National Hospice and Palliative Care Organization

February 28, 2019

Ms. Seema Verma, Administrator
Administrator, Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-2018-0154
Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter Parts 1 and 2

Dear Administrator Verma,

The National Hospice and Palliative Care Organization (NHPCO) is writing today to comment on the 2020 Draft Call Letter for Medicare Parts C and D, Parts 1 and 2 (CMS-2018-0154). NHPCO is the largest membership organization representing the entire spectrum of hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice locations and more than 57,000 hospice professionals in the United States, caring for the vast majority of the nation's hospice patients. NHPCO is committed to improving end-of-life care and expanding access to hospice and palliative care with the goal of creating an environment in which individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.

Our comments follow.

1. Risk Adjustment Model - Number of Illnesses

In the experience of hospice and palliative care providers, many patients with serious and advanced illness have numerous illnesses. As CMS considers alternate risk adjustment

models, we are in support of the model that includes additional Hierarchical Condition Categories ("HCCs") for dementia and pressure ulcers. Based on hospice providers' experiences, these conditions are clinically meaningful, correlate with current and future medical expenditures and can be definitively diagnosed. We believe that the addition of these two HCC categories will represent conditions experienced by many enrollees and should be considered in the risk adjustment model.

2. New 2020 Display Measures - Transitions of Care (Part C)

We note that in the design of the *Transitions of Care* measure, CMS has excluded members who have elected the hospice benefit. However, this transition is a daily occurrence for hospice and palliative care providers and the transition from the inpatient setting to home is a topic of high importance. Hospice and palliative care patients will benefit from increased communication between the hospice and palliative care providers and the MA plan regarding inpatient admissions, discharges, patient engagement after inpatient discharge, and medication reconciliation after inpatient discharge.

Here is one example: An MA plan enrollee who has elected the hospice benefit is taken to the emergency department by family members when a symptom management issue arises. While the hospice care is not covered by the MA plan, a prompt notification to the hospice about an inpatient admission is essential and would improve care coordination between the MA plan and the hospice. Similarly, communication with the patient's hospice or palliative care provider regarding any patient engagement efforts initiated post discharge would be very important for care coordination and improving outcomes when transitions of care occur. NHPCO is available to discuss this display measure in more detail.

3. Value-Based Insurance Design (VBID) Model Test

NHPCO is beginning to prepare for the addition of hospice benefits to the VBID model in CY2021, announced at the end of January 2019. There is a great deal of hospice provider interest and concern. We appreciate the CMMI team joining us for our "Virtual Town Hall: Value-Based Insurance Design (VBID) Model and Hospice" on February 27, 2019 to listen to our membership's concerns regarding the following 6 key topics:

A. Beneficiary Access:

We have significant concerns regarding "closed networks" without recourse or opportunity to engage with the Medicare Advantage plans. We strongly encourage CMS to consider requiring a mix of providers as part of the network adequacy requirement and guaranteed referrals.

In the model design, we caution the use of palliative care consults as a substitute or delay beneficiary access to hospice care because of the perceived immediate cost savings without considering the overall financial impact.

B. Integrity of the Hospice Benefit:

We believe that MA plans should retain the current hospice benefit structure, payment model, and care delivered by an interdisciplinary team. We appreciate the CMMI team recognizing this concern during our Virtual Town Hall. We emphasize that retaining the current benefit and structure supports hospices assuming risk for the cost of the plan of care as developed by the hospice interdisciplinary care team. We are concerned that technical and substantive information about benchmarking, use of Hierarchical Condition Categories (HCC), risk adjustment, and substantiating the VBID actuarial guidance has not been publicly discussed. CMS should educate and collaborate with hospices and plans to understand the methodology expected for the VBID model to support MA plan design of the CY 2021 VBID application.

C. Quality Oversight and Accountability:

We believe quality metrics and measures to address coverage and quality of care must be developed collaboratively with hospices. Quality should be measured utilizing a standard set of measures and hospice programs should be required to maintain a certain level to participate in the VBID model. To assure the high quality of hospice services, we are concerned about professional judgment debates between the hospice medical director and the plan regarding what is appropriate pain and symptom management modalities, which must be made on a case-by-case basis to honor the hospice philosophy. We are also concerned about the possibility of prior authorization for the election of hospice services or for a change in level of care, as this could result in significant delays in care and/or death before care is provided.

D. Reimbursement Model & Financial Sustainability:

We have significant concerns regarding the goals and purpose of including hospice in MA plans. If possible, we encourage CMS to consider revising the current fee-for-service hospice benefit by eliminating the 6-month prognosis requirement or payment structure to better address the goals to "**promote patient-centered care**, provide greater **price transparency**, increase enrollee **choice and access to timely and clinically-appropriate care**, including through telehealth, to improve quality and reduce costs" as described in CMS' January 18, 2019 VBID Press Release (https://www.cms.gov/newsroom/press-releases/cms-announces-new-model-lower-drug-prices-medicare-part-d-and-transformative-updates-existing-model)

We also have significant concerns that the VBID model may not support the current hospice payment structure and rate and open the MA plan to restructure the payment rate or reduce financial sustainability of the hospice. Given these concerns, we encourage CMS to include a VBID appeals and grievance processes to ensure hospice and plan accountability.

E. Administrative Burden & Data Collection:

We have significant concerns regarding administrative burden that could be placed on hospices through the VBID model. For example, Medicare Advantage plans or Medicaid or commercial managed care organizations often require a variety of contracting requirements per plan and additional reporting or documentation requirements that is not currently reported for fee-for-service. In addition, electronic health records and interoperability for hospice software are still in their infancy. Integrating EHR records with those of multiple MA plans is not currently possible from a technical and financial sustainability standpoint but is essential to care coordination.

We share these initial thoughts regarding the concerns of the CY 2021 VBID model design in hopes to engage further with CMS through stakeholder opportunities. NHPCO is supportive of the availability of the VBID model in all states. As we watch the developments in VBID for 2020, we will actively participate in stakeholder engagement for VBID design changes for 2020 and for 2021, when the VBID model is proposed to include hospice.

4. Non-Opioid Pain Management Supplemental Benefits

NHPCO supports the inclusion of non-opioid pain management services for members. Hospice and palliative care providers regularly employ non-opioid pain management techniques for addressing chronic and end-of-life care pain. However, we note that many members receiving palliative care and hospice will continue to need opioid therapy in addition to non-opioid treatments for effective pain and symptom management.

5. Special Supplemental Benefits for the Chronically Ill (SSBCI)

A. <u>Definition of Supplemental Benefits for the Chronically Ill</u>

NHPCO supports the ability of an MA plan to offer "non-primarily health related" supplemental benefit to enrollees to enhance services, improve quality and reduce the use of other services and program costs. However, we have concern that the definition of "reasonable expectation of improving or maintaining the health or overall function of the enrollee" may exclude members who could most benefit from SSBCI. As enrollees age, decline is inevitable and those enrollees who are chronically ill may also be classified as "seriously ill", and the criteria of "maintaining health or overall function"

may not be feasible. Among the enrollees who could benefit from SSBCI include those with M.S. or Parkinson's disease, with a need for home-based palliative care and inevitable decline. SSBCI interventions may slow the decline but would not necessarily "maintain health or overall function." For many seriously ill members, maintaining function or slowing the decline in function is the best outcome. Would those enrollees not qualify for these supplemental benefits?

B. Plan Flexibility for What Chronic Conditions Meet the Statutory Standard

NHPCO supports Plan flexibility for what chronic conditions meet the statutory standard. In our experience with palliative care teams, a tiered approach for risk stratification is often used, where diagnoses and functional status are grouped into tiers. We urge plans to use both chronic conditions and functional status in determining plan flexibility. In addition, we urge plans to establish mechanisms for assessing patients and making timely referral to hospice when appropriate.

C. Coordinate MA Benefits with Community and Social Services (§422.122(b)(3)

NHPCO strongly supports the ability of MA plans to coordinate with community and social services. We believe that the partnership between plans and hospice and palliative care providers is in the best interest of enrollees and offers the widest array of services for enrollees with advanced illness. We request that CMS elaborate on their intent, as plans contract with community-based organizations to provide new supplemental benefits. How would it work if a plan contracts to provide transportation to an enrollee who then is referred to hospice. Does the SSBCI transportation service discontinue because they have been referred to hospice? We request that CMS clarify this section to provide more detail on how the SSBCI benefits should be offered.

D. Waiver authority

In the 2020 Draft Call Letter, CMS proposes to *"allow plans to vary or target SSBCI to meet the individual enrollee's specific medical condition and needs."* However, the waiver "*may not be provided to a chronically ill enrollee if that benefit does not have a reasonable likelihood of improving that specific enrollee's health or overall function as related to the specific chronic illness."* As noted above, NHPCO is concerned that the inevitable disease progression of a chronically ill enrollee may transition them to an enrollee with advanced or serious illness, or even terminal illness. Does this waiver authority mean that once the disease reaches the seriously ill status, the plan will discontinue SSBCI services?

6. **Naloxone Co-Prescribing:**

NHPCO is supportive of safety measure that should be in place to address the opioid crisis. We also note that this provision does recognize the reference to the CDC guidelines and HHS guidance, which excludes patients with advanced cancer and those receiving hospice and palliative care. We strongly support the exclusion of hospice and palliative care patients from any requirement or incentive for naloxone co-prescribing. We also support any efforts from Part D sponsors to educate enrollees about the appropriate use of opioid medications, with the caveat that opioid use frequently is appropriate and needed for this patient population. Is there any opportunity to identify patients receiving palliative care so that there is not a requirement for co-prescribing?

7. **Part D Mail Order Auto-Ship Modifications**:

Enrollees that are referred to hospice often have mail order prescriptions in place for treatment or management of one or more conditions. As hospice care is initiated, all medications are reviewed by the hospice and some will likely be discontinued as no longer being medically appropriate for the palliation and management of the patient's terminal condition. There is a provision in this proposal that there be a "full refund policy (and to delete the PDE) for any refills auto-shipped that a beneficiary reports as unneeded or otherwise unwanted, regardless of whether the medication is returned by the beneficiary (or representative)." A beneficiary who has elected to receive hospice care is likely unable to report that a medication is no longer needed or wanted, and the patient's family or representative may not have readily accessible information about the auto shipment of prescriptions. We are concerned the result will be that drugs set up for auto-shipment will continue to be sent to hospice patients even if they are no longer medically appropriate or included on the patient's hospice plan of care.

In addition, we remain concerned about the provision in this proposal that "*Similar to the conditions in place for the current exceptions permitting auto-ship, we would* ***expect pharmacies to promptly discontinue automatic deliveries*** *after information becomes available from CMS that a beneficiary entered a skilled nursing facility or elected hospice coverage."* CMS communication to Part D plans and pharmacies about hospice election has been problematic for some time, and timely notification of the hospice election through current notification systems (Common Working File and MarX systems) has not been available. NHPCO has worked for several years with CMS Part D staff and participates in the NCPDP Hospice Workgroup to identify systems and processes that will eliminate payments for drugs through Part D when the hospice is responsible. We are concerned that without better, and more timely, notification systems in place, auto-ship provisions may exacerbate existing challenges, result in shipment of drugs that are no longer appropriate, and

adversely impact the proper payment of medications by the hospice for an enrollee who has elected the hospice benefit.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Judi Lund Person, Vice President, Regulatory and Compliance, NHPCO at (703) 837-1500 or at jlundperson@nhpco.org.

Sincerely,

Edo Banach, JD
President and CEO