benefit, but come at significant cost to hospice providers. In addition, beginning January 1, 2016, CMS implemented a new payment system for hospice Routine Home Care. While the new payment system is designed to redistribute payments so that they better reflect actual costs of care across a patient's length of hospice service, the full impact of these changes is not yet known. Hospice providers may be hesitant to contract with MA plans without a better sense of the impact that payment changes on the fee-for-service side will have on their financial viability. This may particularly be the case for those hospices that, generally, have patients on service for shorter lengths of time before death. Further, given the Congress' and CMS' desire to have hospice payments better reflect the actual costs of care, it is not clear how that goal would be maintained should hospice services be brought under the MA benefit package. These are concerns that policymakers must consider closely in relationship to the change being contemplated.

### **RECOMMENDATIONS:**

Given the aforementioned and other concerns, we do not advocate a move toward inclusion of hospice services under the MA benefit package. With the existing comprehensive approach to care required under hospice, it is not clear that such an action would advance team-based care; instead, we believe that the value of the services provided by the hospice team could be greatly diminished. Further, while some complexities related to current coverage changes would be eliminated, a great many more would ensue.

If Congress does wish to further explore bringing hospice under the MA benefit package, we would advise the following:

- Coverage of hospice under MA should be explored as a demonstration that compares success across the different type of managed care models. This type of demonstration should include utilization of a broad array of quality measures. In all cases the quality and coordination of care as patients transition to end-of-life care should be closely assessed as part of the MA plan satisfaction ratings. (Additional and more detailed comments on MA and quality measures are provided later in this these comments.)
- If Congress determines that it is advisable for hospice to be brought under the MA benefit package, MA beneficiaries should retain the right to disenroll from MA so that they may elect hospice care from the provider of their choice.
- MA plans should be required to contract with Medicare-certified hospices based on fee-for-service benefit levels and payment terms.
- The hospice inter-disciplinary group and the patient's attending physician (if applicable) should remain the ultimate authority on hospice eligibility, the hospice plan of care, and determinations of which conditions are related and unrelated to the patient's terminal prognosis.
- Additional issues related to the current hospice benefit structure and associated requirements must be thoroughly explored to ensure that the integrity of the existing hospice benefit is retained when it is brought under the MA benefit package.

### **MA, End-of-Life Care and Quality Considerations**

As we see the number of individuals living with a chronic, serious, advanced or terminal illness increase (along with lengthening of the average lifespan), the emphasis the health care system places on the cost and quality of care for these individuals becomes ever more important. Until policymakers are able to thoroughly study all aspects of end-of-life care in the MA environment, hospice care should not be included as part of the MA benefit package. There are simply too many potential negative consequences that could occur without the proper studies to inform decision makers.

Numerous studies have shown that individuals hold quality of life as the most important aspect of end-of-life. Therefore, good measures of quality of care at the end of life are essential. At this time, there are no palliative care-related measures in the MA Five-Star Quality Rating System or the Medicare

Shared Savings Program. Therefore, we encourage the Committee to study the models that have implemented palliative care early in the disease trajectory before incorporating palliative care or hospice in the MA benefit package. There are various state programs that could be studied, as well as:

[Aetna's Compassionate Care Program](#)

[Highmark Blue Shield Advanced Illness Management Program](#)

[Sutter Health Advanced Illness Management \(AIM\) Program](#)

[Gunderson Respecting Choices Program](#)

[The Advanced Care Project by the Coalition to Transform Advanced Care](#)

Study should focus not just on containment or reduction in overall costs, but also on development of validated quality measures and best practices. The quality measures should encourage those items that studies have shown to be key to quality end-of-life care:

- Earlier access to palliative care
- Integrated care coordination

Moving toward earlier access and integrated care advances team-based care, which, as the Committee summarizes in its Policy Options document, leads to stronger patient outcomes and reduced overall expenditures.

There are measures being used in other care sectors that could be used as indicators of outcomes achieved when palliative care is employed earlier in a person's serious/chronic illness journey. These include:

- Decreased hospital readmissions
- Reduction in ICU days
- Reduction in number of hospital days
- Reduction in number of hospital stays
- Reduction in ED visits
- Number of hospice referrals
- Number of hospice admissions
- Length of stay on hospice

There are also a number of existing measures endorsed by the National Quality Forum (NQF) or currently under consideration that could be utilized and further developed, including:

Measure 0210 - Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life.

Measure 0211 - Percentage of patients who died from cancer with more than one emergency room visit

in the last days of life.

Measure 0213 - Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life.

Measure 0215 - Percentage of patients who died from cancer not admitted to hospice.

Measure 0216 - Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there.

Measure 1625 - Percentage of hospitalized patients who die an expected death from cancer or other terminal illness and who have an implantable cardioverter-defibrillator (ICD) in place at the time of death that was deactivated prior to death or there is documentation why it was not deactivated.

Measure 1626 - Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.

Measure Under Consideration 578: Advance care plan

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

**Note for measure under consideration 578:** We believe this measure is a good starting point to promoting advance care planning, a necessary component to quality care. We recommend that this measure be added to the quality programs of other provider types and, eventually, be expanded to include measures assessing provider compliance with patient's advance directive. Consideration should also be given in the future to including in the measure assessment of whether providers inform patients of the availability of advance care planning discussions, and provide referral in cases where the patient indicates an interest, if not directly having the discussion. This would be an especially appropriate measure for all physicians considering the fact that two new physician billing codes for advance care planning were added to the Physician Fee Schedule in 2016.

Numerous studies have underscored the need for advance care planning. As evidenced by development and consideration of an advance care planning measure by NQF and HHS, it is clear that health policy experts see a compelling need for greater progress relative to utilization of advance care planning. We strongly encourage the Committee to promote use of an advance care planning measure in the Physician Quality Reporting System, the MA 5-Star Rating program and the Medicare Shared Savings Program, at minimum; and to further study an advance care planning measure that could be utilized across the care continuum.

The Policy Options document contains several policies that are closely related to advance care planning

and would be of great help to better informing individuals (and their representatives) about their health status so that these individuals could make more informed decisions about the plans for their care. These policy options include a one-time visit code post initial diagnosis of Alzheimer's/dementia or other serious or life-threatening illness; improving care management services for individuals with multiple chronic conditions (high severity chronic care management code); and addressing the need for behavioral health among chronically ill beneficiaries. The Advancing Team-Based Care section of the document is of great interest to us as numerous studies have proven that team-based care that is coordinated results in greater patient satisfaction because their wishes are addressed and met as much as possible and also results in better quality outcomes. This approach is the basis of the palliative care philosophy on which hospice care is based.

Practices that would promote earlier access to hospice and palliative care and integrated care coordination include screening tools that would identify individuals that could benefit from hospice and palliative care referral and linking quality measures and incentives to those providers making the referral. By referring more individuals to hospice at the right time and to palliative care services at the right time the following should be minimized: futile care, care that is not reasonable and necessary, ineffective care that increases burden and decreases quality of life. Simultaneously, such referrals will increase quality of life and decrease overall health care costs.

We also note that, in previous comments to the Committee, we have strongly advocated for creation of an effective advance care planning benefit under Medicare that is provided by a multi-disciplinary team. Members of the Committee have recommended such as part of the Care Planning Act, and urge the Committee to explore options for implementing a benefit along these lines. The benefits of this approach for beneficiaries, Medicare and the health system generally cannot be overstated.

#### **Additional Comments:**

#### **Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness**

The Committee asked for feedback regarding establishing a one-time visit code post initial diagnosis of Alzheimer's/Dementia or other serious or life-threatening illness. Specifically, the Committee seeks feedback on the scope of diseases that would be considered a serious or life-threatening illness. We believe the types of diseases that would fall into the broad category of serious or life threatening are those that are not curable but require medical supervision of at least two visits per year and an ongoing regimen of treatment. For example, diabetes, multiple sclerosis, congestive heart failure, asthma, Parkinson's, advanced rheumatoid arthritis, Alzheimer's and other dementias. The definition could further include individuals who are mentally incapacitated. Because of the broad scope of such a category, it is not practical to develop criteria for each illness that fits within the scope of serious or life-threatening illness; rather, it is best to develop guidelines applicable to all serious and life-threatening illnesses. It is also important in the definition of a serious or life-threatening illness to differentiate this type of illness from a chronic condition. While a chronic condition can be a serious illness, not all

chronic conditions would fall into this category (i.e. osteoarthritis).

In closing, we hope that these comments are of some assistance as you continue to explore options for improving care of individuals with chronic and advanced illness, and look forward to additional discussions with you regarding the unique attributes of the hospice benefit. We stand ready to assist in any way that we can. Should you have any questions regarding these comments, please contact me at 202-547-7424 or at [tmf@nahc.org](mailto:tmf@nahc.org).

Sincerely,

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