



1/25/2016

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:

I am writing to you on behalf of Hospice & Palliative CareCenter a not-for-profit provider of end-of-life care in the Piedmont region of North Carolina. Our organization has been providing care in our region for 36 years, and it is our privilege to be able to help those facing advanced illness. Our founding in 1979 was the result of the collaborative effort of volunteers who were engaged in caring for those facing terminal illness. Our founders represented the faith community, community volunteers, physicians, and the two major medical centers in our region – now Wake Forest Baptist Health and Novant Health. We have continued to serve our region under a collaborative spirit with our communities; ensuring access to all who need support at end of life. We also continue to work collaboratively with a variety of medical providers to adapt to the changing needs of our community and the health care industry.

I have read the Bipartisan Chronic Care Working Group Policy Options Document. As I'm sure you are aware hospices are experts in both in-home case management and team-based care, therefore much of this report speaks to the type of work we believe in. However, I am not in favor of the proposed policy revision that would incorporate the Medicare Hospice Benefit into the Medicare Advantage structure.

The Options Document notes that Medicare Advantage plans are not required to assume the financial risk of enrollee's hospice care, and I would argue that is a good situation and should not be changed at this time. End of life care shouldn't be driven by financial policies. When an individual has been told that they are facing end-of-life they are faced with many difficult decisions. Among those is the option of pursuing curative treatment or strictly palliative/supportive care. In our experience individuals seek information from their family, physicians, spiritual counselors, and others when making these decisions. Even with this support, this is a difficult period for anyone. This highly personalized decision should not be limited or negatively impacted by financially-driven policies that could be utilized in managed care programs.

My perspective derives from our experience working with managed care plans for those requiring hospice care. While the majority of our patients are covered by Medicare or Medicaid, we do work with private insurance plans for some of our patients. At this time, we work with about a half dozen health insurance companies (sometimes with multiple plan structures) to provide end of life care for their enrollees. It is this experience over the years that drives my concerns about hospice under Medicare Advantage. For example:

- There is an inconsistent philosophy between the current Medicare expectation of services provided by hospice (nearly all) and the current managed care approach in the market. For example, we have experienced various coverage terms for medications: one plan might cover oral medications provided by the hospice only if the patient has a cancer diagnosis, and never cover IV medication (which our medical staff find to sometimes be a more tolerated route). Another plan may require that all medications be provided by the hospice under the contracted rate. And a third can state that no oral or IV medications are to be provided. Even with a limited number of managed care contracts, we have found that coordinating and providing patient-centered care has been challenging. Clearly there are philosophical inconsistencies about how to case manage end of life care among plans, and that is reflected in their contracts. Our organization would need to hire additional financial staff to coordinate compliance with an expanded number of plans, adding to our administrative burden.
- As noted above, contracts may cover only part of the care, such as nursing visits, and not other parts, such as medications which would fall under the plan's formulary. For example, intractable nausea and vomiting is not unusual among hospice patients, however we have had a managed care company conclude that the medications needed for this symptom fell in a higher-tier than would be approved under the contract. These medications might be atypical for the average managed care patient, but are not atypical for hospice patients.
- Current utilization review practices might not account for the needs of the individual hospice patient. An insurance company might approve a limited number of inpatient hospice facility days due to policy, without regard to the patient's medical condition. In one situation we were told by an insurance company "the patient is not dying fast enough". While this was an isolated incident, it reinforced our belief that our medical staff (those providing the care at the bedside) should be making the decisions about what is needed, not a utilization review contact on the telephone. Prognostication is not perfect, and hospices adapt to uncertain trajectories of illness on a routine basis.
- Pre-authorization policies can be challenging at best, and barriers at worst, when patients are facing end of life. Some of the plans we have worked with will only process authorization requests by fax or online submittal, with a turnaround time of several days. For others approvals are given over the phone after lengthy wait times. In our experience as patients face end-of-life their symptoms can exacerbate suddenly and require immediate intervention. Pre-authorization policies can be a barrier to care in these situations. Our staff provided care in homes, hospitals, and our inpatient facilities throughout this past weekend's wintry weather. I cannot imagine the disruption in care that would have occurred had we waited for approval from multiple managed care plans during this time.

In addition, one of the elements of success in managed care is maintaining a limited network of providers and I believe this practice will result in limited choice to enrollees or greater out of pocket

expenditures. With regard to our experience with managed care plans, we are considered in-network with some plans and out-of-network with others. I imagine there was an increased cost to the enrollee in those cases where they chose to use our services despite the fact that we are considered out of network. At this point in time no managed care plan has asked us to provide any information regarding our quality of care processes or outcomes, indicating that current hospice network decisions are not being made with regard to patient care quality. At some point hospice quality definitions may have matured to the point that this will change, however at this time this is an emerging topic.

One of the primary ethical principles of hospice care, and one that makes it a successful model of care, is autonomy. Hospice care is truly person-centered care where a team of expert providers work with a patient and their loved ones to determine their goals. Care is then tailored and case-managed to meet those goals. It is not a service that should be standardized by formularies and UR policies that strive to meet a per-member per-month cost calculation. Instead, the hospice benefit includes provisions that allow for the patient to have a voice in their care plan, which is managed under the oversight of experts in end of life care. Rather than enhance transitions and care-coordination, the current proposal to 'carve-in' hospice under the Medicare Advantage program would increase the challenges of providing the right care at the right time in the right setting.

Thank you for the opportunity to share our perspective.

Sincerely,

A handwritten signature in cursive script that reads "Linda W. Darden".

Linda W. Darden, MHA, CPA
President & CEO