



May 15, 2009

The Honorable Max Baucus
The Honorable Charles Grassley
Senate Finance Committee
215 Dirksen Senate Office Building
Washington, DC 20510

Re: Comments on Senate Finance Committee Policy Options for Transforming the Health Care Delivery System

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the National Hospice and Palliative Care Organization (NHPCO), the nation's oldest and largest hospice and palliative care leadership organization, I want to commend you and your colleagues for your efforts to reform our nation's health care system. As the organization representing the end-of-life care providers for more than 1.4 million patients and their families last year, and the hundreds of thousands of others who could have appropriately benefited from hospice services, we appreciate the opportunity to submit comments on the April 29, 2009 Health Care Delivery System Policy Options paper.

As you undertake efforts to reform the health care system, we understand the considerable challenges you face and hope these comments will help to inform your thinking about hospice and end-of-life care. As you consider hospice issues in the context of health reform, we would urge you to keep the following thoughts in mind regarding the Medicare hospice benefit. Eligibility for care should be based upon an assessment of the patient to ensure appropriate eligibility and supported, to the extent practical, by evidence-based guidelines. Patients and families should know what to expect and receive: consistent, measurable, and high-quality services delivered by a skilled interdisciplinary team within every hospice program in the country. Equally as important, the hospice and palliative care community must continuously demonstrate their commitment to program integrity, transparency, accountability and fiscal responsibility.

Section I: Payment Reform -- Options to Improve Quality and Integrity of Medicare Payment Systems

Payment for Transitional Care Activities

The options paper proposes reimbursing physicians under an integrated, transitional care management model for targeted interventions that have demonstrated success. In addition to this transitional care model for the chronically ill, we would encourage the Committee to consider a similar transitional care management model for Medicare beneficiaries approaching the end-of-life.

There are any number of studies and findings that readily point to a disproportionate amount of expenditures and health care system utilization in the last year of life. Medicare beneficiaries with advanced illnesses who are not yet eligible for the Medicare hospice benefit may not receive the necessary counseling, supportive services and pain and symptom management that would help them make informed choices about their care options and increase their quality of life. Without access to interdisciplinary care and palliative care expertise, a core competency of hospice programs, beneficiaries receive unnecessary treatments, hospitalization, imaging tests and other high-cost health care services that they otherwise may not elect.

Access to the proper tools and resources for end-of-life planning, including a new “transitional care management benefit” delivered by the hospice team for those with advanced illnesses, as well as the greater use of advanced directives, will enhance quality of life and increase the avoidance of unnecessary health care expenditures. This new “transitional care management benefit” provided by Medicare-certified hospices could be created to provide Medicare beneficiaries with advanced illnesses access to an episodic benefit including: palliative care services, end of life care planning, counseling, supportive services, and care management delivered by a hospice team prior to eligibility for the Medicare hospice benefit. As a result, patients and families would be able to make informed choices on their care options, variability in quality of care will be reduced, and interventions to manage suffering will increase, while the use of nonproductive care will decline.

NHPCO would encourage the Committee to also consider alternative care models for terminally ill patients who are not yet ready to waive their right to pursue ‘curative’ treatments to enter into hospice under Medicare. Currently, election of the Medicare hospice benefit requires beneficiaries to waive their right to payment for treatment, or any care related to their terminal diagnosis that is not provided or arranged by the hospice. In an effort to further reduce end-of-life care expenditures, NHPCO would propose that the Committee explore a concurrent model of care for terminally ill, otherwise hospice-eligible patients. Under this model, beneficiaries would receive hospice services concurrently with other Medicare-covered services related to their terminal diagnosis. By granting terminally ill beneficiaries, who might otherwise not elect hospice and palliative care, the option to seek concurrent care will likely reduce the overall Medicare costs for these patients. In particular, savings could be achieved through greater care coordination, more effective pain and symptom management and by avoiding costs related to unnecessary emergency room visits, ambulance charges, acute care hospital stays, and other expensive but futile care often provided at the end of life.

Additional details regarding the transitions care management model and the concurrent care model are provided as an addendum to our comments.

Section II: Long-Term Payment Reforms -- Options to Foster Care Coordination and Provider Collaboration

Chronic Care Management

CMS Chronic Care Management Innovation Center

Given the need for innovative approaches to increasing the quality of care and reducing expenditures, NHPCO supports the idea of authorizing a new center for the purpose of testing and disseminating payment innovations that foster patient-centered care coordination for high-cost, critically ill Medicare patients. The two options described above, Transitions Care Management Model as well as the Concurrent Care model are two excellent candidates for such testing and analysis.

Hospital Readmissions and Post-Acute Bundling Policy

There is much evidence and little doubt that preventing and avoiding hospital readmissions is an important objective in health care reform. Critical to such an effort is the recognition that end-of-life care is a specialized delivery system with a long track record of high-quality care being delivered in a cost-efficient manner.

Incentives, as well as adequate informational opportunities, ought to be provided in order to foster greater access to hospice services in this context, and if the Committee moves forward with a bundled payment system, that hospice be viewed as a logical “outlet” for these service packages, when the patients are appropriate candidates for end-of-life services. Care ought to be given that patients and families be made aware of and fully informed about their advance care planning opportunities. Early referrals of appropriate patients to hospice programs, under a bundled plan, ought to be encouraged.

Given the unique nature of the hospice payment and care delivery system, NHPCO would encourage the Committee to exclude end-of-life care from the proposed bundled service option set forth in your paper. Given its risk pooling approach to financing care at the end of life, hospice ought to remain outside efforts to package post-acute services. The Committee should also be aware that Bundling could have a significant impact on hospital referrals to hospice and could result in patients not receiving timely and appropriate access to hospice services. Any efforts to encourage greater efficiency and to reduce the number of hospital readmissions should not discourage or create incentives to steer patients away from hospice care that might otherwise be appropriate for a patient.

Section III: Health Care Infrastructure Investments -- Tools to Support Delivery System Reform

Health IT

The American Recovery and Reinvestment Act included incentives for physicians and hospitals to adopt and use electronic health record (EHRs). The hospice community would support expanding access to EHR Medicare incentive payment eligibility to Medicare certified hospice programs to assist in the purchase, use and training of professionals as they migrate to EHRs. The hospice community has been slow to adopt modern electronic data systems and because they typically deliver the vast majority of their care in the patient’s residence, enhanced services and

equipment is practically important. The availability of incentives, targeted toward the hospice and palliative care community, would greatly enhance the likelihood of EHRs being adopted and will help providers to compile more accurate and detailed data regarding services provided and further discussed below.)

Section V: Public Program Integrity -- Options to Combat Fraud, Waste and Abuse

Provider Compliance and Penalties

Integrity, Transparency, Accountability and Comprehensive Data Collection

To improve transparency and accountability in the hospice reimbursement system, Congress should expand upon the ongoing efforts of CMS, and require hospices to report more comprehensive data to reflect the number, type and length of services (including telephonic contacts) provided to Medicare patients by all members of the hospice interdisciplinary group and by all hospice employees and volunteers. These data collection mandates should be implemented following development of an appropriate data set. Data collection requirements should take into account the unique features of the Medicare hospice benefit, including the patient-centered focus on palliative care, the interdisciplinary team approach to providing care, and the provision of counseling and other services not otherwise covered by Medicare. CMS should first implement the enhanced data collection requirement through a pilot program of limited duration to test the accuracy and consistency of the data collection systems.

Hospice Financial Data -- Hospice cost reports should be changed to add new data fields to capture the full range of hospice revenues in order to provide a more accurate picture of hospice's financial performance for both freestanding and provider-based hospices. In addition, other refinements are necessary to ensure clarity and accuracy of data. Provisions should be made for cost reports to be audited by the fiscal intermediary or MAC contractor, to increase the accuracy of cost report data through feedback to providers and requests for corrections. Data can then be used more reliably in analyzing hospice payment issues. Such an effort should be undertaken with hospice community input, collaboration and cooperation, as well as input from other end-of-life care stakeholders.

Recertification of Long Stay Patients -- MedPAC recommended, and NHPCO supports, a requirement that either a hospice physician or other qualified healthcare professional visit the patient to determine continued eligibility prior to the 180-day hospice recertification and each subsequent recertification and attest that such visits took place. In addition, all recertifications should include a brief narrative describing the clinical basis for the patient's prognosis. All stays in excess of 180 days should be medically reviewed for programs for which stays exceeding 180 days make up more than 40 percent of their total cases. Special consideration ought to be given to the unique issues facing rural and small hospice providers in assessing the impact and implementation of such measures.

Increased Review by Appropriate Government Entities -- With the increased utilization of hospice care and growth in the number of providers, it is prudent to encourage appropriate local, state and federal government entities to review financial and contractual relationships between

hospices and other healthcare facilities that may give the appearance of a conflict of interest and potentially influence referrals to hospice. If any instances of fraud and/or abuse are discovered, they should be immediately reported to the appropriate authorities.

Increased Survey Frequency -- In order to assure that hospice patients and their families are receiving the highest quality of care available, CMS ought to be allocated adequate resources to implement a mandatory system of standard site surveys that are more timely than current practice and which occur at least as frequently as every three years. Such surveys should be undertaken by highly trained and competent governmental professional using the recently revised Hospice Conditions of Participation.

Paramount among our beliefs is making sure that future patients and families can access, in all service settings, the high-quality care that hospice and palliative care have come to symbolize. We very much appreciate the opportunity to comment on the options, as outlined in the document and pledge to work with the Committee in its efforts to reform the health care system. Should you have any questions or need additional information, please contact Jonathan Keyserling, Vice President for Public Policy and Counsel at (703) 837-3153.

Sincerely,

A handwritten signature in black ink, reading "J. Donald Schumacher". The signature is written in a cursive, flowing style.

J. Donald Schumacher, PsyD
President & CEO

ADDENDUM

There is a wealth of research that shows that there are disproportionate expenses in the last year of a patient's life. Many of these expenses are incurred on complicated and intensive interventions of questionable value and with questionable outcomes. Innovative approaches to better inform patients and families of the full range of options might help to avoid many of these costs and ensure the delivery of care that meets the needs of patients and their family. Such results might also be yielded by the development of a transitional care management model as well as a concurrent care model. By introducing good palliative care and the principles of hospice care earlier in the course of a condition, patients might be less inclined to continue pursuing futile treatments when hospice is the most appropriate care.

Transitional Care Management Model

Key Components of the benefit:

- **Eligibility** -- Medicare and Medicaid beneficiaries with a prognosis of 18 months or less to live would be eligible for transitional benefits from a hospice program.
- **Reimbursement for benefit would be episodic** -- payment would be based on the Medicare physician fee-schedule but would vary based on who was providing the service.
- **Services provided** -- would include: palliative care consultation services, care management, counseling of individual and family members, planning and supportive services, and encouragement of patient-centered care.
- **Delivery of services** -- would be modeled upon the existing delivery structure of the Medicare hospice benefit delivered by the hospice team. *Counseling regarding advanced care planning would be a required component of the delivery of services.*

Creation/Continuation of a Not-for-profit Care Planning Clearinghouse that provides an education campaign to raise public awareness of the importance of planning for care near the end of life, a publicly accessible national clearinghouse for downloading information about advance care planning resources, including state-specific advance directives forms, and other end-of-life planning materials and supports. (*Authorize \$1 million a year or such sums as necessary.*)

- **Hospice and end-of-life planning materials** such as advance directives and hospice benefit information, should be part of the "Welcome to Medicare" toolkit.
- **Convene an Advisory Board** for a period of three years composed of advocates, researchers, government officials, providers and other experts in the field –that would be dedicated solely to the issues surrounding advanced illnesses and end-of-life care and provides guidance on how to increase patients' quality of life, reduce current legal hurdles to the enforcement of advance directives, and encourage provider participation in educational and training activities surrounding advanced illnesses and end-of-life care planning.

Concurrent Care Model

Beneficiaries enrolled in this must be terminally ill, with a 6 month prognosis, the same prognosis requirement for eligibility under the Medicare hospice benefit. Terminally ill patients would be admitted to a hospice program but would not be required to waive their right to payment for all treatment related to their terminal condition that is not provided or arranged by the hospice. Within this care model, the hospice would be responsible for all care related to palliation and management of the terminal condition, and would bill Medicare for the hospice care provided under the Medicare hospice benefit. The beneficiary also would be permitted to access all other Medicare covered services, and the providers of those services would bill and be paid by Medicare as they would if the beneficiary had not elected the hospice benefit.