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Michael E. Chernew, PhD, Chair, and Members
Medicare Payment Advisory Commission
425 I St NW, Suite 701
Washington, DC 20001

Dear Dr. Chernew and Members of the Commission:

Since 1982, the National Association for Home Care & Hospice (NAHC) has been the largest organization representing hospice, home health, and home care providers across the nation. Our members include a wide array of provider types, including nonprofit and proprietary, urban and rural, hospital-affiliated, public and private corporate entities, and government-run agencies. We are writing today to provide our input on the Medicare Payment Advisory Commission's (MedPAC's) planned agenda for exploration of important issues related to the Medicare Hospice Benefit (MHB), including the effect of hospice on Medicare spending, the effect of the hospice aggregate cap on various beneficiary populations and outcomes, non-hospice spending for beneficiaries enrolled in hospice, and end-of-life care for beneficiaries with end-stage renal disease (ESRD). We welcome the opportunity to provide our perspectives on these important aspects of care at the end of life.

Hospice's Effect on Net Medicare Spending

Beyond its proven ability to improve patient and family quality-of-life for those facing many different terminal illnesses, including cancer¹, dementia², heart disease³, and ESRD⁴, a number of important research studies have recently confirmed that utilization of the MHB is also associated with large aggregate cost-savings to the broader Medicare program. As staff referenced as part of the Commission's November 2nd presentation, a seminal March 2023 analysis from NORC at the University of Chicago⁵ found the **total cost of care for Medicare beneficiaries in the last year of life who used hospice in 2019**

¹ Kumar et al. [Family Perspectives on Hospice Care Experiences of Patients with Cancer](#) (Feb 2017)

² Harrison et al. [Hospice Improves Care Quality For Older Adults With Dementia In Their Last Month Of Life](#) (June 2022).

³ Cross et al. [Hospice Use Among Patients with Heart Failure](#) (May 2019).

⁴ Schwarze et al. [Hospice Use and End-of-Life Care for Patients With End-stage Renal Disease: Too Little, Too Late](#) (June 2018).

⁵ NORC at the University of Chicago. [Value of Hospice in Medicare](#). (March 2023).

was **\$3.5 billion less than the adjusted spending of beneficiaries who did not use hospice**, representing a 3.1% reduction in costs attributable to hospice utilization. Additional key findings from NORC’s analysis include:

- **Hospice stays of six months or more add value to Medicare.** For those who spent at least 6 months in hospice in the last year of their lives, spending was 11 percent lower than the adjusted spending of beneficiaries who did not use hospice. When sorted by disease group, spending ranged from being 4 percent lower for neurodegenerative disease to 25 percent lower for chronic kidney disease/end stage renal disease (CKD/ESRD).
- Examination of Medicare spending in policy-relevant length of stay groupings (0-14 days, 15-30, 31-60, etc.) found that total **Medicare spending in the 12 months preceding death is consistently lower for beneficiaries with LOS of 15 days or more**, compared to beneficiaries who did not use hospice, regardless of disease group.
- Furthermore, analyses to find the specific day when Medicare spending for non-hospice users equals spending for hospice users—revealed the “break-even” point at day 10. **Starting on day 11 (prior to death), hospice users’ Medicare spending is lower compared to spending for non-hospice users.** In other words, earlier enrollment in hospice—and longer lengths of stay—may reduce Medicare spending.

In addition to NORC, a number of other recent academic research investigations have found major cost-savings associated with hospice utilization⁶, including for patients suffering from Alzheimer’s Disease and related dementias (ADRD)^{7 8}, a population that many policy stakeholders are especially interested in given their likelihood to have longer stays on hospice.

Despite the fact that only about half of the people with Medicare who die each year access any hospice at all, and almost a quarter of patients are on hospice for a week or less, in recent years CMS and others have implemented or called for policies that would serve to discourage longer-stays on hospice, including payment model changes and an increased audit focus on long lengths of stay. Unfortunately, research⁹ has shown that these policies likely contributed to a decrease in access to hospice care for patients with ADRD for whom prognostication can be very difficult and therefore can be more likely to stay on hospice longer than people with other terminal illnesses. This is especially concerning given that hospice both improves dying ADRD patients’ quality of life, as well as contributes to overall decreases in Medicare expenditures for this patient population.

Given research demonstrating the MHB’s positive care quality and financial impacts, **NAHC recommends an increased emphasis in MedPAC’s hospice-focused analysis toward examining policies that can address the larger problem of too many beneficiaries receiving no hospice at all or receiving service for only very short periods of time.** We were encouraged by the comments of many MedPAC Commissioners at the November 2nd meeting expressing concerns about beneficiaries getting to hospice

⁶ Aldridge, et al. [Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018](#). (Feb 2022).

⁷ Aldridge, et al. [Health Care Costs Associated With Hospice Use For People With Dementia In The US](#). (Sept 2023)

⁸ Gruber et al. [Dying or Lying? For-Profit Hospices and End of Life Care](#). (March 2023)

⁹ Gianattasio et al. [Evaluation of Federal Policy Changes to the Hospice Benefit and Use of Hospice for Persons with ADRD](#) (May 2022).

“too late”, and encouraging further research into the reasons behind these late transitions and potential ways to increase more timely access to hospice care. Facilitating eligible patients’ earlier enrollment in hospice and increasing their lengths of stay on the benefit (median length of stay is currently only 17 days) would likely reduce Medicare spending even more. As part of our efforts with Congress, NAHC has urged greater recognition of the value hospice brings to patients, families, and taxpayers, and support of policies and programs that protect and increase more timely access to the MHB. **Specifically, we have recommended that Congress:**

- **Oppose calls for drastic cuts to hospice payment rates**, including MedPAC’s recommendation to reduce the hospice benefit’s aggregate payment cap by 20%. We view this proposal as a blunt instrument that threatens to reduce access to this special kind of care and also – as emerging research shows -- is fiscally shortsighted as it does not account for the significant savings MHB utilization drives to the Medicare program as a whole.
- **Encourage CMS and its oversight contractors to reexamine its current audit focus areas and practices to ensure they do not continue to target mostly compliant hospices** that are operating in good faith and with great frequency, after great time and expense, have their claims denials overturned on appeal. The intense audit scrutiny centered on retroactive second-guessing of hospice patient eligibility has created a chilling effect across the hospice community, such that some providers are hesitant to take patients with certain terminal diagnoses that may result in longer stays on the benefit and generate additional oversight activity.
- **Mandate a study focused on the drivers and potential solutions for late referrals/admissions and very short stays on hospice.** This study should include a focus on identifying a core set of expensive “outlier” treatments that could be considered both palliative and disease-focused (examples include palliative dialysis, chemotherapy, transfusions, or radiation). These types of interventions are prohibitively expensive for most hospices to cover under current reimbursement structures, and therefore act as a barrier to hospice for patients that have illnesses that could be appropriately palliated by these kinds of treatments.
- **Require CMS to create education and awareness campaigns on hospice’s structure, requirements, and benefits** for primary care providers, hospital discharge planners, specialty physicians and non-physician practitioners, and other provider types upstream of hospice who often serve as referral sources for the hospice benefit. Congress has required CMS to undertake analogous efforts in the past, including for a CMS-led outreach campaign to providers on the cognitive assessment and care planning codes¹⁰.
- **Require CMS to explore the feasibility and value of creating quality measures that encourage thoughtful and timely consideration of advance care planning and referral to hospice** for appropriate upstream provider types to ensure accountability for positive end-of-life care outcomes. Metrics of this type already exist for and are applicable to CMS’ PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program¹¹. Examples include “*Proportion of Patients Who Died from Cancer Not Admitted to Hospice (PCH-34)*”; “*Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (PCH-35)*”; “*Proportion of Patients Who*

¹⁰ CMS. [Report to Congress: Centers for Medicare & Medicaid Services \(CMS\) Provider Outreach & Reporting on Cognitive Assessment & Care Plan Services](#). (Dec 2021)

¹¹ <https://qualitynet.cms.gov/pch/measures/end-of-life>

Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (PCH-32)”; “Proportion of Patients Who Died from Cancer Admitted to the ICU in the last 30 Days of Life (PCH-33)”

We also believe that it may be appropriate that CMS revise hospital mortality measures so that hospitals are incentivized to refer patients to hospice at an appropriate time in their stay. The current mortality measures exclude patients who have had hospice care at any time in the 12 months prior to the index admission or on the first day of the index admission. This type of calculation does not encourage discussion of end-of-life care for patients during the hospital stay. Hospices report that hospitals refer patients to hospice while they are actively dying which severely limits the realization of the relief of symptoms and quality of life. The CMS post-acute transfer policy may also have an impact on hospice referrals and timeliness of referral. Under this policy hospitals are paid under a per diem rate instead of the DRG rate for specified diagnoses if the patient is transferred to hospice within a certain number of days (DRG-specific).

The Hospice Aggregate Cap and Beneficiary Outcomes

As noted during the MedPAC staff presentation on November 2nd, each year since 2020 the Commission has recommended that the hospice aggregate cap be wage adjusted and reduced by 20%. In 2020, out of concern that MedPAC’s proposal to wage index and reduce the hospice aggregate cap by 20% could negatively impact access to care for certain types of hospice patients, NAHC commissioned a study by Dobson DaVanzo and Associates (DDA) to explore how hospice characteristics, differences in patient case-mix, and differences in type of care provision for Medicare beneficiaries receiving hospice services could impact aggregate cap status and how changes to the aggregate cap could incentivize hospice operational changes in order to stay under the annual aggregate cap. DDA also considered the extent to which control of these characteristics is either possible or socially desirable in terms of possibly limiting care access for particular types of patients. Following are some findings from the DDA study.

- **Patient access will be reduced:** *“The factors that most increase the risk of exceeding the cap are linked to the admission of patients with chronic and neurological conditions as they have a tendency towards longer lengths of stay and related difficulty in establishing a definitive life expectancy while still meeting eligibility requirements for the Medicare hospice benefit. Providers may have limited access to additional referral sources (such as hospitals and oncology practices) whose patients could help “balance” cap liability. As a result, these hospice programs may be required to adjust their overall case mix towards acute and cancer diagnosis patients to reduce their cap liability. Doing so could lead to delay in care or restrictions in access for beneficiaries with non-cancer diagnoses seeking end of life care.”*
- **Reducing the aggregate cap could further exacerbate health disparities in hospice access and utilization:** While progress has been made in recent years to increase the diversity of patients served by the Medicare hospice benefit, in 2020, 80% of those who received hospice services were White¹². To address these stubborn disparities, we need policies that encourage greater access to hospice for patients from underserved minoritized communities, who are unfortunately more likely to die in a hospital, have intensive treatments at the end-of-life and

¹² CMS hospice data: <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/medicare-hospice>

are less likely to conduct advance care planning compared to white Americans¹³. Unfortunately, the individuals most likely to have their access to hospice reduced by the cap reduction (those with dementia and other neurological diagnoses) are also more likely to be from these minoritized communities. Older African American and Hispanic Americans are disproportionately more likely than older White Americans to have dementia: 18.6% of African Americans and 14% of Hispanics age 65 and older have Alzheimer’s dementia, compared with 10% of White older adults¹⁴. The DDA research found that “*Relative to hospices which would remain below the proposed reduced cap, hospices which would be affected by the policy change tend to have higher portions of care-days for minority patients and those with chronic and neurological conditions.*”

- **Reducing the cap may result in increased overall spending under Medicare:** Hospice is looked to as a cost saving measure because it prevents avoidable hospitalizations and procedures that are unnecessary or unwanted; it also better aligns with patients’ goals and preferences. A February 2022 JAMA article found that hospice use by Medicare beneficiaries was associated with significantly lower total health care costs *across all payers*. Further, the study found no evidence of cost shifting for hospice from Medicare to families, and families had significantly lower out-of-pocket health care costs in the last 3 days to last month of life when patients enrolled with hospice¹⁵. This lower out-of-pocket spending is especially important for those patients and families with lower socioeconomic status, who tend to disproportionately be from racial and ethnic minority populations. Any proposal that could limit hospice use, such as the cap reduction, may result in increased overall spending for Medicare, as those patients who might have been served by cost-saving hospice end up utilizing more expensive and aggressive care such as hospital, ER, and nursing home services.
- **The cap reduction does not account for the changing demographics and diagnoses of the modern hospice patient population:** When the hospice benefit was established, cancer patients who had predictable trajectories towards death and short lengths of stay accounted for the majority of those served by the Medicare hospice benefit. However, because of changing demographics and advances in medical technology that allow more people to live longer with more serious illnesses, today, non-cancer diagnoses, led by organ failure and dementia, are the top-reported hospice diagnoses. Hospices are significantly more likely to exceed the cap for patients with neurological diagnoses like dementia. Based on DDA’s findings, all else being equal, under the existing cap policy, a hospice increasing its share of care-days provided to neurological condition patients by 10 percentage points would have a 6% higher chance of exceeding the aggregate cap. If the cap is cut by 20 percent, the chance of such hospice providers exceeding the cap will increase to 11 percent if they increase the share of care days for neurological patients by the same amount.

¹³ *Racial and ethnic differences in end-of-life care in the United States: Evidence from the Health and Retirement Study (HRS)*. (2019). <https://www.sciencedirect.com/science/article/pii/S2352827318302714>

¹⁴ 2021 Alzheimer’s Disease Facts and Figures. *Alzheimer’s Association*. <https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf>

¹⁵ *Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018*. (2022). <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2788935?resultClick=1>

Nonhospice Spending for Beneficiaries Enrolled in Hospice

Spending outside of hospice has been a long-standing concern for the Centers for Medicare & Medicaid Services (CMS), policymakers, and the hospice sector. While CMS has frequently noted that it is the expectation that virtually all care while a patient is on hospice should be the responsibility of the hospice, we have concerns that this perspective fails to recognize the changes in the hospice patient population that have occurred since the early 1980s. We would also note that while in the aggregate such spending has reached significant levels, the percentage of spending outside of hospice while patients are on service is – in relative terms – modest. NORC found that Medicare spending outside of hospice while patients are on service ranges from 1% of total costs for patients on service up to 30 days to 3% for patients on service between 91 and 180 days. For patients on service for 266 days or more (up to 365 days) 6% of total Medicare spending is outside of hospice care.

Part D spending has been a particular concern for CMS and the Office of the Inspector General (OIG). Implementation of timely filing for the hospice Notice of Election (NOE) and significant penalties for failure to submit the NOE timely have created a strong incentive for hospices to submit NOEs timely to facilitate updates to beneficiary status information so that other providers are able to determine when a patient is on hospice care. Despite this, CMS systems do not process hospice NOEs on a timely basis, so other provider types do NOT have access to timely information about patient election of hospice care, nor do they have the incentive to coordinate care. Further, non-hospice providers lack sufficient knowledge about how the services they provide may interact with the hospice benefit, including an understanding of hospice “related” services and the fact that, except in the case of hospice attending physician services, hospices are required to arrange for all services related to the patient’s terminal illness or related conditions. To our knowledge they are also not required to check CMS systems to determine whether patients are enrolled in hospice (it should be noted, though, that even if non-hospice providers check beneficiary election information in CMS systems that hospice election information may not be available due to delays in posting timely). Absent an overhaul of CMS systems and enhanced non-hospice provider education, spending outside of hospice will continue to be a problem. If hospice EMR interoperability were accessible (supported and incentivized) it could help to promote increased knowledge of a beneficiary’s hospice status as well as better coordination of care; unfortunately, hospice and other post-acute providers have not been provided the same benefits that hospitals and physicians have relative to interoperability. The lack of access to interoperability by hospice and post-acute providers has been identified in the Office of the National Coordinator’s recent report¹⁶ to Congress as a “barrier to progress” relative to access, exchange, and use of electronic health information.

Hospices have utilized numerous strategies to limit inappropriate utilization outside of the hospice benefit, including supplying patients with wrist bands and other items that patients are instructed to utilize to contact the hospice when care needs arise. Hospices work to build strong relationships with hospitals or enroll in services that alert the hospice when a patient that has elected hospice presents at

¹⁶ 2022 Report to Congress: Update on the Access, Exchange, and Use of Electronic Health Information, United States Department of Health and Human Services, Office of the National Coordinator for Health Information Technology (ONC).

the hospital so that the hospice can intervene and directly address the patient's needs or discuss with them the consequences of entering the hospital for services prior to formal admission. Despite these and other efforts, the failure of CMS systems to timely provide information about election of hospice care continues to hinder all providers' abilities to properly manage and coordinate care for hospice-enrolled patients.

Hospices have limited to no influence on the billing habits of other provider types. Under the hospice benefit, patients are financially responsible for items/services/drugs that are related but are not reasonable and necessary. As part of the election process, hospices inform patients/families of this. However, at times when a hospice will not cover services, the patient may seek them elsewhere, and they may be billed to Medicare by the provider. We understand that with some frequency non-hospice providers utilize the GW modifier as a "workaround" as they have learned that it will allow claims to process, regardless of whether the item/service/drug is related to the hospice prognosis. Use of the GW modifier also allows the provider to avoid burdening the patient with the cost of the services provided.

NAHC and other national associations have been involved with the National Council of Prescription Drug Program's (NCPDP's) efforts to create a pilot under which hospice enrollment data is communicated to Part D plans in close to real time. By ensuring that this information is available to the Part D plans on a timely basis, they are able to impose the prior authorization checks for the four classes of drugs that are considered to be hospice related. This also opens up lines of communication between the hospice and the Part D plan such that they are positioned better to share information about drugs that the hospice will cover as related to the terminal prognosis, thereby avoiding the need for Part D plans to later seek compensation from the hospice for hospice drugs. While we are hopeful this will contribute to a reduction in inappropriate drug spending under Part D, this is only one part of the problem and does not address expenditures under Parts A and B.

We are familiar with the new PEPPER target areas related to Part B spending outside of the hospice benefit, as well as the recent CBR report for Part B providers who have billed for care while patients are on hospice. These reports are an important step in getting data to providers so that they have a better sense of the volume of services being billed outside of hospice for patients on care with them, how they compare with other hospice providers, and notifying Part B providers that they play a role in ensuring that services are appropriately billed under Medicare. However, hospice providers could benefit from greater detail about what specific services are being billed for their patients and whether the services are linked to patients in specific facilities (nursing homes, SNFs, ALFs). We have heard with some frequency of instances under which nursing facilities are billing physician services in order to comply with requirements at 483.30(c)(1) that a resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At times the facilities attempt to bill the hospice for these physician visits but since the visits are in fulfillment of an administrative requirement and are not arranged by the hospice, we believe them to be the responsibility of the facility. We suspect that some of these visits may be being billed directly to Medicare by facilities. We also hear of instances in which companies offer various services to hospices (such as complex wound care) that they indicate can be provided and billed outside of the hospice

benefit. While the hospices we hear from decline this “assistance” we suspect there are numerous examples of this type of abuse that occur and believe that it may be appropriate for CMS and/or the HHS OIG to issue alerts focusing on such schemes that target hospices and hospice patients for services that should be included as part of the hospice benefit and should be arranged by the hospice.

Use of Hospice and Palliative Care among Beneficiaries with End-stage Renal Disease (ESRD)

In recent years certain treatments previously viewed as “curative” in nature have come into use as palliative interventions that, in the right circumstances, can be very effective in managing symptoms associated with various terminal conditions. Among these treatments are blood transfusions, chemotherapy, radiation, and dialysis. Since these treatments that “straddle” the curative/palliative sectors have historically been curative in nature, hospices are at varying levels of understanding about which of these treatments are appropriate palliative interventions versus curative in nature, and under what circumstances. As some hospices have admission policies under which they do not cover treatments that they believe will either hasten or delay death (interference with the dying process); these hospices may not cover some treatments (such as dialysis), which could be viewed as “curative” in nature or life-prolonging. Further, various programs (including the VA and the MA VBID Hospice Component Demonstration) identify many of these disease-directed treatments as “concurrent” care – implying that they are to some degree curative in nature but also appropriate for administering in conjunction with the hospice benefit.

Over recent years we have conducted discussions with a wide array of hospice providers and other stakeholders related to such palliative interventions. As a general rule, most hospice providers make determinations on a case-by-case basis to ensure that the goals of the treatment are consistent with the goals of hospice and that the treatment will be beneficial to the individual patient. Coverage determinations are made based on the intent of the intervention rather than whether the type of treatment is customarily viewed as “curative” in nature. Hospices make every effort to establish an understanding with the patient and family about the process for use of these treatments and when ceasing these treatments is appropriate. Providing treatment of patients with ESRD can be particularly complex. Many hospices also report allowing continuation of dialysis on a short-term basis to allow for closure or for treatment as a palliative measure for some patients. However, when it comes to the provision of services on a long-term basis that are not able to be provided in the home (and managed by the hospice) there are greater difficulties. This is frequently the case with the provision of dialysis. Hospices report issues as follow:

- Scheduling of treatments: contracted facilities for dialysis frequently do not have immediate availability or availability at a time that would be most beneficial to provide palliative intervention and relief to the hospice patient.
- Securing contracts with hospitals or centers: hospices report challenges securing contracts with dialysis facilities; since hospices are required to have a contract with all providers of services that the hospice arranges this creates significant challenges.

- Costs for these types of treatments can be substantial. Dialysis costs can be significant, with pre-PHE estimates for regular dialysis sessions of \$400 per session (\$120 per session for home peritoneal dialysis). Some hospices report supplying peritoneal dialysis as an alternative to facility treatments. Where regular dialysis is used transportation and staff costs must also be considered. Further, management of renal disease can include high-cost drugs, as well.
- Treatment regimens: dialysis that is provided for the purpose of managing symptoms may vary somewhat from dialysis treatments that are aimed at maintaining an individual at maximum potential functioning. However, centers may not be willing to contract at reduced rates or to provide varying treatment regimens to accommodate a hospice patient’s needs.
- While larger hospices (i.e., large independent non-profit, and for-profit and non-profit affiliation/chain multi program organizations) report covering a variety of palliative interventions, small hospices of all types have difficulties providing some of these more expensive treatments to all who might benefit—they do not have the scale such that they can absorb the high costs for numerous patients needing such treatments and the related staffing requirements – so they must limit the number of individuals they can admit with these needs.

Recent research¹⁷ comparing kidney disease patients receiving the Medicare hospice benefit with similar VA patients who had access to hospice care and concurrent care services (including dialysis) indicates that the VA patients were more likely to receive dialysis treatments during their hospice stay, and to remain on hospice care for substantially longer periods of time (43 days vs. 4 days). These findings support the growing belief that Medicare hospice patients could benefit from access to various treatments that are currently not widely available to them. The current hospice payment system does not take the cost of many of these treatments into consideration because most of them were not available when the hospice payment system was created. As a result, the introduction of these treatments represents “scope creep” under the hospice benefit, so actual costs of care are increasing for those hospices that offer such services. As medical care continues to advance, we expect the introduction of more treatment modes like these, which may create further challenges for the hospice community. Absent the allowance of concurrent coverage under Medicare, it may be necessary to develop some type of risk-adjustment, outlier payment, or other mechanism under the hospice benefit to address these costs and ensure a higher quality end-of-life for Medicare beneficiaries.

Additional areas for further MedPAC research

NAHC was encouraged by commissioners’ recommendations for additional areas of hospice research beyond the four formal work plan items. Of those discussed, we support further investigation into:

- Analysis of the different pathways and mechanisms by which beneficiaries come onto the hospice benefit.

¹⁷Association of Hospice Payer With Concurrent Receipt of Hospice and Dialysis Among US Veterans with End-stage Kidney Disease, October 21, 2022; <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2797675>

- How Medicare Advantage organizations understand and service plan members that choose hospice or are hospice eligible, to include exploration of what guardrails and protections might be necessary to ensure high-quality care for hospice patients with MA coverage, including those who are currently or will be a part of CMMI's Value-based Insurance Design (VBID) demonstration. The hospice community has major concerns about the patient access and quality of care consequences of carving hospice into MA. Deeper and more holistic analysis and monitoring of this integration experiment is critical to ensure some of the common features of MA (i.e., narrow networks, prior authorization, and the like) do not negatively impact the system's sickest and most vulnerable patients who are at the end of their lives.

Thank you for the opportunity to provide comments on the November 2nd meeting and MedPAC's hospice workplan. NAHC looks forward to continuing to work with MedPAC staff and commissioners to ensure all Medicare beneficiaries have access to appropriate, high-quality hospice care when they need it. If you have any questions or if we can be of any assistance, please feel free to contact Theresa Forster (tmf@nahc.org), Davis Baird (dbaird@nahc.org) or Katie Wehri (katie@nahc.org).

Sincerely,

A handwritten signature in black ink, appearing to read "William A. Dombi". The signature is fluid and cursive, with the first name "William" being the most prominent.

William A. Dombi, Esq.
President