WHAT CONGRESS CAN DO TO
PRESERVE AND PROTECT THE MEDICARE HOSPICE BENEFIT
AND SUPPORT AMERICANS WITH ADVANCED ILLNESS

– HOUSE –

Support the Personalize Your Care Act of 2016 [HR 5555]. The Personalize Your Care Act aims to improve advance care planning so that an individual’s end-of-life wishes will be honored even if they are no longer able to communicate them. This legislation also establishes the Advanced Illness Management and Choices Demonstration, which will provide hospice care alongside a functional assessment of the individual, in-home services and supports, 24/7 emergency supports, and other palliative care services. In addition, the Personalize Your Care Act:

- Provides grants for the establishment or expansion of physician orders for life-sustaining treatment (POLST) programs.
- Requires that’s certified electronic health records can display current advance directives and POLST;
- Allows that advance directives to be portable across state lines.
- Requires the Secretary of the Department of Health and Human Services to develop quality measures for end-of-life care.
- Supports the development of tools and materials to increase public awareness of advance care planning.
- Provides advance care planning and palliative care education and training for clinicians who care for people with advanced serious illness.

The Personalize Your Care Act is sponsored by Congressmen Earl Blumenauer (D-OR) and Phil Roe (R-TN). Please contact Aaron Bill (Aaron.Bill@mail.house.gov) or Kristen Donheffner (Kristen.Donheffner@mail.house.gov) to be added as a cosponsor.

Support the Rural Access to Hospice Act. When patients enroll in hospice, they select a physician or nurse practitioner to serve as their attending physician. The attending physician collaborates with the hospice in the development of the care plan, and is kept informed of the patient’s care. Attending physicians are typically reimbursed for their services under Medicare Part B. However, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are paid a fixed, all-inclusive payment for services provided to Medicare beneficiaries that does not include for hospice. This statutory barrier prevents hospice patients from having their rural health clinician serve as their attending physician during hospice care. Patients often choose to forgo hospice care when they discover their primary care provider cannot serve as their attending physician. The Rural Access to Hospice Act addresses this issue by allowing RHCs to receive payment for hospice services.

The Rural Access to Hospice Act is sponsored by Congresswoman Jenkins (R-KS) and Congressman Kind (D-WI). Please contact Andrew Franke (Andrew.Franke@mail.house.gov) or Elizabeth Stower (Elizabeth.Stower@mail.house.gov) to be added as a cosponsor.

For additional information, please contact spearce@nhpco.org.
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-- SENATE --

Support the Care Planning Act [S 1549]. The Care Planning Act is designed to give people with serious illness the freedom to make more informed choices about their care, and the power to have those choices honored. Specifically, the Care Planning Act (1) establishes a new Medicare benefit called Planning Services for those with advanced illness, allowing for a team-based approach of care planning discussions with doctors, nurses, and other healthcare professionals; (2) creates a pilot program for Advanced Illness Coordination Services to allow for home-based support of patients with multiple and complex chronic conditions; and (3) directs the Secretary of HHS to develop quality metrics, public educational efforts, and resource development on advance care planning.

The Care Planning Act is sponsored by Senators Warner (D-VA) and Isakson (R-GA). Please contact Marvin Figueroa (Marvin_Figueroa@warner.senate.gov) or Jordan Bartolomeo (Jordan_Bartolomeo@isakson.senate.gov) to be added as a cosponsor.

Support the Rural Access to Hospice Act [S 2786]. When patients enroll in hospice, they select a physician or nurse practitioner to serve as their attending physician. The attending physician collaborates with the hospice in the development of the care plan, and is kept informed of the patient’s care. Attending physicians are typically reimbursed for their services under Medicare Part B. However, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are paid a fixed, all-inclusive payment for services provided to Medicare beneficiaries that does not include for hospice. This statutory barrier prevents hospice patients from having their rural health clinician serve as their attending physician during hospice care. Patients often choose to forgo hospice care when they discover their primary care provider cannot serve as their attending physician. The Rural Access to Hospice Act addresses this issue by allowing RHCs to receive payment for hospice services.

The Rural Access to Hospice Act is sponsored by Senators Capito (R-WV) and Shaheen (D-NH). Please contact Dana Richter (Dana_Richter@capito.senate.gov) or Alison MacDonald (Alison_MacDonald@shaheen.senate.gov) to be added as a cosponsor.

Oppose the MA Carve-in of Hospice. The Senate Finance Committee’s Chronic Care Working Group (CCWG) proposed that Medicare Advantage (MA) plans assume both the clinical management of and financial responsibility for the hospice benefit. A “carve-in” of the Medicare Hospice Benefit into MA plans would have a significant impact on the hospice community. NHPCO is 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 prognosis. 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.

NHPCO encourages Senators to reject this proposal. If this proposal does move forward, 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.

For additional information, please contact spearce@nhpco.org.
Advance Care Planning

As America’s aging population grows, individuals with chronic and advanced illnesses will need access to resources and tools to help make informed choices about advance care planning. Research shows that individuals who have discussions about end-of-life care have fewer and less invasive medical treatments, and a higher quality of life. The Care Planning Act (S. 1549) and the Personalize Your Care Act (H.R. 5555) will help individuals receive person-centered care planning to ensure that doctors and hospitals understand the choices that the patient and family have made.

Care Planning Act (S. 1549)

Senators Mark Warner (D-VA) and Johnny Isakson (R-GA) introduced the Care Planning Act, which will give patients and families living with advanced and life-limiting illnesses knowledge and access to the kind of information and services they need. The Care Planning Act creates a Medicare Planning Services benefit for those with serious or life-threatening illness. Unlike the current Advance Care Planning codes, the Planning Services benefit includes a team-based discussion of goals of care and values, disease progression, a range of treatment options, and a documented plan that reflects the individual’s preferences. The Planning Services benefit will ensure that patients and families are able to navigate the journey at the end of life with the necessary information and support that will bring dignity, quality care, and hope when they are needed the most.

The Care Planning Act also directs the Center for Medicare and Medicaid Innovation to conduct an Advanced Illness Coordination Services demonstration. This demonstration will allow an interdisciplinary team to provide wrap-around, home-based services to individuals with multiple and complex chronic conditions.

“I know from my own experience with my parents that having a plan makes a world of difference in ensuring a high quality of life during a loved one’s last days. [The Care Planning Act] will go a long way in honoring patients’ wishes and empowering people to take charge of their own health care.”
– Senator Johnny Isakson

Personalize Your Care Act (H.R. 5555)

The Personalize Your Care Act will improve our nation’s ability to care for individuals who are facing advanced or life-limiting illness. Introduced by Congressmen Earl Blumenauer (D-OR) and Phil Roe (R-TN), the Personalize Your Care Act increases accessibility to and public awareness of advance care planning.

The legislation also requires that advance directives be included within a patient’s electronic health record in order to increase the likelihood that the documents are kept up-to-date and easy to locate, and are upheld in a state other than where the care plan was established.

“I’ve been on both sides of these discussions – as a physician and a family member – and I know firsthand the peace of mind that comes with knowing a patient or loved one’s wishes. This bill will ensure patients, families and medical professionals have the resources and tools they need to navigate these sensitive but necessary conversations.”
– Congressman Phil Roe

For more information on the Care Planning Act and the Personalize Your Care Act, contact Sharon Pearce at spearce@nhpco.org.
Rural Health Centers, Federally Qualified Health Centers, and Hospice

Background
Rural Health Centers (RHC) were created in 1977 as a response to a shortage of physicians serving Medicare patients in rural America. Through increased use of physician assistants and nurse practitioners, RHCs provide primary care in more than 4,000 communities across the country.\(^1\) Fourteen years later, Federally Qualified Health Centers (FQHCs) were established to promote primary care service delivery in underserved urban and rural communities.\(^2\) For some patients, RHCs and FQHCs are their only source for primary care. Over 21 million Americans were served at 9,000 FQHC sites in 2013.\(^3\)

RHCs/FQHCs and Hospice
Despite recent growth in hospice utilization, hospice care is underutilized in rural areas. A March 2015 report from the Medicare Payment Advisory Commission (MedPAC) found that 48.5 percent of Medicare decedents in an urban area utilized hospice, compared to 32.2 percent of decedents in frontier regions.\(^4\)

One reason for this disparity is a statutory barrier that inhibits access to hospice in rural communities. When patients enroll in hospice, they select a physician or nurse practitioner to serve as their attending physician. The attending physician collaborates with the hospice in the development of the care plan, and is kept informed of the patient’s care. Typically, the attending physician is reimbursed for these services under Medicare Part B. Unfortunately, RHCs and FQHCs do not bill Medicare under Part B; they are paid a fixed, all-inclusive payment for all services provided to Medicare beneficiaries. Unfortunately, due to a statutory oversight, hospice is not included under this all-inclusive payment.

This glitch keeps some patients from having their primary care physician of 20 years serve as their attending physician. The National Advisory Committee on Rural Health and Human Services notes that when rural patients discover that their primary care provider is unable to serve as their attending physician, patients choose to dis-enroll from hospice, or not to enroll at all.\(^5\)

The Solution
Skilled nursing facilities (SNFs) faced a similar prohibition from RHC physicians providing services to SNF residents. In 2003, Congress passed legislation that allowed RHC and FQHC physicians to bill Medicare separately for their services in a SNF. We believe a similar approach would ensure patient access to the hospice benefit in rural communities.

Sen. Shelley Moore Capito (R-WV), Sen. Jeanne Shaheen (D-NH), Rep. Lynn Jenkins (R-KS) and Rep. Ron Kind (D-WI) have introduced the Rural Access to Hospice Act (S. 2786/HR ______), to allow RHCs and FQHCs to receive payment for serving as the hospice attending physician. NHPCO and HAN urge all members of Congress to cosponsor this common-sense, non-controversial legislation, and ensure that terminally ill beneficiaries in rural communities can access the hospice benefit.

For more information on this legislation, contact Sharon Pearce at spearce@nhpco.org.


Issue Briefing: Hospice and the Medicare Advantage “Carve-In”

Background
In 2015, 31% of Medicare beneficiaries were enrolled in a Medicare Advantage Plan, although enrollment rates vary greatly by state and locale. This is up from 19% in 2007.¹ Once a beneficiary elects to receive hospice care, the hospice is responsible for all medical care related to the beneficiary’s terminal prognosis—their primary diagnosis and related conditions—as well as coordinating unrelated care.

Currently, Medicare Advantage Plans do not cover hospice care. When an individual with Medicare Advantage coverage decides to elect the Medicare Hospice Benefit, he or she typically disenrolls from the MA plan, and can then select any Medicare-certified hospice, without any network restrictions. All Medicare-covered services a beneficiary receives while in hospice care are covered by fee-for-service Medicare. This includes any Medicare-covered services for conditions unrelated to the terminal prognosis. If the beneficiary’s Medicare Advantage Plan includes additional services not covered under fee-for-service Medicare (such as vision and dental benefits) and the patient does not disenroll from the Medicare Advantage Plan, the MA Plan will continue to cover those additional services.

Potential Changes to the Medicare Advantage Hospice “Carve-Out”
The Medicare Payment Advisory Commission’s (MedPAC) March 2014 Report recommended that Medicare Advantage (MA) plans assume both the clinical management of and financial responsibility for the hospice benefit. This proposal is rooted in an effort to promote coordination of care management between MA plans and hospices. In December 2015, the Senate Finance Committee’s Chronic Care Working Group (CCWG) released a similar proposal.

Implications for Hospice Patients and Families
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. If hospice is carved-in to MA, however, beneficiary access could be severely limited. Additionally, MA plans could also assign additional co-pays, deductibles, or prior-authorizations for both in-network and out-of-network hospice utilization. For individuals and families facing terminal illness, these restrictions and financial requirements create an additional burden during an already stressful time.

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. 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 patients die within two weeks of electing hospice care.² The limited networks with potential pre-authorization requirements are a bad fit for hospices and patients alike.

² 2014, NHPCO National Data Set and/or NHPCO Member Database.
The hospice interdisciplinary team (IDT) includes physicians, nurses, social workers, chaplains, volunteers, and other professionals. The IDT ensures that the whole patient and family are treated—not just the physical illness. Many hospice providers have witnessed managed care organizations in other markets asking them to offer a subset of services, such as pain management or in-home care, but at a reduced fee-for-service rate. NHPCO is concerned that a “hospice lite” model may undermine the integrity of the hospice benefit.

Implications for Hospice Programs

A “carve-in” of the Medicare Hospice Benefit into MA plans would have a significant impact on the hospice community. NHPCO is 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 prognosis. 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.

Finally, an MA carve-in would likely undermine the financial viability of many hospice programs. 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. Hospices would be required to negotiate, manage, and process claims from each MA plans with whom they contract.

It is presumed under current proposals that MA plans would be able to set their own reimbursement rates for hospice care. This 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.

What Would the “Carve-In” Cost?

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—or in terms of quality or cost of care— to the consumer or the taxpayer. In fact, an estimate prepared by Avalere Health suggests that making this change would cost the Medicare program more than $895 million over ten years.

Policy Recommendations

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 if care is “related” or “unrelated” to the terminal prognosis; MA plans should have the option to appeal these decisions 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 or MA. 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.

“The success of our program [the Aetna Compassionate Care program]—and other MA programs—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.”— Randall Krakauer, MD, former Vice President, National Medical Director, Medical Strategy, Aetna

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