National Partnership for Hospice Innovation
IMPROVING THE CARE EXPERIENCE

The Honorable Orrin G. Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Ron L. Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Johnny H. Isakson
Co-Chair, Chronic Care Working Group
131 Russell Senate Building
Washington, D.C. 20510

The Honorable Mark R. Warner
Co-Chair, Chronic Care Working Group
475 Russell Senate Building
Washington, D.C. 20510

Re: 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:

The National Partnership for Hospice Innovation (NPHI) appreciates the opportunity to provide comments on the Bipartisan Chronic Care Working Group's (working group) Policy Options Document released in December of 2015. NPHI is a nationwide collaborative of not-for-profit, community-integrated hospice and palliative care provider members who serve as a crucial safety net for the sickest, most vulnerable patients in the communities we serve. Our organizations are mission-driven and committed to improving access to high-quality care. In addition to advancing policies that protect vital hospice and palliative care benefits for our terminally-ill seniors, we design and operate hospice programs for special populations, such as children, minorities, and prisoners. Our members are leaders in hospice and palliative care innovation, such as integrated professional training programs and the use of telehealth, and in the empirical development of quality benchmarking metrics.

Given the broad scope of our services and our commitment to care for all hospice patients regardless of diagnosis, insurance status, or life circumstances, our programs survive with limited resources and despite small margins. Philanthropic support helps us to further our ability to deliver innovative palliative care and serve as safety-net providers in our communities. Given this context and our commitment to providing high quality care, we recognize the importance of value-based purchasing and support its tenets to improve the delivery system overall. Although it is a newer concept within the context of end-of-life care, we see opportunities to pursue initiatives in this area and to work fairly and constructively with our members' primary payer, the federal government.

We strongly support the efforts of the working group and believe the policy options document will further the goal of improving care for the millions of vulnerable Medicare beneficiaries – including those enrolled in Medicare Advantage plans – who have multiple chronic conditions and those approaching the end of life. NPHI agrees that increasing care coordination, improving disease management, and ensuring access to high quality care while maintaining affordability all contribute to achieving this goal. Given the importance of an individual's last days of life, we also applaud the working group for recognizing the role of hospice along the spectrum of chronic care.

NPHI strongly believes that an active and ongoing collaboration between our community of not-for-profit, safety-net hospice organizations and the federal government can advance the long-term benefits of hospice for an aging population. Through this collaboration, our members can assist policymakers in the development and evaluation of policies that promote quality, safety, and efficiency, while concurrently providing actionable feedback on federal initiatives that impact our hospice members' ability to deliver high-quality hospice care. To that end, we will be commenting on 1) Providing Medicare Advantage Enrollees with Hospice Benefits; 2) Expanding the Independence at Home Model of Care; 3) Developing Quality Measures for Chronic Conditions; 4) Expanding Innovation and Technology; and 5) Improving Care Management Services.

Advanced team based care: providing Medicare Advantage enrollees with hospice benefits

NPHI Recommendation

Test the Medicare Advantage (MA) hospice carve-in proposal before attempting implementation. Legislating on the hospice carve-in for MA plan benefits before there is sufficient data to show needed safeguards to preserve the integrity of the Medicare hospice benefit would be premature. An untested carve-in could be detrimental both to Medicare beneficiaries and to community-integrated, not-for-profit, safety-net providers, like our members, who may face substantial financial challenges that could undermine their core mission, particularly if the carve-in does not protect the current models of care. Hospice providers and MA plans need data from a pilot program in order to construct an MA benefit that not only protects the full scope of the current hospice benefit but addresses legitimate concerns about the scope of services provided, access, quality, reimbursement structure, and potential administrative burdens.

Including hospice benefits in the MA program's required benefits and payment rate structure could positively impact end-of-life care by integrating hospice services earlier in the care continuum. For instance, MA plans could elect to provide palliative care to members sooner in the terminal illness cycle (e.g., before a physician certifies the terminal illness will likely result in death within 6 months.) This would preserve the integrity of hospice services and allow for more consistent and streamlined care at the end of life. However, simply transplanting hospice program fee-for-service requirements to MA carries some potential risks. Without safeguards and a thoughtful approach to the integration of hospice and palliative services into an MA environment, a potential concern would be that MA beneficiaries would only receive piecemeal, inadequate care at the end of life, a sharp contrast to the essential, quality and coordinated care that millions of beneficiaries have received for more than 30 years.

Before supporting a carve-in approach, NPHI would like the opportunity to pilot what an MA hospice benefit could, and should, look like. This view is consistent with current policy related to hospice – CMMI is currently testing the extent to which concurrent care leads to improved quality and savings through the Medicare Care Choices Model. Over 50% of our membership is participating in that model (in which providers receive Medicare reimbursement for certain hospice and palliative care services outside of the hospice construct) and we are excited to see its results.

NPHI is in a unique position to call for the carve-in to be tested as we are already in the process of constructing a nation-wide, Medicare Advantage carve-in demonstration pilot. We believe that a premature requirement for MA plans to offer hospice benefits will result in a scramble by all parties to

determine how to implement such a mandate and poorer care for beneficiaries. Testing the carve-in would allow for a data-driven approach to benefit design, generate broad support among parties involved in care delivery, and protect the integrity of hospice for those who need to receive it.

NPHI Medicare Advantage Carve-In Pilot

NPHI is currently engaged in creating a nation-wide demonstration pilot to test the concept of carving the hospice benefit into the Medicare Advantage program. We believe it is essential that the working group and other Congressional leaders first consider the results of this pilot before extending hospice services to MA members as part of the MA plan's services. As legacy hospice providers, NPHI members have unparalleled experience in delivering interdisciplinary, quality, coordinated care under the existing Medicare hospice benefit, and thus are natural choices to lead testing the carve-in of the hospice benefit to the MA program, so that the full scope of hospice services are protected and provided, regardless of the payer.

Given our pilot development, NPHI has begun to think through a number of safeguards and quality measures that should exist in any carve- in, but strongly recommend that our pilot be allowed to be fully implemented in order to test these ideas and gather data for Congress to consider. First, there are well-established networks of community-integrated hospice providers throughout the country – and any consideration of a carve-in for hospice benefits should build on these existing, integrated networks and not create incentives to dismantle them. Second, quality, outcomes, and patient satisfaction should play a substantial role in the design of a potential MA hospice benefit. Quality metrics should be considered both in the MA contracting policy and in the revision of the MA star rating program. Third, concerns exist that direct negotiation of rates with MA plans directly for hospice services could result in larger, for-profit providers, potentially with lower quality indicators, underbidding for services to gain market advantage – thereby excluding community-based not-for-profit providers. This would compromise the ability of this critical group of not-for-profit, safety-net hospice providers from continuing mission-critical operations in many parts of the country, and have adverse spillover effects on care for the fee-for-service population. Fourth, the design of a carve-in's approach to provider contracting should minimize administrative burdens to hospice providers, especially not-for-profit, safety-net community based providers for whom existing administrative burdens threaten the viability of the programs.

Safeguards that should be in place to ensure MA enrollees have access to high quality hospice services

Maintain the existing benefit: NPHI applauds the working group for highlighting that the *full scope of the hospice benefit*, including the care team and written care plan, would be required of any MA hospice carve-in. This requirement is essential to preserving and protecting the hospice benefit that has served so many beneficiaries and their families since 1983. If hospice is to be carved into MA, it must be, at a minimum, the full benefit as it exists under FFS Medicare. MA plans should not be permitted to substitute less comprehensive versions of palliative care or support services in place of hospice (additional services can and should be offered by MA plans to wrap-around hospice and provide a continuum of care for beneficiaries). However, allowing MA plans to offer additional benefits under this framework that enhances palliative care should be considered.

The care team in the existing Medicare hospice benefit goes beyond medical care; it is truly interdisciplinary, and NPHI members are committed to delivering and preserving that aspect of hospice. Hospice is the original provider of interdisciplinary care, and now other facets of the medical system, including those within ACOs, are looking to emulate that success. Any MA hospice benefit must be robust across the scope of the benefit – for example, true bereavement services and robust volunteer programs. Additionally, the autonomy of hospice medical directors must be preserved. The hospice medical director and his/her staff have the experience and expertise in delivering hospice care – the MA plan should not assume clinical responsibility for what quality hospice care looks like, but could be incentivized to develop collaborative approaches.

Access: Network adequacy standards should reflect an openness to patient interests and needs in locations where more than one hospice program option exists and should ensure the inclusion of them in networks of community-based, safety-net, not-for-profit providers. Beneficiary hospice choice should not be arbitrarily restricted by MA plans. This principle of having multiple accredited hospice providers able to offer services to MA plan beneficiaries is important; the quality of service and care are enhanced when hospice providers seek to maintain a high service and quality of care level or risk transfers to other hospice providers. MA contracting requirements should consider elements such as distance to a provider, the scope of services provided by a hospice (including provision of all currently-required levels of care), inclusivity of provider-based and freestanding hospice providers, and contracting with hospices that meet the below plan-level metrics that indicate quality. One major goal of the NPHI pilot is to gather data on the quality metrics that could be used as benchmarks for contracting, as well as how to design an adequate network to maintain beneficiary choice of hospice provider.

Quality: A revision of the MA star quality rating program that would allow acceptance of hospice-specific measures, as well as patient and family experience (measures that would be endorsed by public-private partnerships such as the National Quality Forum). NPHI is working with its members and with NQF on the development of hospice-specific quality measures that will be incorporated and tested in our pilot. Time to develop further what measures represent a quality hospice will be instructive in the development of an adequate hospice network for MA plans, as well as a potential tool for the development of additional reimbursement options.

Reimbursement: Under a carve-in approach, the revision of MA benchmarks to reflect hospice benefits should reflect the current provision of services for the four hospice service levels under the current Medicare Hospice Benefit. Specifically, the current per diem rates for the routine home care level under the new two tiered structure with service intensity add-on visits as currently defined should be maintained. We are concerned about a negotiating environment in which downward pressure on MA reimbursement rates flows to hospice providers, particularly in certain markets with low MA rates relative to fee-for-service. Our member providers already face tight margins and would face difficulties competing in an environment where large, for-profit entities underbid our programs with a less robust benefit.

We believe that in order to protect beneficiaries and high-quality programs, the reimbursement rate for an MA hospice benefit should reflect resources provided today under the fee-for-service program, as well as account for the cost of more complex populations by different providers. NPHI sees an opportunity to include shared savings approaches that reward providers for innovative palliative services.

Limit administrative burdens: NPHI wants to ensure that any potential MA carve-in does not create additional administrative burdens, such as complex new reporting requirements. Our members are currently operating under growing administrative burdens that place further financial pressures on their ability to meet the needs in their communities. For instance, one NPHI member has estimated that the regulatory requirements promulgated in the past four years cost the program over $3.5 million annually – a startling 2 to 3 percent of the overall budget. In a carve-in environment, NPHI would want to address cash flow challenges like Accounts Receivable (AR) days, as payment migrates from fee-for-service to MA for these patients in hospice. For example, Medicare/Medicaid averages about 3% of total AR days greater than 180, where private insurance averages about 20% greater than 180 days. Once again, NPHI wants to underscore that testing a potential carve-in presents an opportunity to avoid additional administrative burdens that might impact the ability of providers to deliver quality hospice care.

Specific plan-level measures that can be used to ensure that MA hospice beneficiaries are receiving appropriate and high-quality care

Through both the process of construction of our MA pilot and our data and quality initiative, NPHI has developed a number of specific indicators of appropriate and high-quality hospice care that could be used by an MA plan or by CMS in its consideration of a hospice carve-in. We want to note that many of these underscore the provision of the full breadth of the hospice benefit regardless of reimbursement. For example, robust volunteer programs and post-death bereavement services to family and caregivers are not currently reimbursed by Medicare, but are crucially important aspects of the MHB and must be looked at to assess high quality hospice programs.

Other metrics that indicate quality hospices include but are not limited to:

- Hospices must serve a broad range of clinical needs (e.g. both cancer and non-cancer diagnoses)
- Family/caregiver satisfaction
- Presence of hospice acute and residential facilities
- Hospital-based palliative care programs
- Home and nursing home-based palliative care provided
- Adult grief programs
- Child/teen grief programs
- Pediatric hospice and palliative care programs
- Fellowships and traineeships for medical professionals
- Robust volunteer programs
- Documentation of individuals' preferences, values, and goals

NPHI believes that these types of metrics would be crucial indicators for consideration by any MA plan when looking at hospices with which to contract. NPHI stresses that through the dual efforts of our pilot and our data and quality initiative, we will be able to provide solid data on the metrics that are most effective in indicating quality.

NPHI's pilot will provide crucial data to develop a potential carve-in. We hope to collaborate with the working group, other members of Congress, and the Administration in using our pilot to develop the carve-in in a way that preserves the integrity of the Medicare Hospice Benefit while maximizing opportunities to achieve the goal of less fragmented, quality care delivery for MA beneficiaries at the end of life.

Receiving high quality care in the home: expanding the Independence at Home (IAH) model of care

NPHI Recommendation

NPHI supports the expansion of the Independence at Home model of care into a permanent Medicare benefit. NPHI believes that hospice providers must play a crucial role in a successful IAH benefit as referral partners and as IAH providers.

NPHI supports the expansion of the Independence at Home model of care and applauds the working group's recognition that the success of this program needs to be scaled and replicated. The IAH model is an example of how a coordinated, team-based care approach can improve the quality of care for Medicare beneficiaries. The Medicare hospice benefit is the original coordinated, interdisciplinary, person-centered model of care. Given this legacy, NPHI not only supports the expansion of the IAH model, but also is confident that hospice providers can contribute to and enhance the model.

Given the criteria to receive care under IAH, NPHI believes that proper hospice referrals contribute to the success of the IAH model. We encourage the working group to examine timely hospice referrals as a quality metric for the program to ensure that individuals in need of hospice care receive appropriate transitions across the care continuum. Additionally, evidence demonstrates that timely referral to hospice can reduce Medicare spending.[1] NPHI strongly encourages CMS to measure the degree to which hospice referrals contribute to IAH savings. Furthermore, partnerships between quality hospices and IAH practices would improve seamless care transitions for individuals at a particularly sensitive time – and when they need as little disruption in care as possible.

Hospice and palliative care providers know how to deliver care in the home and how to lead home care teams. Experience with the provision of home-based primary care for patients with multiple chronic conditions is one of the key requirements for provider participation in the IAH model. Hospice providers are low-hanging fruit for expanding this model; we have the requisite experience and are eager to touch the lives of these beneficiaries earlier in their care trajectory through the IAH model. NPHI member hospices already provide palliative care and care management services in the home outside the scope of the hospice benefit. Implementing a permanent IAH benefit would be a natural next step.

Overall, the working group's recognition of the importance of the IAH model highlights a path forward for more coordinated, integrated care across the spectrum of advanced illness. As hospice providers, we are

[1]See Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, et al. Family perspectives on end-of-life care at the last place of care. JAMA. 2004;291(1):88–93 and Wright AA, Keating NL, Balboni TA, Matulonis UA, Block SD, Prigerson HG. Place of death: correlations with quality of life of patients with cancer and predictors of bereaved caregivers' mental health. J Clin Oncol. 2010;28(29):4457–4464.

an essential component of that spectrum and applaud the working group for looking toward the future in expanding home-based care with IAH.

Identifying the chronically ill population and ways to improve quality: developing quality measures for chronic conditions

NPHI Recommendation

NPHI supports the inclusion of hospice and end-of-life care in CMS' quality measures plan, but underscores that there is an important distinction between health outcome measures suitable for managing chronic conditions and outcome measures that are suitable for quality end-of-life and hospice care. NPHI endorses the recommendation that a GAO report be conducted on community-level measures as they relate to chronic care management.

NPHI's data and quality initiative aims to aggregate, benchmark, and report data from hospices beyond the Medicare requirements in order to facilitate comparisons across hospices, identify operational best practices, establish publicly recognized standards for high-quality hospice care, and positively influence hospice trends to ensure accountability, transparency, and more person-centered care. Given this background, NPHI applauds the working group for recognizing that hospice must establish benchmarks and measures to illustrate quality end-of-life care.

Though measures to demonstrate quality are critical to hold providers accountable for delivering exceptional care during the last stage of life that meets patients' goals, values, and wishes, it is important to highlight differences between quality care in curative settings and quality care in hospice. In the context of the Policy Options Document, there is an important distinction between health outcome measures suitable for managing chronic conditions and outcome measures suitable for quality end-of-life and hospice care. Metrics concerning symptom management, (e.g., pain) for instance, more appropriately assess hospice care, while not necessarily assessing chronic disease treatment and management. NPHI supports using process and outcome measures, provided they are relevant in assessing end-of-life care and the unique circumstances our patients and their families face while in hospice. For patient-centered metrics, NPHI underscores the importance of measures that ensure patient safety and demonstrate family/caregiver experience. In addition to patient-centered metrics, metrics that address the hospice provider can be equally important to patients as they select their end-of-life care provider, including the scope of services provided (e.g., robust post-death bereavement services), and the process of eliciting and documenting end-of-life preferences. Given our commitment to ensuring that everyone receives exceptional end-of-life care, NPHI urges that CMS-required metrics should include both types of metrics.

NPHI supports the recommendation that a GAO report be conducted on community-level measures as they relate to chronic care management. We recommend that the GAO report also look at community-level measures of patient and family experience and satisfaction with end-of-life care so that comprehensive quality measures can be developed that extend beyond the limited scope of process measures. NPHI is ready and able to work with the Congress and CMS to facilitate appropriate measure development that uniquely addresses the patient experience while receiving hospice care.

Expanding innovation and technology

NPHI Recommendation

NPHI has advocated for reimbursement for telehealth services in the existing hospice benefit, and equally advocates for the inclusion of telehealth services in hospice if an MA hospice benefit were to be carved in, particularly to complete the face-to-face recertification.

NPHI's mission is to influence the future of hospice and advanced illness care through innovation and collaboration. Given this mission, we could not agree more with the working group that significant gaps in care exist for chronically-ill beneficiaries, and that these gaps could be reduced or eliminated through expanding the use of technology and other innovations. While we agree wholeheartedly with the spirit of all the proposals on this topic, we focus our comments on the recommendation "Increasing Convenience for Medicare Advantage Enrollees through Telehealth."

Given our commitment to our patients, many of our member programs use telehealth even in the absence of reimbursement to enable patients to access their providers more readily. NPHI advocates for reimbursement for telehealth services in the existing hospice benefit, and equally advocates for the inclusion of telehealth services in hospice, if an MA hospice benefit were to be carved in, particularly to complete the face-to-face recertification. As outlined previously, NPHI members' pilot design for an MA hospice carve-in is underway. NPHI recommends waiting until data is collected before moving forward with an MA hospice carve-in.

On that point, NPHI proposes to pilot the face-to-face recertification via telehealth services, noting that such a recertification would only occur after a beneficiary has received hospice for more than 180 days and would not eliminate visits from nurses or other hospice staff. The technology would enable hospice providers to perform multiple recertifications in a day, and thus be more available for other services. Our hospices only have, on average, roughly 11% of patients over 180 days, but the face-to-face requirement necessitates hiring extra providers solely for this purpose. This provider time or funding could be utilized more efficiently with the appropriate technology, benefiting both providers, patients, and the overall quality of hospice programs.

NPHI recognizes the working group's innovative recommendation and highlights that hospice programs are able, and need, to participate in technological innovations, regardless of the status of an MA hospice carve-in.

Improving care management services for individuals with multiple chronic conditions

NPHI Recommendation

NPHI recommends two metrics to measure the effectiveness of the proposed high-severity chronic care management code: documentation of individual's preferences, values, and goals and timely referral to hospice. NPHI believes the effectiveness and utilization of this new code would be amplified if implemented in conjunction with the passage of S. 1549, the Care Planning Act.

NPHI endorses the establishment of a new high-severity chronic care management code. NPHI recommends the following two metrics to measure the effectiveness of the proposed high-severity

chronic care management code. One would be documentation of the patient's values and preferences. The other would be timely referral to hospice. Many of the beneficiaries eligible for care management under this proposed code would benefit from hospice care at the end-of-life and timely referral is crucial to experiencing the full benefits of hospice care. NPHI believes that the passage of S. 1549, the Care Planning Act, which would create a Medicare and Medicaid reimbursable team-based advanced care planning benefit, in conjunction with the creation of this new code, would be the most effective means to achieve the goal of compensating providers for comprehensive and quality management of beneficiaries with multiple chronic conditions.

NPHI thanks the working group for the opportunity to comment – and for its work – on this document. NPHI and its member hospices are ready and willing to assist the working group's efforts to improve care for the chronically ill, particularly those nearing the end of life. Please do not hesitate to contact us.

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