February 16, 2024

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

RE: Request for Information for the Value-Based Insurance Design Model

Dear Administrator Brooks-LaSure:

As representatives and leaders of hospice providers and professionals who care for people affected by serious and life-limiting illness we appreciate the opportunity to provide feedback on the value-based insurance design model and to be partners in supporting patient-centered hospice and palliative care for Medicare beneficiaries.

For the reasons highlighted in this letter below, we urge the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation to move with caution when considering network requirements and prior authorizations for the hospice carve-in of VBID. Specifically, ***we urge CMS not to allow Medicare Advantage (MA) organizations to limit beneficiary access to in-network providers without sufficient guardrails in place to minimize any disruptions in care – and to not move forward with hospice prior authorization at this time***. Hospice is a unique sector of the healthcare field and was carved out of MA plans for a reason. As CMS moves forward with the inclusion of hospice into MA, it is imperative to consider patient choice and the importance of timely care access—given the median hospice length of stay is only 17 days in 2021[1] and, generally, hospices only have one opportunity to care for these patients.

Network Adequacy
As CMS considers network access requirements, it is imperative to understand the importance of patient choice and the stature of the hospice provider in the community. The ability of a terminally ill beneficiary to select an attending physician is a fundamental patient right under the Medicare hospice benefit. Limiting this selection to in-network practitioners and providers without appropriate safeguards would deprive patients and their loved ones at a time of utmost vulnerability of this critical choice—a core pillar of hospice. Hospice is the only Medicare benefit required to include volunteers in care delivery and provide four different levels of care, depending on the needs of the person receiving the care.

Another consideration before adding network adequacy requirements is the impacts of Certificate of Need (CON) for hospice services. Since 2011, CMS has defined an adequate MA network as meeting two criteria: a minimum number of providers and maximum travel time and distance to those providers. Because of variances in geography, as well as a potentially limited number of available providers in an area, in states with CONs, there may only be one or two providers offering hospice services in the service area. Further limiting options to patients by requiring patients to only select their hospice care from in-network providers could be detrimental to patients who are seeking these critically important services. We have grave concerns regarding how network adequacy will be determined when there is a limited number of providers in the area, particularly in CON states where access to hospice services is carefully preserved.

[1] See MedPAC March 2023 Report to Congress, Table 10-4.

Prior Authorization

In 2021, 10% of Medicare decedents received hospice care for only two or fewer days, and 25% of decedents were enrolled for only five or fewer days.[2] A delayed or denied prior authorization for hospice can mean the difference between a beneficiary accessing the hospice benefit they are entitled to or never being able to use it. Time is of the essence for these beneficiaries and their families, and the risk of a beneficiary—and also their loved ones–not being able to receive the support and care at the end of life is too great to rush into prior authorization policies without proper data and understanding of its impact.

As CMS acknowledged in the Advancing Interoperability and Improving Prior Authorization Processes final rule, "[p]atients need to have timely access to care, and providers need to receive timely responses to their requests for authorization to requests for services for their patients, particularly when waiting for answers can delay the pursuit of alternatives."[3] These delays are particularly devasting for individuals suffering from terminal illness. Hospice consists of a specialized focus on comfort and palliative interventions rather than curative or disease-modifying care, for which there are limited opportunities for any alternatives. Indeed, even MA expedited prior authorization review timeframes extend beyond what may be considered reasonable timeframes when patients urgently need this specialized care.

With only two years of VBID data available and only limited data on patient and family experiences, it is too early to implement a policy that would limit medically necessary access to hospice services.

Again, ***we urge CMS to be exercise extreme caution in creating policies that would limit beneficiary access to MAO networks and delay care through prior authorization procedures without appropriate safeguards in the value-based insurance design hospice carve-in***.

We have submitted additional individual comments but believe it important to share our unified comments with you as well. We welcome continued engagement with you and your staff and the opportunity to meet to discuss this further. Thank you for your commitment to supporting care for Medicare enrollees with serious illness.

Sincerely,

American Academy of Hospice and Palliative Medicine
National Coalition for Hospice and Palliative Care
LeadingAge
National Association for Home Care and Hospice
National Hospice and Palliative Care Organization
National Partnership for Healthcare and Hospice Innovation
Physician Associates in Hospice & Palliative Medicine

[2] See MedPAC July 2023 Health Care Spending and the Medicare Program Data Book, Chart 11-13.
[3] 89 Fed. Reg. 8758 at 8952.