National Hospice and Palliative Care Organization

Chairman Glenn M. Hackbarth, J.D.
425 Eye Street, NW Suite 701
Washington, DC 20001

December 5, 2013

Dear Chairman Hackbarth,

The National Hospice and Palliative Care Organization (NHPCO) strongly opposes MedPAC's recent consideration to change the carved-out Medicare Hospice Benefit (MHB) for Medicare Advantage (MA) plan members to a carved-in benefit. Based on the presentations and discussions to date, the questions, complexities, added burdens and costs do not seem to be offset by any tangible gains.

As you know, 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 loved ones. The current carve-out for the MHB provides MA plan members: the security of selecting any Medicare-certified hospice without network restrictions; the certainty that they will have access to the MHB without needing preauthorization from their MA plan; and the assurance that their care will be managed by hospice professionals who have highly specialized training and will not be influenced by any potential financial concerns of their MA plan.

Patient choice is a foundational cornerstone of hospice. NHPCO believes that protecting patient choice is an issue of paramount importance. Choosing a hospice is one of the most important decisions a patient and family can make when facing life-limiting illness. NHPCO member hospices hear firsthand every day that patient and family choices are based on their own personal or family experiences, the engagement of the hospice in their community, their spiritual beliefs and the overall quality and personnel of the hospice. With a carved-in MHB, MA plans would be able to limit patient and family choices to a few network hospice providers, in effect, taking away this a very personal choice. In addition, NHPCO supports a patient and family's right to change hospices if they are not satisfied with the care they are receiving. Again, the potential limitations of MA Plan networks severely restrict patient and family choice when changing hospice providers.

Hospice providers and MA plans are similar in that they both manage the care of patients under a capitated reimbursement system. Hospices manage patient care related to the terminal condition just as MA Plans manage all other medical care prior to the hospice referral for a set reimbursement rate. With MedPAC's proposal to carve-in the MHB to the MA plan, it would seemingly add another layer of 'managed care' to what is essentially managed care (MHB), and in doing so create redundancy, complexity and increased administrative costs for both hospices and MA Plans. Specifically, hospices and MA plans would need to allocate staffing and other

valuable resources toward establishing and negotiating contracts as well as developing the administrative infrastructure needed to support billing and data reporting.

Importantly, with the proposed MA plan oversight of the MHB, NHPCO is concerned that MA plans will serve as gatekeepers for the MHB and potentially limit access to hospice by requiring preauthorization. Even though MA plans currently refer their members to hospice at a higher rate than Medicare Fee-for-Service (FFS) and with longer lengths of stay, this might not be the case if MA plans were financially responsible for the hospice benefit. Since the reimbursement rates for MA plans to cover the hospice benefit have not been determined, it is impossible to know if the rates will adequately cover the cost of hospice. NHPCO fears that MA Plans might be incentivized to circumvent the MHB by offering hospice-like services (i.e., palliative medicine, support services) that are less comprehensive and cheaper options but fail to meet the needs of patients and families when they are the most vulnerable and really need hospice. In the end, MA plans may refer patients to hospice only when death is imminent and thereby resulting in a shorter, not longer, length of stay in hospice. Depending on the financial model that is made available to MA plans, there might be strong incentive to limit referrals to hospice, thus undoing the good track record of MA plans with their increased referral patterns.

It also is worth noting that MA plans have experience managing the care for chronically ill patients with the intention of life prolongation, whereas hospices have expertise managing the care for terminally ill patients. This is a fundamentally different managed care proposition. NHPCO seeks to ensure that the experts, who have experience partnering with patients and families regarding end-of-life care, are actually managing that care.

MedPAC's analysis of the potential carve-in seems to ignore the established fact that upon the patient's admission to hospice, the hospice program becomes responsible for the professional management of ALL of the patient's medical care. While the hospice is directly responsible for the costs and provision of the care related to the terminal illness, nevertheless, they are also responsible for the coordination of the unrelated care. While there may be limited instances of gaps between an MA plan and hospice's overall care coordination, by and large the perceived gap is not as large as it seems.

NHPCO supports MedPAC's overall goals of promoting coordination and care management between MA plans and hospices as well as allowing MA plans to offer concurrent care, but NHPCO believes these goals can be best achieved with the current carved-out MHB. Rather than implementing a monumental policy shift resulting in complexity and an expensive infrastructure and staffing investment for hospices and MA plans, NHPCO calls on MedPAC to explore alternatives that incentivize hospices and MA plans to collaborate and develop stronger care coordination strategies and systems while maintaining the integrity and stability of the current MHB for MA plan members. To date, NHPCO has worked with a number of health insurance plans to help them target and better meet the needs of patients facing life-limiting illness. By expanding on these types of collaborative efforts, we can collectively improve coordination and care management in the transition to hospice care.

One alternative discussed in our meeting on November 18, 2013 is to transfer the financial responsibility for care unrelated to the terminal condition from FFS to MA plans. With premium

adjustments made to MA plans for this added responsibility, MA plan members would be assured of receiving care unrelated to the terminal illness from their MA plan providers, and MA plan providers would be assured of receiving payment for their services from the MA plan. With this change, CMS would not be administratively or financially involved in the payment for these services, MA plans would seamlessly pay for care just as they have done prior to the hospice referral, and the patient and family would receive the best possible hospice care. Through this type of change along with other innovative strategies, MA plans and hospices can better ensure a seamless healthcare experience for MA plan members and their families.

Prior to MedPAC moving toward this significant policy change, with its attendant disruptions and unintended consequences, perhaps a more in-depth look at the Medicaid experience in this area is warranted. Based on our evaluations, the state experiences are all across the board and fraught with problems.

NHPCO will continue to advocate for a MHB that provides all Medicare beneficiaries with equal access and choice to the best quality hospice care. We urge MedPAC to withdraw its proposal to carve-in the MHB for MA plan members in order to preserve one of the most highly regarded, cost-effective Medicare programs available. NHPCO looks forward to working with MedPAC and other policymakers and stakeholders to improve coordination and care management to benefit all Medicare beneficiaries and their families.

Sincerely,

Don Schumacher
President/CEO
National Hospice and Palliative Care Organization

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