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The Honorable Chiquita Brooks-LaSure
Administrator, The Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20101

RE: Request for Information for the Value-Based Insurance Design Model: Innovating to Meet Person-Centered Needs

Dear Administrator Brooks-LaSure:

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to submit comments on the Request for Information for the Value-Based Insurance Design Model. We look forward to our strong, continued collaboration with the Centers for Medicare & Medicaid Services (CMS) regarding the full range of issues impacting the hospice and palliative care provider community and the patients and families we serve.

NHPCO is the nation's largest membership organization for hospice providers and professionals who care for people affected by serious and life-limiting illness. NHPCO members provide care in more than 4,000 hospice and palliative care locations and care for over two-thirds of the Medicare beneficiaries served by hospice. In addition, hospice and palliative care members employ thousands of professionals and volunteers.

We have focused our comments on the potential impact of these proposals on hospice providers serving patients with serious and life-limiting illness and their families. Comments from providers are from large and small hospices, for profit and not for profit providers, as well as from hospices throughout the country.

While NHPCO has attempted to provide thoughtful and constructive feedback; there are only minimal data on provider and patient experiences, the utilization of the services has been low, and there has been no comparison of VBID against the current Medicare hospice benefit for quality of care or access to care. Updates to the hospice component of VBID must be evidence-based which requires transparency in the data Medicare Advantage Organizations (MAOs) and CMS collect. For VBID to be successful, providers must be seen and treated as equal partners to MAOs in improving care continuity and high quality care for enrollees. The requirements of VBID create the greatest potential overhaul of hospice since it was added as a Medicare benefit in 1983. As MAOs adjust from transitioning enrollees to hospice to managing this benefit for enrollees, MAOs must learn and demonstrate understanding of the hospice benefit before

embarking on deploying the traditional tools of MA (e.g., limited networks, prior authorization). We urge severe caution in the next steps of VBID and request the next steps be driven by data and principles focused on the enrollee receiving these services. We only get one chance to provide quality hospice care to enrollees and we need to ensure the changes we make to these services are to their benefit.

I. Advancing Health Equity by Best Identifying and Meeting Needs

Role of hospices: Hospice is intended to treat the whole person as well as their loved ones and, therefore, providing care by identifying and addressing the needs of patients is core to the mission of hospice. Hospices deliver person-centered care to patients, families, and loved ones in a culturally sensitive manner, and are committed to providing care to enrollees to address all their needs and connecting them to appropriate services. When an enrollee elects hospice, the interdisciplinary team develops a plan of care to address all the enrollee's and their loved ones' needs, including social and spiritual needs.

Indeed, hospices have been at the forefront of our nation's healthcare community in serving patient populations traditionally underserved. For example, from the beginning of the AIDS epidemic, hospices worked tirelessly to provide care for patients suffering from a then-unknown illness in their homes and communities. Similarly, hospices were working on the front lines providing care in patients' homes during the COVID-19 pandemic at a time when our nation was brought to its knees. In other words, hospices are well-equipped and positioned to address our nation's most vulnerable and terminally ill population, and we encourage CMS and MAOs to work collaboratively with these providers to reduce disparities and advance equitable care among MA enrollees.

Operationalization: Operationalizing the Area Deprivation Index (ADI), health-related social needs (HRSNs), and ICD-10-CM Z codes for the currently small VBID hospice patient population would require new policies and procedures to try and target these areas to serve patients. This means any new requirements would require time and money to operationalize.

Although using Z codes may be feasible in some situations, it would take education and training on how to appropriately use the codes, improved and updated electronic medical records to require the input of the Z codes, and a review of the new practice and feedback to providers using the system.

Another consideration is that some providers outsource coding which is another layer hospices will need to operationalize. For these providers to use Z codes, the coders will not know the appropriate Z codes and, therefore, it would need to come from the referring provider. While interoperability and enhanced meaningful use of EMRs continues to be an area of opportunity for which hospice providers look to the federal mechanism for support, requirement of Z codes would create further confusion, uncertainty, and ambiguity in documentation during care delivery.

Through clear communication strategies, collaboration with healthcare providers, and support from CMS, MAOs can effectively communicate about ADI targeting all beneficiaries, including those who may not be familiar with their census block. Advanced illness organizations should be included in any effective communication plan. In addition, we urge CMS to consider additional funding that would

both incentivize providers to report Z codes and recognize the resources necessary to care for populations with unique and specific care needs.¹

Technology and education: Hospice providers were not included in interoperability initiatives and funding. Due to this, many hospices have minimal access to data outside of their program so any requirements from MAOs for population data will be limited from hospice providers. Hospice providers would need updated software to access and share this information. In addition, hospice providers would benefit from support and infrastructure akin to the inpatient and other care settings during their Meaningful Use journey. There is much to extrapolate from this successful initiative.

Once providers have the right technology, providers will need to educate internal staff and referral sources on the use of the ADI, HRSNs, and Z codes. This would also require training of hospice’s own staff on admission, coding, and billing considerations. In other words, to the extent CMS moves forward with any policies, sufficient time should be allowed for hospices to engage in appropriate training to realize any benefits.

Transparency on data: Before requiring hospice providers to collect additional information – which as mentioned above would require new technology and training – MAOs and CMS must share the current data they receive and use. Hospice providers report feeling in the dark about the data MAOs possess as well as how the data hospices submissions are used by MAOs. Additionally, when data are shared it is done so with a time lag rendering the data to be retrospective and often inactionable. To ensure hospices are able to expand their outreach to all populations of enrollees, the flow of data between MAOs and providers needs to be improved to be more transparent.

II. Expanding Access to Higher Quality Hospice Care

1. *How can CMS implement network access policies for hospice providers in line with current MA program policies (e.g., the ability for health maintenance organizations (HMOs) to limit access to in-network providers) while minimizing confusion among enrollees/patients, caregivers, and hospice and non-hospice providers?*

Patient choice: It is a fundamental right of the terminally ill hospice patient to “[r]eceive effective pain management and symptom control from the hospice for conditions related to the terminal illness[.]”² Indeed, as CMS has observed, “[p]atients should not have to experience long waits for pain and symptom management, medications, or interventions to address the patient’s condition.”³ Given

¹ Cf. Centers for Medicare & Medicaid Services, FY 2024 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule — CMS-1785-F and CMS-1788-F Fact Sheet (“CMS finalized a change to the severity designation of the three ICD-10-CM diagnosis codes describing homelessness (e.g., unspecified, sheltered, and unsheltered) from non-complication or comorbidity (NonCC) to complication or comorbidity (CC), based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes. This action is also consistent with the Administration’s goal of advancing health equity for all, including members of historically underserved and under-resourced communities as described in the President’s January 20, 2021, Executive Order 13985 on ‘Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.’”).

² 42 C.F.R. §418.52(c)(1).

³ Centers for Medicare & Medicaid Services, Medicare State Operations Manual, Appendix M – Guidance to Surveyors: Hospice, § L512.

the importance of a patient’s choice in selecting a hospice and attending physician, it is paramount to ensure these individuals can access hospice care timely and have the autonomy to choose the provider and the physician who will have the most critical role in the management of the patient’s terminal illness at a critical juncture in their illness.⁴

If CMS moves forward with permitting MAOs to require enrollees to only receive hospice services from in-network providers, there will be significant disruptions in patient care, access, and coordination. Enrollees must already contend with coverage variation and access to different providers within an MA network, including hospice in the mix will add an additional stressor at a time of utmost vulnerability for terminally ill patients and their families. To the extent CMS moves forward with this policy, MAOs should be held accountable for ensuring network provider lists remain zealously up to date to mitigate any disruptions. One provider recommended, *“If a provider is in-network for one payor’s plan they should be in-network for all payors[’] plans. Most of the confusion for enrollees is the variation of coverage and in-network providers within one payor.”*

Quality of care and payments: CMS must set Medicare Fee-For-Service (FFS) rates as an MA payment floor—not the ceiling—to ensure appropriate and equitable access to high-quality hospice care. In the absence of any payment floor, CMS and MAOs must provide incentives and opportunities for high performing hospices to bring in the resources necessary to continue providing high quality care. CMS has acknowledged provider challenges with the additional administrative processes, reporting requirements, and the low referrals for transitional concurrent care.⁵ These challenges require new investments by the providers which results in higher costs for billing, authorizations, and payment collection.

Networks should not be created based on providers who are willing to accept the payment and the requirements set by MAOs. This is not what is best for enrollees, nor is it consistent with promoting high quality care, particularly in rural and traditionally underserved communities. This is particularly true for smaller, non-profit, and rural providers, where there are limited resources to attract and retain a skilled and robust workforce. Reducing hospice payments could adversely impact care access for MA enrollees, particularly those who are lower income, older, and traditionally underserved enrollees who are increasingly enrolling in MA.⁶ MAOs having contract provider rates below Medicare FFS rates do nothing to promote quality, and instead can act as a stranglehold that prevents many high performing hospices from entering into MA markets, to the ultimate detriment of patient communities.

Payer-owned facilities: With the recent acquisition of hospice providers by insurance payers, there is an understandable movement by MAOs to better control costs, mitigate risk, and improve outcomes

⁴ See FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements, 88 Fed. Reg. 51164 at 51189 (“[O]ur definition of attending physician in § 418.3 describes the latter as being identified by the beneficiary, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual’s medical care.”).

⁵ Centers for Medicare & Medicaid Services, Value-Based Insurance Design (VBID), Hospice Benefit Component, 2021-2022 Findings at a Glance (October 2023).

⁶ See Kaiser Family Foundation, Disparities in Health Measures by Race and Ethnicity Among Beneficiaries in Medicare Advantage Report (2022), <https://www.kff.org/report-section/disparities-in-health-measures-by-race-and-ethnicity-among-beneficiaries-in-medicare-advantage-report/>

within their networks. While relationships like these are in many ways reflective of our national health system's move towards value-based care; in the context of MA hospice care, it will be important to implement appropriate safeguards to ensure enrollee access to all hospice providers in MAO networks, regardless of owner.

Reliable information: To minimize confusion for enrollees, MAOs need to verify the data and information they are sharing with providers. Providers have stated the provider directories being shared with enrollees are frequently out of date and difficult to decipher. In addition, providers have received lists of enrollees eligible for palliative and transitional concurrent care benefits so out of date, the enrollee has died or has disenrolled from the MA plan.

Considerations for networks: We understand and appreciate the importance for MAOs to establish networks and rely upon metrics to measure quality and contain costs, given the financial risk they assume for the healthcare services provided to their enrollees. And indeed, this type of network model works for many types of providers. But flexibility is needed when considering the unique role hospices play at the end of MA enrollees' lives. For this reason, we do not dispute the need for MAOs to identify metrics and set quality outcomes as thresholds to determine hospice provider network participation in a service area, but MAOs should not be permitted to exclude hospices in these network service areas where they have met the quality threshold criteria. Such a result would deprive MA enrollees of a critical choice so essential to the Medicare hospice benefit—to choose with whom and where to meet their end.

When considering network adequacy, hospices should be measured based on Medicare conditions of participation, quality metrics, and related considerations under the Medicare hospice benefit. In other words, when considering network access, MAOs should consider hospice performance relevant to indicators of quality, such as the hospice's provision of all four levels of care, whether the hospice reports quality data, visits in the last days of life, and rates of live discharges.

There are concerns about MAOs stating their networks are "full" regardless of quality outcomes of providers and their willingness to participate. In addition, MAOs should be required to accept all providers who meet a certain threshold of the quality measures and are willing to contract with the MAO. By having this threshold in place, it will ensure enrollees have adequate access to hospice while MAOs are able to create networks of quality providers. We reiterate that with only incomplete data, allowing MAOs to limit networks would be akin to building a house without a blueprint. At this time, we encourage additional conversations to create appropriate networks with sufficient access with the patient in mind.

Provider engagement and training: Hospice providers are intricately connected to the communities they serve and the providers who refer to hospice. MAOs should regularly communicate with hospice and non-hospice providers within their network to address concerns and questions the providers may have regarding network access. By doing so, MAOs can foster a collaborative and informed healthcare community and help ease confusion among enrollees.

MA is a new system for many hospice providers and it requires education, training, and time to work within the new system. MAOs must commit to working with hospice providers and their teams to ensure all parties understand what is expected of them and what the enrollee will need and expect.

Transparency: To confirm patients are receiving the care they need within the networks established by the MAOs, CMS should require MAOs to report quality measures annually. This report could include measures such as the use of in-network against out-of-network providers, distance between enrollees' residence and an in-network provider, and utilization of services within the hospice component of VBID. These data should be easily accessible and consistently updated so providers better understand who they are contracting with and enrollees understand who will be providing their care.

2. *How should statutory protections ensuring access to covered benefits, even out of network, where services are “medically necessary and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization” be potentially applied in the context of the hospice benefit? Additionally, how could such protections be operationalized by participating MAOs?*

Access to services: As stated previously, MAOs should be required to allow services to be provided by in-network and out-of-network providers but with different benefits for the in-network provider to ensure there is timely access to services. When an enrollee and their loved ones are told the enrollee has a diagnosis of less than six months to live and are referred to hospice, everything feels “medically necessary and immediately required.” Navigating which hospices are participating in an MA network is an additional hurdle patients and families should not have to contend with. Electing hospice is a stressful time for both the enrollee and their loved ones and adding additional administrative steps to evaluate whether it is necessary required immediately does not lessen the stress.

Medical reasonableness and necessity: A major concern of providers is that MAOs decide what is “medically necessary and immediately required.” Hospice care is unlike many other disciplines in that it is focused on symptom management for terminally ill enrollees so medically necessary and immediately required may have a different meaning. Due to the unique nature of hospices, caregivers' definition of “medically necessary and immediately required” will need to be adjusted when the goals of care change from curative focused care to symptom management. This does not occur instantly.

For hospice providers, some patients are discharged from the hospital directly to hospice with some enrollees being admitted at the general inpatient level of care due to uncontrolled symptoms. It would be detrimental for these enrollees to be transferred out of the facility until their symptoms are managed. These services must be covered for the enrollees and MAOs must have clear guidance for this situation and coverage of the services.

To ensure the protection of “medically necessary and immediately required” care, MAOs must develop clear guidance for both in-network and out-of-network providers. Considerations for this guidance should include sudden and rapid symptom changes, geographical limitations, and continuity of care for the enrollee.

3. *To what extent should CMS implement new or additional access safeguards specifically in the VBID Model Hospice Benefit Component to address situations when an enrollee may want to elect hospice in situations when hospice care is urgently needed?*

Access to services: We reiterate our above comments and emphasize that CMS must require MAOs to offer both in-network and out-of-network benefits to enrollees to ensure enrollees have access to hospice when they need it. For too many enrollees, hospice is recommended too late and creates an urgent situation for enrollees to be admitted.

Incentive payments: To ensure enrollees are promptly admitted into hospice, MAOs can provide a one-time incentive payment for admission within 24 hours of a referral and on weekends or holidays. This payment could work similarly to the Service Intensity Add-on (SIA) payment but instead of occurring in the last seven days of life, it occurs at the beginning of care.

Education: MAOs must educate their in-network providers who refer to hospice on the importance of hospice, how to have conversations surrounding end-of-life care and decisions, and when the appropriate time is to refer to hospice. To have a strong network, MAOs must connect the dots between the providers in their network to facilitate seamless transitions for the enrollees through the continuum of care. This connection is essential in minimizing late hospice admissions which can fail to realize the full benefit of hospice care for enrollees and their loved ones. CMS should require MAOs to demonstrate their efforts in educating providers and enrollees on the continuum of care from palliative care to transitional concurrent care to hospice. One provider recommended MAOs “[e]stablish a dedicated 24/7 hospice support line where enrollees, caregivers, and healthcare providers can seek guidance and assistance in urgent situations. This helpline could serve as a central resource for immediate support and information.”

Quality of care: Similar to providers, MAOs should be assessed by enrollees and their caregivers on the enrollee’s ability to access the services they wanted and need within the network the MAO has developed. These data should be easily accessible and consistently updated so providers better understand who they are contracting with and enrollees understand who will be providing their care.

4. *To what extent should CMS modify the current Model-specific network adequacy standards, including the minimum number of providers requirement and the comprehensive network development strategy? For example, should CMS include any special consideration for states with certificate of need for hospice providers or use alternative datasets to set and implement the network adequacy standards?*

Choice of providers: Modification to current model-specific network adequacy standards should prioritize the benefit and choices of enrollees. Hospice is patient-centered care and it is imperative to continue this by allowing enrollees to exercise their right to choose the hospice provider who aligns with their personal preferences and values.

In focusing on enrollee choice, the network adequacy standards should include all eligible hospice providers within a geographical area. MAOs can establish the minimum standard for their network but

then all eligible providers willing to accept the contract should be considered in-network. By having a diverse network of providers, an MAO ensures enrollees have choices of providers which will foster competition and quality improvement within the hospice industry.

One provider stated, *“With conviction, I firmly believe that eligibility standards should inherently encompass quality and performance benchmarks. This approach empowers CMS and MAOs to unequivocally assert that organizations within their network not only meet but exceed the established standards.”*

Certificate of Need: The impacts of Certificate of Need (CON) for hospice services are an important part of the discussion of network adequacy standards. Since 2011, CMS has defined an adequate MA network as meeting two criteria: (1) a minimum number of providers and (2) maximum travel time and distance to those providers. Because of variances in geography, as well as a potentially limited number of available providers in an area, in states with CONs, there may only be one or two providers offering hospice services in the service area. CON states limit the total number of hospices serving geographic regions. By MAOs further limiting options of enrollees by requiring enrollees to select their hospice care only from in-network providers will be detrimental to enrollees who are seeking these critically important services. We have grave concerns regarding how network adequacy will be determined when there is a limited number of providers in the area, particularly in CON states where access to hospice services is carefully controlled. MAOs should be required to work directly with each state regarding the CON to ensure enrollees are able to access services.

Transparency: In considering network adequacy for the hospice component of VBID, CMS needs to hold MAOs accountable for the transparency in their selection process and how they ensure they are maintaining their networks. We reiterate our above comments that these data should be easily accessible and consistently updated so providers better understand who they are contracting with and enrollees understand who will be providing their care.

5. *To what extent should CMS maintain its Model-specific requirement to not allow any prior authorization requirements for hospice care? If CMS should change the policy, what would the alternative look like and how could it be operationalized?*

Now is not the time to implement prior authorization for hospice care in MA. In 2021, 10% of Medicare decedents received hospice care for only two or fewer days, and 25% of decedents were enrolled for only five or fewer days.⁷ A delayed or denied prior authorization for hospice can mean the difference between an enrollee accessing the hospice benefit they are entitled to or never being able to use it. Time is of the essence for these enrollees and their loved ones, and the risk of an enrollee—and also their loved ones—not being able to receive the support and care at the end of life is too great to rush into prior authorization policies without proper data and understanding of its impact.

⁷ See MedPAC July 2023 Health Care Spending and the Medicare Program Data Book, Chart 11-13.

As CMS acknowledged in the Advancing Interoperability and Improving Prior Authorization Processes final rule, “[p]atients need to have timely access to care, and providers need to receive timely responses to their requests for authorization to requests for services for their patients, particularly when waiting for answers can delay the pursuit of alternatives.”⁸ These delays are particularly devastating for individuals with a terminal illness. Hospice care consists of a specialized focus on comfort and palliative interventions rather than curative or disease-modifying care, for which there are limited opportunities for any alternatives. Indeed, even MA expedited prior authorization review timeframes extend beyond what may be considered reasonable timeframes when patients urgently need this specialized care.

NHPCO is committed to engaging with MAOs and CMS on prior authorization alternatives but with only two years of VBID data available and only limited data on patient and family experiences, it is too early to implement prior authorization policies that would limit medically necessary access to hospice services. Better assessment of the impacts of VBID on patient choice need to be available before investigating the inclusion of prior authorization into the hospice component of VBID.

Hospice is a unique sector of the healthcare field and was initially carved out of MA plans for a reason. As CMS moves forward with the inclusion of hospice into MA, it is imperative to consider patient choice and the importance of timely access to care—given the median hospice length of stay is only 17 days in 2021.⁹ Indeed, hospices only have one opportunity to care for these patients.

Providers are interested in finding innovative ways to care for enrollees and we look forward to partnering with MAOs and CMS to accomplish this. Thank you for your consideration of NHPCO’s comments on this request for information. We welcome continued engagement with you and your staff and the opportunity to meet to discuss our recommendations. If you have questions or would like to schedule a meeting, your staff should feel free to contact Patrick Harrison, senior director, regulatory and compliance, at pharrison@nhpco.org.

Sincerely,



Ben Marcantonio
Interim Chief Executive Officer

⁸ 89 Fed. Reg. 8758 at 8952.

⁹ See MedPAC March 2023 Report to Congress, Table 10-4.