2/4/2016

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:

Thank you for the work of the United States Senate Committee on Finance Bipartisan Chronic Care Working Group and for the opportunity to comment on the recommendations included in the Policy Options Document.

As Executive Director of the Virginia Association for Hospices & Palliative Care my comments represent the majority of hospices across the Commonwealth. As a constituent and Medicare beneficiary, they reflect my personal concerns as well.

Virginia has been well served by hospice programs since before the inception of the Medicare Hospice Benefit, boasting the oldest pediatric hospice in the nation and a number of volunteer hospices. Many of our community-based hospices continue to deliver high quality services while retaining the small operations best suited to their communities' preferences. Bigger is not always better in end-of-life-care.

These smaller hospice programs will be disadvantaged in negotiations with Medicare Advantage (MA) plans as they may not be able to absorb the additional administrative burden in staffing and administrative ratios, especially if associated with lower reimbursement rates that characterize the MA plans.

The Virginia Association for Hospices and Palliative Care
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Additionally, I fear that the quality and integrity of the Medicare Hospice Benefit may be diluted by MA plans being unfamiliar with, and therefore skimping on, some services that are the hallmark of hospice; such as services designed to meet the spiritual and psychological needs of the dying and the bereavement needs of their families.

The inclusion of hospice in MA plans will limit beneficiary access to the hospice of their choice if they must choose from an in-network hospice program. This, coupled with the potential for MA plans to undermine the autonomy of the hospice Medical Director (by overruling what is related to prognosis for example), will hamper the hospice's ability to provide the quality of care our Virginia communities have come to expect.

I applaud the Working Group's efforts in addressing the increasing burden chronic diseases are placing on individuals, families, communities and our nation and I encourage the Group to rethink its proposed policy for end-of-life care. The Medicare Hospice Benefit is one of the "jewels in the crown" of our current health care system and should continue to be accessible to all beneficiaries in its current form.

Please do not force the inclusion hospice care in MA plans.

Sincerely,

Executive Director

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