July 27, 2015

Mr. Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244–8016

Attention: CMS–2390–P

Dear Mr. Slavitt,

NHPCO appreciates the opportunity to comment on CMS 2390-P, Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability. NHPCO is the largest membership organization representing the entire spectrum of not for profit and for profit hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice locations and more than 70,000 hospice professionals in the United States, caring for the vast majority of the nation’s hospice patients. The organization is committed to improving end-of-life care and expanding access to hospice 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.

Hospice providers are an integral player in the health care continuum, providing care to Medicare, Medicaid, and Medicaid Managed Care beneficiaries. In some cases hospice care is included in the services covered by Medicaid managed care plans, but often it is not, even though hospice patients may be enrolled in Medicaid managed care plans for other aspects of their care, and continue to receive certain non-hospice services through the plans after electing to receive hospice care. In reading the proposed rule, the word “hospice” only appears one time in the document at 438.10(c)(4)(i) in an extensive list of services that must be defined by plans.

Hospice providers are concerned that hospice is not being addressed as changes are being made to modernize Medicaid and increasing numbers of Medicaid beneficiaries are enrolled in managed care plans. This has become more prevalent as long term care has been included within Medicaid managed care. Our members and state hospice organizations report that in their dealings with Medicaid managed care, hospice care often is simply forgotten, or is not understood and therefore not addressed
by state Medicaid agencies or managed care plans in a way that is consistent with the Medicaid statute, or with the way hospice care is provided. Not only does this result in significant administrative burdens and expense for hospices, but also results in poor care coordination. More importantly, it burdens patients and families at what is often the most vulnerable and difficult stage of their lives.

As detailed below, we welcome the opportunity to comment on this proposed rule. We ask CMS to provide guidance and clarification to state Medicaid agencies and plans regarding the existing statutory requirements, and the provision of hospice care to Medicaid beneficiaries. This includes all beneficiaries who are enrolled in Medicaid managed care plans, whether they receive all of their care through the plan, or only their non-hospice care. This also includes all those who are dually eligible for Medicare and Medicaid, in which case they would receive hospice care through their Medicare benefit but may rely on Medicaid managed care for nursing home or other services not covered under the Medicare hospice benefit, or not included in the per diem hospice payment.

**The Medicaid Hospice Benefit - Statutory Requirements**

**Medicaid Hospice Benefit:** Although hospice is an optional Medicaid benefit, 49 states have opted to include hospice care in their Medicaid benefit, and the Medicaid statute requires that for the most part the Medicaid hospice benefit must mirror the Medicare hospice benefit.\(^1\) This includes the requirement to provide all levels of hospice care\(^2\), and that in electing to receive hospice care, individuals do not waive their right to continued payment for physician services provided by their attending physician (if not an employee of the hospice) or provided or arranged by the hospice program.\(^3\) The Medicaid statute even requires that the state pay for hospice care “in amounts no lower than the amounts, using the same methodology, used under Part A [of Medicare].”\(^4\)

**Payment for room and board services for dually eligible individuals:** The statute also addresses the provision of hospice care to individuals residing in nursing facilities. Given the age and demographics of most hospice patients this is not uncommon and many hospice patients are dually eligible for both Medicare and Medicaid. The statute provides that when a patient who elects the hospice benefit is residing in a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID)\(^5\), and they are, or would be, eligible to have that facility care covered by Medicaid if they hadn’t elected to receive hospice care, the state is to make a payment to the hospice to cover the room and board furnished by the facility, and that payment must be equal to at least 95% of the rate that would

\(^1\) Social Security Act §1905(o); §1902(a)(13)(B)

\(^2\) Social Security Act §1905(o)(1)(A), which cross references §1861(dd)(1) and (2) regarding the Medicare definitions of hospice care and hospice program. The four levels of hospice care are Routine Home Care, Inpatient Respite Care, Hospice Inpatient Care, and Continuous Care. The vast majority of hospice care is provided at the Routine Home Care level.

\(^3\) Social Security Act §1905(o)(1)(A), which cross references §1812(d)(2)(A).

\(^4\) Social Security Act § 1902(a) (13) (B).

\(^5\) The statute still uses the outdated term "intermediate care facilities for the mentally retarded".
have been paid by the state for that individual’s care in that facility. This is separate from coverage for their hospice care. The hospice then pays the facility for the room and board services. This is the case both for dually eligible individuals as well as those only eligible for Medicaid.

**NHPCO Comments Regarding the Proposed Rule**

**Confusion and inconsistency:** Currently, there is a great deal of confusion and inconsistency regarding the provision of, and reimbursement for, hospice care for individuals enrolled in Medicaid managed care, and this will increase as more states enroll Medicaid recipients in managed care plans and include long term care and dual eligible individuals in these plans. While we believe, as noted below, that consideration of hospice care should be included in some specific provisions of the proposed regulations, more generally we ask that in the final rule, and going forward, CMS provide clarification and guidance to state Medicaid agencies and plans regarding the provision of hospice care to individuals who receive some or all of their care through Medicaid managed care plans, and insure that this is included in plan contracts, policies and procedures.

**Access to hospice services:** Hospice is a small part of the overall health care system, and it includes some unique features, but it is essential that all terminally ill Medicaid beneficiaries who elect to receive hospice care are provided access to it, and are provided with the full package of hospice benefits. It is also essential that their final days, weeks or months aren’t burdened with administrative complexities caused by a managed care plan’s lack of knowledge or understanding. Timely and efficient access is particularly important given that 34.5% of patients enrolled in hospice die within 7 days, and 61.5% die within one month. Our hospice members who are already dealing with Medicaid managed care plans on behalf of their patients tell us that the plans, and states, generally want to do the right thing; they simply don’t understand the hospice benefit and/or have failed to address it in their plan documents and policies.

**Challenges:** To illustrate the challenges, some examples of problems that our members report having with patients who receive some or all care through Medicaid managed care plans are as follows:

- When hospices seek to contract with a Medicaid managed care plan, they are sent a template contract that doesn’t address any hospice-specific issues, including requirements for different levels of hospice care, billing for services that are payable outside the hospice per diem rate

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6 See also, 1905(o)(3) regarding individuals who are dually eligible for Medicare and Medicaid.


8 Ibid.
(such as physician services), or room and board payments for patients residing in nursing facilities.

- Plans impose unwieldy prior authorization requirements for hospice care or for specific levels of hospice care, such as Hospice Inpatient Care or Continuous Care. As noted above, many patients come to hospice with only days or a few weeks to live. If a hospice patient needs Inpatient Care or Continuous Care, it’s because their symptoms have become unmanageable and they typically are in crisis. Requiring patients and hospices to go through a time consuming and complex prior authorization process burdens patients and families at what is already a particularly difficult time.

- Plans don’t understand the room and board payment requirement for hospice patients in nursing facilities or intermediate care facility for individuals with intellectual disabilities (ICF-IID). Plans often deny this as a non-covered service or require special authorization. They may also pay the facility directly even though the statute requires that the payment be made to the hospice, and the hospice may already have paid the nursing facility or ICF-IID under an existing contract. We understand that nursing home room and board payments in the hospice context are unique, but CMS needs to provide guidance and ensure that when nursing facility or ICD-IID care is covered under Medicaid managed care, plans are providing and paying hospices for room and board as required by statute.

- When Medicaid managed care enrollees elect hospice, plans often refuse to pay for anything outside the hospice per diem payment, such as attending physician services or care that would otherwise be covered by the Medicaid managed care plan and that is unrelated to the patient’s terminal prognosis. There is misunderstanding and confusion among plans, whether they are covering the hospice care or if the hospice care is not provided under Medicaid managed care but the plan continues to be responsible for certain other services. CMS should educate state Medicaid agencies and Medicaid managed care plans about the scope of the hospice benefit and their responsibilities. This may require coordination of care provided both within and outside the plan’s coverage.

- Looking forward, payment complexities are likely to increase as the payment methodology for the Medicare hospice benefit changes. In the FY2016 Hospice Wage Index proposed rule, CMS proposed a new 2 tiered payment rate for hospice Routine Home Care (RHC), based on a patient’s number of days in hospice care, and a new Service Intensity Add-On (SIA) payment for hospices when they provide visits involving certain skilled services to patients during the last week of life. Since the statute requires Medicaid to pay for hospice care in the same amounts, using the same methodology, as Medicare, these new payment rates and methodologies will have to be incorporated into Medicaid programs.
In our discussions with state leaders, they report that many, if not most, state Medicaid agencies, are unaware of this proposed change and unprepared to make changes in the hospice reimbursement system at the state level, or to communicate the statutory requirements for the Medicaid hospice benefit to Medicaid managed care organizations. As we noted to CMS in our comments on the proposed Medicare rule, we also believe that many state Medicaid plans don’t currently have systems that would allow hospice providers to view a patient’s history in hospice in order to determine the count of days and bill at the correct RHC rate. NHPCO has significant concerns about the ability of CMS, the MACs, state Medicaid agencies, and hospices to be able to implement these system changes without considerable problems. Adding Medicaid managed care plans to the mix introduces further complexities.

**NHPCO Comments on Specific Sections of the Proposed Rule**

In addition to our general comments and our request that CMS provide guidance and clarity regarding care provided to hospice patients who are enrolled in Medicaid managed care plans, whether the plans cover the hospice care or cover other care to which the patients are entitled, we provide the following comments regarding specific provisions of the proposed regulations:

**42 C.F.R. §438.3—Standard contract requirements**

This proposed regulation would require (in subsection (a)) that CMS review and approve all MCO, PIHP and PAHP contracts; would require (in subsection (f)) that all contracts comply with applicable federal laws; and would require (in subsection (t)) certain coordination of benefits for individuals dually eligible for Medicare and Medicaid.

- CMS should ensure that all Medicaid managed care contracts address access to, provision of, and payment for hospice services for Medicaid-eligible individuals, whether or not the plan itself covers the hospice care. In addition, if the plan covers nursing facility and/or ICF-IID facility services, the contracts should address how room and board payments should be made when residents of these facilities elect to receive hospice services and the plan would otherwise cover services for these individuals in these facilities. The Coordination of Benefits agreement should address how benefits are to be coordinated when dually eligible individuals are receiving Medicare hospice care but also are eligible for Medicaid benefits, including nursing home room and board, through a Medicaid managed care plan.

**42 C.F.R. §438.10 (g) and (h)—Information requirements**

This proposed regulation specifies certain information that plans must provide to enrollees and potential enrollees. Subsection (g) specifically addresses requirements for the enrollee handbook, and subsection (h) addresses requirements related to the provider directory.
CMS should ensure in the final rule that this includes information about hospice care and electing the hospice benefit, to enable the enrollee to understand what hospice is and how to access it. In addition, specific information should be included in the enrollee handbook for individuals residing in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID) on how to access hospice services, and payment for room and board services. If hospice care is covered by the plan, hospices should be added to the list of provider types in proposed §438.10(h)(2) for which the plan must provide specific information in their provider directory.

42 C.F.R. §438.66—State monitoring requirements

This proposed regulation would require the state agency to have a monitoring system for all managed care programs.

CMS should ensure that the state monitoring system includes claims management monitoring for appropriate payment amounts and payments for hospice services and room and board services. CMS also should ensure that providers have a mechanism for addressing systemic concerns, separate from the appeals process available to individual beneficiaries. Our members report that it is often difficult to identify a central contact within the Medicaid managed care plan with whom to discuss general concerns or systemic issues related to how the plan deals with enrollees who are receiving hospice care.

42 C.F.R. §438.68—Network adequacy standards

This proposed regulation addresses the obligation to establish and enforce network adequacy standards.

CMS should ensure that if a plan includes coverage of hospice services, they must contract with an adequate number of hospices serving all areas in which plan enrollees reside.

42 C.F.R. §438.70—Stakeholder engagement when LTSS is delivered through a managed care program

This proposed regulation requires the state to solicit input from a broad range of stakeholders when LTSS is delivered through managed care.

Since hospice is often offered as a part of community-based and facility-based LTSS services, the final rule should specify hospice providers among the stakeholders to be included in stakeholder meetings and engagement.

42 C.F.R. §438.206—Availability of services

This proposed regulation requires the state to ensure that “all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.”
• Although hospice is an optional benefit under Medicaid, it is offered in 49 states and states should ensure that it is available and accessible to enrollees of Medicaid managed care plans, whether through the plan or otherwise.

42 C.F.R. §438.208—Coordination and continuity of care

This proposed regulation requires the state to ensure through its contracts that plans implement procedures to provide coordination and continuity of care for plan enrollees.

• Care coordination is essential for hospice patients, and since plan enrollees may receive all care through the managed care plan, may receive their hospice care outside the plan but continue to receive other services through the plan, and may be dually eligible for Medicare and Medicaid, CMS should require states to ensure that plans address the coordination of care for all enrollees receiving hospice care, even when the hospice care itself is not provided by the plan.

42 C.F.R. §438.210—Coverage and authorization of services

This proposed regulation requires contracts between the state and plans to identify, define, and specify the amount, duration, and scope of services the plan is required to offer, and that this be no less than the amount, duration, and scope of the same services provided under fee for service Medicaid. Subsection (b) also addresses plan requirements for authorization of services, and subsection (d) establishes timeframes for authorization decisions.

• As noted above, both states and plans need guidance from CMS regarding the coverage of hospice services for Medicaid beneficiaries, and how services are to be provided to Medicaid managed care enrollees, whether all of their care is provided through the plan, or only some of their care is provided by the plan and some through fee for service Medicaid or through Medicare.

Pediatric Concurrent Care Benefits

NHPCO also wants to flag for CMS the statutory requirement to provide “pediatric concurrent care” for children covered by Medicaid or CHIP programs, as more children are now covered by Medicaid managed care or CHIP programs. Ordinarily the election to receive hospice care requires individuals to waive their right to other curative or non-palliative services that are related to their terminal prognosis. However, the Affordable Care Act amended Section 1905(o)(1) of the Social Security Act to allow terminally ill pediatric patients who have elected the hospice benefit to continue to receive Medicaid and CHIP services “without forgoing any other service to which the child is entitled under Medicaid for treatment of the terminal condition.” This is referred to as “concurrent care for children”.

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9 State Medicaid Director Letter, #10-018, Re: Hospice Care for Children in Medicaid and CHIP, September 9, 2010.
To explain this benefit, on September 9, 2010 CMS issued a State Medicaid Director Letter (#10-018) that states:

Section 2302 of the law amends sections 1905(o)(1) and 2110(a)(23) of the Social Security Act to remove the prohibition of receiving curative treatment upon the election of the hospice benefit by or on behalf of a Medicaid or Children’s Health Insurance Program (CHIP) eligible child.

Hospice services are covered under the Medicaid and CHIP programs as an optional benefit. However, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provision requires Medicaid and CHIP programs operating as Medicaid expansions to provide all medically necessary services, including hospice services, to individuals under age 21. In order to qualify for the hospice service in either Medicaid or CHIP, a physician must certify that the eligible person is within the last 6 months of life.

The Affordable Care Act does not change the criteria for receiving hospice services; however, prior to enactment of the new law, curative treatment of the terminal illness ceased upon election of the hospice benefit. This new provision requires states to make hospice services available to children eligible for Medicaid and children eligible for Medicaid-expansion CHIP programs without forgoing any other service to which the child is entitled under Medicaid for treatment of the terminal condition. These services and supports may include pain and symptom management and family counseling provided by specially-trained hospice staff. States with stand-alone CHIP programs continue to have the option to provide hospice services, but if they cover hospice services they must comply with the new requirements under the Affordable Care Act.10

**NHPCO Comments**

**Lack of awareness of concurrent care for children provision:** State hospice leaders report that as states have moved toward enrolling more Medicaid beneficiaries in managed care, plans are completely unaware of the statutory requirement to offer concurrent care for terminally ill children covered by Medicaid or CHIP. One state reports: “Medicaid managed care vendors have stated that they ‘don’t do pediatric palliative care,’ even though the state has a State Plan Amendment addressing this issue. Another state leader reports that the Medicaid managed care entities in their state asked “what is pediatric palliative care?” Because the number of terminally ill children is small, requests for pediatric concurrent care payments easily “fall through the cracks” and often there is confusion among providers about how, or if, they can bill, after the child has elected their hospice benefit. Often, payment to the hospice is “per visit” reimbursement, rather than the hospice per diem reimbursement, or the Medicaid MCO wants to pay a lower daily rate than is statutorily required.

10 State Medicaid Director Letter, #10-018, Re: Hospice Care for Children in Medicaid and CHIP, September 10, 2010.
Implementation in all states: NHPCO continues to be concerned that the pediatric concurrent care benefit has not been uniformly implemented in all states, whether or not Medicaid managed care is involved. With Medicaid expansion under the ACA, and states providing more Medicaid services through managed care plans, CMS should provide clarity in the final rule about the ACA statutory provision for concurrent care for children, and require that it be addressed in state contracts with Medicaid managed care organizations.

CHIP: The pediatric concurrent care provision applies to both Medicaid Managed Care Organizations and to the CHIP program. In the final rule, we request that CMS address the requirement to provide pediatric concurrent care benefits to children covered by Medicaid or CHIP who are receiving their care through managed care plans.

NHPCO stands ready to discuss our comments for further clarification and to work with CMS in whatever ways possible as we move toward the final rule and beyond. Thank you for the opportunity to comment.

Sincerely,

J. Donald Schumacher
President and CEO
National Hospice and Palliative Care Organization