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Care Organization

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January 24, 2024

Michael Chernew, PhD
Chairman, Medicare Payment Advisory Commission
425 I Street, N.W.
Suite 701
Washington, DC 20001

Re: **MedPAC Hospice Workplan**

Dear Dr. Chernew:

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to provide comments on the **MedPAC hospice workplan and recommendation presented at the November 7, 2023, December 7, 2023, and January 12, 2024 public meetings**. We look forward to our strong, continued collaboration with MedPAC 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 nationwide. In addition, hospice and palliative care members employ thousands of professionals and volunteers.

We are pleased to see the direction MedPAC is headed in analyzing hospice and palliative care as presented in the workplan but do have concerns regarding the 2024 recommendation. Our members are passionate experts in hospice and palliative care and welcome the opportunity to work with the commissioners and MedPAC staff to provide additional support for your work on hospice and palliative care.

Workplan

1. Hospices' effect on Medicare spending

NHPCO is pleased to see MedPAC citing the new NORC research[1] on hospice and its significant cost savings to the Medicare system, including when the length of stay is greater than 266 days. Specifically, the research found the total costs of care for Medicare beneficiaries who used hospice in 2019 was 3.1% lower than those who did not use hospice, and earlier enrollment in hospice and longer lengths of stay likely reduce overall Medicare spending. The report calculates this reduction in spending translates to an estimated $3.5 billion less in Medicare outlays for beneficiaries in their last year of life. This report demonstrates the value of hospice in the Medicare program and contributes to the body of evidence reflecting savings under the Medicare hospice benefit.

Hospice providers understand the benefit they are providing to Medicare beneficiaries and their caregivers along with the Medicare program at large. Expanding the benefits of hospice and palliative care earlier and to more beneficiaries can improve quality of life and care for beneficiaries as highlighted in the final Medicare Care Choices Model (MCCM) report by CMS. Providers are excited for these benefits to be shared to the larger healthcare system and support MedPAC's future in analyzing the impact of hospice on Medicare spending.

2. Effect of hospice aggregate cap

NHPCO applauds MedPAC's shift from recommending a cut to the aggregate cap and is encouraged to see the upcoming evaluation of the impact of the hospice aggregate cap. Studies have shown the cap can hinder access to care and we are especially concerned for people living in rural and underserved areas. Hospice providers have noted the cap and any cuts to the cap could result in unintended hospice closures, particularly in low wage index and underserved areas. With less than 50% of Medicare decedents utilizing hospice,[2] we should be focused on creating increased and equitable access to the benefit. As one commissioner noted in the November meeting, the cap can be a "blunt tool for cost containment."

In addition to access of care concerns, MedPAC must examine the use of live discharge as it relates to the aggregate cap. Providers are concerned with exceeding the cap and patient with a length of stay over 180 days because it draws program integrity scrutiny – even if the beneficiary remains eligible for hospice as certified by their providers. Live discharges must be examined from the perspective of the beneficiary and family caregivers because for so many, a live discharge is a steep cliff in care.

In addition, as MedPAC reviews hospices' effect on Medicare spending and non-hospice

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[1] NORC at the University of Chicago, *Value of Hospice in Medicine*, (March 2023), https://www.norc.org/research/projects/value-of-hospice.html

[2] MedPac March 2023 Report to Congress, Table 10-3

spending, the necessity and use of the aggregate cap should be examined. MedPAC should review the aggregate cap as a part of the big picture of hospice care and beneficiary access and determine the extent this "blunt tool for cost containment" continues to be necessary.

3. **Non-hospice spending for beneficiaries enrolled in hospice**
   NHPCO continues to support MedPAC's initiative to highlight non-hospice spending for beneficiaries in hospice and looks forward to its analysis of the provider interviews. It is important to note non-hospice spending is not solely the responsibility of the hospice; rather, this is a shared responsibility of the healthcare community. Any project on limiting non-hospice spending should start with supporting the work hospice providers are already doing to prevent this spending. As mentioned at the December 7 public meeting, providers attempt to educate beneficiaries and caregivers as well as other providers on the Medicare hospice benefit. This education includes insisting beneficiaries discuss all potential treatment and care with the interdisciplinary group (IDG) caring for them; however, beneficiaries and their caregivers often do not communicate this with the IDG.

   In addition, non-hospice spending often arises through actions of non-hospice providers and suppliers regardless of any education provided by the hospice to these providers and suppliers. One way to support hospice providers' efforts is through improvement of the Medicare claims processing system. Currently there are no flags in the system to prohibit a provider or physician office from filing and getting paid for an office visit or treatment when the patient has elected hospice or notify the hospice provider. NHPCO has recommended some type of flags for hospice enrollment in the claims processing system since meeting with CMS senior staff on May 20, 2015, where flags in the system were suggested, as well as education for physicians and other non-hospice providers. Little action has occurred since this time.

   The hospice often has no way of knowing, in real time or sometimes at all, whether any spending has occurred. Because hospice and other post-acute care providers are not included in CMS's interoperability focus and funding, other providers often have no way of knowing the patient's hospice election and the hospice has no way of knowing a visit, treatment, admission, or service has been provided. The inclusion of hospice and other post-acute care provider EMR software considered for interoperability may help with both billing provider knowledge and hospice tracking in the future. Providers have shared with NHPCO that the EMR updates required to be operable with the greater healthcare system are cost prohibitive for hospices across the country; therefore, any changes to interoperability must be paired with funding and support.

During the December 7 public meeting, three possible policy directions were presented for non-hospice spending:

1. *Administrative approach*

   Although the definition of relatedness is murky, creating a more concrete definition of relatedness would diminish the value of the clinical assessment by the clinician caring for the beneficiary. One clinician may decide a condition is related to the terminal diagnosis; whereas another clinician may disagree. By allowing the clinician most connected to the beneficiary to make the decision on what is related, we are ensuring personalized care for the beneficiary. For example, a pharmacist or physical therapist who is addressing one symptom or condition is not in the best place to make such a definition, regardless of if the definition of relatedness is clarified. To help clinicians work through the decision-making process for relatedness, NHPCO has created a flow chart.

   Other potential administrative approaches, such as education and improved data, may be possible and NHPCO is happy to partner with MedPAC to determine their usability and effectiveness in addressing non-hospice spending.

2. *Bundled payment approach*

   Hospice care has been shown to have significant cost savings to the Medicare program compared to beneficiaries who did not utilize hospice.[3] This is done by working with beneficiaries and caregivers to deprescribe unnecessary medications and treatments while utilizing a comprehensive IDG to care for the beneficiary. However, it is not always possible or the wish of the beneficiary to stop all medications and treatment immediately upon electing hospice.

   Any consideration of a bundled payment approach must consider mechanisms to account for exceptionally high cost patient cases. This is especially true in the community setting, where the total extent of costs is ill defined and could potentially be far reaching. In addition, it will be necessary to evaluate the types and extent of resources (e.g., EHR systems, staffing) necessary for hospices to assume total costs under any bundled payment approach. This evaluation must consider the availability of these resources particularly in rural and underserved areas, where staffing and interoperability challenges are particularly pervasive. Another potentially high cost area is with drugs and medication. A single high priced drug can impact a hospice's margin and adversely impact its capacity to serve its community, particularly for providers with a high number of short length of stay patients. Hospices are responsible for providing comprehensive interdisciplinary care to patients that align

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[3] NORC at the University of Chicago, *Value of Hospice in Medicine*, (March 2023), https://www.nhpco.org/wp-content/uploads/Value_Hospice_in_Medicare.pdf.

with the patient's goals for care, which sometimes include medications and treatment unrelated to the terminal prognosis. Especially as hospice providers work to increase appropriate access and encourage earlier hospice admissions in the disease process, conversations around medication deprescribing are not a one-time intervention — but take place over many interactions as the patient's medical and functional status declines. Any bundled payment approach would need to consider the potential financial, administrative, and staffing implications for providers if hospices were to be expected to provide care within a bundled payment approach.

In addition, MedPAC should consider how CMS must review bundled payments for hospice. One major concern would be whether any administrative error would require CMS to deny payment for the entirety of services provided by the hospice interdisciplinary team. This level of denial would be devastating for many hospices. In other words, a simple administrative error unrelated to the quality or reasonableness of care delivery could result in the denial of the entire hospice stay. These denials are already debilitating, but with a bundled payment approach, raises a whole new level of concern.

3. *Payment penalty approach*
   Penalizing hospice providers who have higher non-hospice spending compared to other providers with no change to the Medicare hospice benefit would have a chilling effect on access to hospice. However, to the extent any penalties are considered, the role non-hospice providers play in this spending should be considered. Based on the current structure of the benefit, there are acceptable, non-related medications, treatments, and care. By potentially penalizing providers who accept these patients, providers may be hesitant to accept beneficiaries with co-morbidities who will need more coordinated and more expensive care. Another potential outcome would be beneficiaries might wait longer to elect hospice as they do not want to give up medications and treatment they have relied upon for years. The median length of stay in hospice is 19 days[4] and data show 25% of patients have a length of stay in hospice of five days or less. This length of stay is not long enough for the beneficiary and caregivers to receive the full benefits of hospice and, as a healthcare system, we need to work to improve access to hospice. A core question that should be asked in this analysis was highlighted by a commissioner in the November meeting, "from a policy perspective…how do we incentivize people to start earlier in hospice?"

NHPCO is excited to see MedPAC's interest in addressing non-hospice spending as many hospice providers are doing everything in their power to limit this spending while also

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[4] 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. 20022 at 20029-30.

allowing beneficiaries to lead their care decisions and have access to the medication and treatment they need. Much of this spending is out of the control of the hospice, particularly when patients are admitted emergently and immediate coordination of care with the full range of the patient's medical providers may not be feasible. NHPCO recommends MedPAC continue to dive further into the data of what this spend looks like to better determine how much control hospices have before placing additional burdens on hospices and beneficiaries.

4. **End-of-life care for beneficiaries with end-stage renal disease (ESRD)**
NHPCO is excited to see MedPAC's focus on end-of-life care for beneficiaries with ESRD. We have worked with members of Congress on and advocated for initiatives to increase access for these beneficiaries. One of the main concerns is how burdensome the transition is to stop dialysis for beneficiaries with ESRD, despite many of these beneficiaries being eligible for hospice. As the Medicare hospice benefit currently stands, it focuses on a limited continuum of care and results in beneficiaries with ESRD having limited options in their care. A beneficiary with ESRD does not just decide one day to stop dialysis and enter hospice; it is a process requiring education and understanding for the beneficiary, caregiver, and providers. As one provider stated, "Curative and non-curative treatment modalities are worlds apart and leave an ocean between [what] our patients and families must navigate often on their own, with limited information and understanding." In addition, the lack of knowledge among some specialists about palliative treatments, the unwillingness of some specialists to communicate the benefits of hospice earlier in the disease process, or the decision to continue to treat, even when it was very clear the patient was eligible for hospice and could no longer tolerate aggressive treatment. Any policy decision related to beneficiaries with ESRD must consider this transition period and how best to support patients and caregivers while educating providers.

Hospice providers can offer so much to this population of beneficiaries but for too many providers the cost to continue dialysis is more than they are able to take on. The provision of hospice in 2023 is vastly different than the original Medicare hospice benefit designed in the 1980s. Today, there are many treatment options allowing some hospice patients to have reduced symptom burden and improved quality of life; however, many of these treatments are so expensive they cannot be used without a separate payment. For smaller and rural hospices, the cost alone of such treatments would be a substantial financial burden to include one of these treatments on a patient's plan of care and by doing so could seriously compromise the financial viability of the hospice. Given the flat per diem reimbursement rate for hospice care, there is a cost threshold for higher cost treatments, such as ESRD, which makes them unaffordable for hospices to provide to many patients. We recommend MedPAC explore what the cost threshold options could be through an outlier or add-on payment to allow additional reimbursement when these treatments are provided.

In addition, NHPCO recommends MedPAC review the following successfully models in providing care to beneficiaries with ESRD:

- **Dialysis Clinic, Inc. (DCI) partnered with the University of Pittsburgh Medical Center (UPMC) and UPMC's Family Hospice**[5] to design and implement a concurrent care program. This program allows beneficiaries with ESRD to receive as many as ten hemodialysis sessions after beginning hospice. By removing the dilemma of having to choose between starting hospice and stopping dialysis, DCI and UPMC aimed to improve their patients' experience with end-of-life care.

  Between January 2018 and December 2021, DCI and UPMC enrolled 43 beneficiaries in the concurrent care program in Pittsburgh. Program enrollment has been stable. After piloting the program with four people in 2018, DCI and UPMC have enrolled 13 people per calendar year on average. The race and ethnicity of program enrollees generally reflected the demographics of Pittsburgh according to 2020 Census data. Interestingly, 53 percent (n = 23) of those who enrolled in the program ultimately declined to pursue further dialysis. Of the 20 people who sought dialysis, 15 people received hemodialysis and five received peritoneal dialysis. People on hemodialysis received 3.5 dialysis treatments, on average. No one used all 10 of the available hemodialysis sessions (range one to nine sessions). People on peritoneal dialysis received 19.2 sessions on average (range 3–65). As expected, beneficiaries who received dialysis had a longer length of hospice stay than beneficiaries who received no dialysis (19 days compared with seven days). Beneficiaries who enrolled in the concurrent care program but ultimately declined dialysis spent seven days on hospice, which is slightly higher than the national average of hospice length of stay for beneficiaries with ESRD (seven days compared with five days).

- Another novel effort exists in Washington state at **Northwest Kidney Centers, based in Seattle.**[6] This program embeds palliative care within a kidney center whose clinics treat patients living with kidney disease; and then later pair dying patients with hospice care without forcing them to forgo the comfort dialysis may still provide. Traditional hospice services require kidney patients to abandon dialysis, a decision which hastens death, and almost inevitably comes with acute symptoms, including muscle spasms and nausea. While the goal of both hospice and palliative care is pain and symptom relief, hospice has traditionally been regarded as care without the intent to treat or cure the primary disease. The nuance with dialysis is it is central to keeping a kidney patient's body functioning; discontinuing it abruptly results in death within days. In the Washington state program, there is no limit on the number of sessions a patient can receive. This helps ease the

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[5] CMS, *Case Study: Dialysis Clinic, Inc.'s Concurrent Care Program* (Nov. 2022), https://www.nhpco.org/wp-content/uploads/DCI_and_UPMC_Concurrent_Hospice_on_CMS_Value_Based_Care_Learning_System_Case_Study.pdf.

[6] Northwest Kidney Centers, *Kidney Palliative Care: Improving Quality of Life* (Accessed December 21, 2023), https://www.nwkidney.org/palliative-care/.

patient into the new arrangement, instead of abruptly halting the treatment they have been receiving, often for years.

2024 MedPAC Recommendation

Although NHPCO is excited to see MedPAC remove their cap cut recommendation, we are dismayed to see MedPAC continue to recommend no payment update for hospice providers. In FY 2021 and FY 2022, the final market basket payment updates published by CMS were 2.4% and 2.7%, respectively. However, the data used to set this update did not take into account the record high inflation or the substantial increases in staffing costs, the cost of medical supplies, and the cost of drugs over the previous two years. NHPCO's analysis of the actual market basket update for 2021 is 3.0% and for 2022 is 5.7%, using the IHS Global Inc. (IGI) 2022Q4 forecast.6 This represents a 3.7% variance from the combined FY 2021 and FY 2022 actual market basket updates. The payment updates for hospice providers have not been adequate.

Hospice providers are in a unique position compared to other healthcare providers as Medicare reimbursement accounts for nearly 90% of hospice providers' patient care revenue. This reliance on Medicare, along with a set per-diem payment makes hospice providers uniquely dependent on Medicare for almost all of their reimbursement and leaves no room to offset any losses.

Other Considerations

In addition to the workplan, we recommend MedPAC review the data used for assessing payment adequacy as it is dependent upon CMS data which may be flawed or misleading. For example, CAHPS® participation by providers is dropping and less than half of hospices submit CAHPS® data, with only a 29%CAHPS® Hospice Survey response rate for Q2 2021 through Q1 2023. A closer look at this may provide insight on variance by size and state. The Hospice Care Index (HCI) is not used in MedPAC's framework; however, we recommend considering this claims-based metric (notwithstanding approximately 28% of providers do not have scores available on Hospice Care Compare).[7] CMS data clearly shows the rapid growth of bad actors in Arizona, California, Nevada, and Texas which may skew national data reporting for CAHPS®, HCI, and access to care overall. Cost reports for hospice need to be modernized and CMS needs to require cost report audits to improve the accuracy and usability of the cost data used by MedPAC. This should in include a clearer delineation of cost and revenue from Medicare Advantage, Medicaid, and Accountable Care Organizations (ACO) or other value based payments

Although not specifically included in the workplan, MedPAC should review drug costs and specifically how Part D negotiations is not a practical avenue for hospice providers. Very few hospice providers have the expertise to handle negotiations for all drugs their patients need, particularly within the context of existing hospice relationships with pharmacy benefit managers.

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[7] See CMS, Hospice – Provider Data (updated Dec. 8, 2023). https://data.cms.gov/provider-data/dataset/252m-zfp9

As MedPAC continues to focus on improving access to hospice by providing it earlier in the disease progression, there will need to be more consideration for the drugs beneficiaries will need to access. These drugs will be cost prohibitive for many hospice providers and will likely not be able to be quickly deprescribed.

Thank you for your consideration of our comments. NHPCO is committed to continuing our work with MedPAC on this important issue and we look forward to working with MedPAC staff to analyze proposals on access to care and ensuring the quality of hospice care. If you have questions or to schedule a meeting, your staff should feel free to contact Logan Hoover, Vice President, Policy and Government Affairs at lhoover@nhpco.org.

Sincerely,

Ben Marcantonio
Interim Chief Executive Officer