

August 31, 2022

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

RE: CMS-4203-NC Request for Information: Medicare Program

Dear Administrator Brooks-LaSure:

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to provide comments on Request for Information: Medicare Program (CMS-4203-NC) as it pertains to hospice and palliative care.

NHPCO is the nation's largest membership organization for hospice providers and professionals who care for people affected by serious and life-limiting illnesses. 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. In addition, hospice and palliative care members employ thousands of professionals and volunteers.

Our comments focus on the discharge planning requirements on the care hospice and palliative care providers offer patients with serious and life-limiting illnesses and their families. We have provided comments below:

Health Equity

1. *What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:*
 - a. *Enrollees from racial and ethnic minority groups.*
 - b. *Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation.*
 - c. *Enrollees who identify as transgender, nonbinary, or another gender identity.*
 - d. *Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life.*
 - e. *Enrollees with diverse cultural or religious beliefs and practices.*
 - f. *Enrollees of disadvantaged socioeconomic status.*
 - g. *Enrollees with limited English proficiency or other communication needs.*
 - h. *Enrollees who live in rural or other underserved communities.*
- **Improve data collection:** Providers need better access to better data. Providers collect data on their patient populations but need access to data representative of the entire community they serve. Knowing who is in the community will allow providers to improve outreach strategies and communication. MA plans and CMS are better equipped to collect and share these data. We

recommend the development of a universal database accessible across government to enable programs to accurately assess the extent of the disparities and barriers existing today and to measure progress made in promoting health equity over time.

- **Support and funding:** Providers are trying to create the infrastructure to foster access and inclusion to the entirety of the community they serve; however, many lack the support and funding to have comprehensive infrastructure. Improvement takes staffing and funding, and providers are already stretched thin in both regards. CMS can support these providers through funding opportunities and the development of resources.

2. *What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?*

CMS and MA should develop a focused campaign of targeted outreach to traditionally underserved groups which are individualized to the unique needs and concerns of these populations. The challenge in a targeted approach such as this relates to CMS regulations regarding what is messaged to beneficiaries and how the messaging must be done; however, NHPCO strongly believe such an approach would yield benefits to populations who could benefit from the flexibilities and benefits which come from MA plans.

NHPCO recognizes the urgent need for more equitable policies, programs, and innovations for all patients with serious and life-limiting illness, and we are committed to supporting our hospice and palliative care community as they do all they can to provide high quality, comprehensive, and holistic care. Below are some recommended policies, programs, and innovation to advance health equity in MA:

- **Diversity and outreach teams:** Employ robust Diversity and Outreach teams and identify lay community leaders to serve as community liaisons to participate in community gatherings as well as work with social services agencies and community centers.
- **Job marketing, education, and community outreach:** Open recruitment, creating kiosks for applications in communities with no access to computers, creating employee resource groups, and providing employees the opportunity to conduct remote work for those who want to stay in their communities. Improve recruitment of multilingual and multicultural staff supporting MA plans and working with beneficiaries.
- **Educational efforts:** Use of educational efforts, such as partnering with historically Black colleges and universities to recruit minority health care leaders, making use of apprenticeship programs enacted by state legislatures, creating a program to provide funding and education to individuals in underserved communities pursuing a degree in health care, and providing scholarships for current staff members to continue education.
- **External groups to promote employment and leadership opportunities:** Work with multicultural associations to advise them of employment and leadership opportunities, as well as working with informal community leaders about applicable choice of language when discussing benefits with diverse populations.

- **Engage with the community:** Engage with the community through different programming efforts, including presentations at places of worship in the community, annual lectureships for the community, and involvement in weekly farmers' markets and faith-based and minority outreach programs.
- **Provide education widely:** Work with local educational institutions and provide education to local hospitals, nursing homes, and assisted living facilities, as well as others on MA plans and structures.
- **Community advisory board:** Establish a community advisory board with community representation from organizations established to serve minority and culturally diverse populations.

Many NHPCO hospice and palliative care providers have noted difficulty in data collection and analysis to measure the impact of diversity, equity, and inclusion efforts on health equity outcomes. CMS can better support data collection for these programs through:

- **Use of CAHPS® hospice survey:** Providers have mentioned the utilization of the CAHPS® hospice survey as a way to identify the details of health equity in care delivery. There is a need for more data to be gathered so hospices can identify service trends and better understand methods garnering the largest positive effects on health equity. In considering CAHPS® survey for this use, the survey must include enough detail and nuance to ensure inclusivity of different identities (e.g., gender identity, multiracial and ethnicity options, socioeconomic status, etc.) and strategies to address SDOH.

Currently, the CAHPS® hospice survey does not include any information to directly assess health equity. While assessment of the current domains (e.g., communication skills of providers, ease of access to health care services and patient experience) are particularly important for delivery of quality care, these measures need to be able to be compared across relevant demographic information. As recommended by the Institute for Healthcare Improvement, each hospice should collect, at a minimum, race/ethnicity, socioeconomic status, gender, and a measure of geography such as zip code or US Census tract.

- **Development of universal database:** We support the development of a universal database that will be accessible across the government and will enable providers and MA plans to accurately assess the extent of the disparities and barriers existing today and to measure progress made by providers in promoting health equity over time. This database should be informed by stakeholder feedback to ensure the identification of the right key metrics, encourage data standardization, and incentivize investment in data collection and submission, e.g., investment by electronic medical record (EMR) and electronic health record (EHR) vendors to require interoperability when collecting these important data points. This would also require substantial investment in home and community-based providers' access to the technology necessary to assure interoperability.
- **Community assessment:** MA plans should be able to compare the demographics of the provider's patient population to local population data to determine the provider's reach in the community, identify areas for improvement and assessment of quality care measures as they are rated by diverse racial and ethnic groups, diverse SES groups, and diverse sexual orientation identities.

3. *What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?*
- **Use of standardized SDOH screening tools:** Enrollment documents should ask questions specifically related to SDOH needs of the beneficiaries; responses could better identify those at risk as well as align beneficiaries' self-identified needs with available supportive offerings by the MA plans.
 - **Poorly suited Electronic Medical Record (EMR) systems:** EMR systems may not be well suited to collect accurate information on gender, sexual orientation, SES, or race/ethnicity identities. For example, many only ask participants to choose "one" option out of several races and ethnicities, which overlooks those of mixed races and ethnicities. Gender is also still binary, disregarding patients who may identify as non-binary. CMS should develop a standard set of data points for EMR vendors to use to gather this data across provider types and can provide support to strongly encourage updates to EMR systems and interoperability.
 - **Limitations and lack of DEI specificity in the CAHPS® survey:** Further, while providers have indicated the utilization of CAHPS® report, they also noted a need to develop more data collection methods to analyze and qualify impacts on health equity. Having the CAHPS® survey only as a mail or phone survey is a significant barrier to collecting data. CAHPS® email availability would increase responsiveness for some, but at the same time may be a barrier to others. Utilizing both email, phone and mail options may increase participation.
4. *What have been the most successful methods for MA plans to ensure access to language services for enrollees in different health care settings? Where is improvement needed?*
- **MA staff representative of communities served:** MA plans can make a substantial difference in access to language services by employing people from the community being served. These individuals will be able to provide language appropriate materials and help target the community appropriately. In addition, these individuals should be able to provide simplified language to help beneficiaries understand the differences of various MA plans.
5. *What socioeconomic data do MA plans leverage to better understand their enrollees and to inform care delivery? What are the sources of this data? What challenges exist in obtaining, leveraging, or sharing such data?*
- **Transparency in data:** Currently, providers are struggling to access data about their patients generated by the MA plans. Providers share data on enrollment, services, and regular clinical notes with the MA plan. However, MA plans do not share any comprehensive data analysis about enrollee utilization of hospice and palliative care services. Hospice and palliative care provider can use these data for planning and to adjust their processes. When providers do receive the more comprehensive data analysis, it is not until the data is outdated. For example, palliative care utilization data.

- **Data on beneficiaries above the Federal poverty line:** Some MA plans have missing data on beneficiaries above the Federal poverty line but who still are impacted by SDOH. The collection of these data is essential to have a comprehensive view of enrollees and their communities.

6. *For MA plans and providers that partner with local community-based organizations (for example, food banks, housing agencies, community action agencies, Area Agencies on Aging, Centers for Independent Living, other social service organizations) and/or support services workers (for example, community health workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, how have the compensation arrangements been structured? In the case of community-based organizations, do MA plans and providers tend to contract with individual organizations or networks of multiple organizations? Please provide examples of how MA plans and providers have leveraged particular MA supplemental benefits for or within such arrangements as well as any outcomes from these partnerships.*

No comment

7. *What food- or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are MA Special Needs Plans (SNPs) targeting enrollees who are in most need of these benefits? What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes.*

No comment.

8. *What physical activity-related supplemental benefits do MA plans provide today? At what rate do enrollees use these benefits? How do these benefits improve enrollees' health? What physical activity-related policy changes within the scope of applicable law could lead to improved health for MA enrollees?*

No comment.

9. *How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?*

No comment.

10. *How have MA plans and providers used algorithms to identify enrollees that need additional services or supports, such as care management or care coordination? Please describe prediction targets used by the algorithms to achieve this, such as expected future cost and/or utilization, whether such algorithms have been tested different kinds of differential treatments, impacts, or inequities, including racial bias, and if bias is identified, any steps taken to mitigate unjustified differential outcomes. For*

MA plans and providers that do test for differential outcomes in their algorithms, please provide information on how such tests function, how their validity is established, whether there is independent evaluation, and what kind of reporting is generated.

No comment.

11. How are MA plans currently using MA rebate dollars to advance health equity and to address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?

No comment.

Expand Access: Coverage and Care

1. What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

- **Care navigators are needed to support beneficiaries:** Beneficiaries need additional support to wade through all the possibilities among MA plans. Specifically, providers have seen care navigators and social workers as key to helping beneficiaries move beyond decision paralysis.
- **Comparison of services:** A helpful tool for beneficiaries would be a comparison of services between MA plans. Beneficiaries, their family members, and providers all struggle to discern the differences and similarities of plans and definitions of services.
- **Supplemental services:** Beneficiaries need additional understanding of the supplemental benefits being offered by the MA plan and how these benefits may support their needs. The information can be confusing and challenging to apply to an individual beneficiary's circumstances.

2. What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

- **Gaps in coverage between hospice discharge and MA benefits:** Beneficiaries need additional information regarding the gap of time between when they choose to leave hospice care and before their MA plan begins again on the first of the following month. Hospice providers have worked with patients who elect to leave hospice to have an acute procedure; however, the beneficiary did not realize they would be without coverage until the first of the following month. This can be detrimental to beneficiaries receiving the care they urgently need or want.

3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?

- **Description of hospice and palliative care benefits:** MA plans must improve the description of both hospice and palliative care benefits. In regard to hospice, providers are finding enrollees who are unaware of the services included in the hospice benefit. Enrollees also struggle with switching

to Traditional Medicare for hospice and continuing with their MA plan for other coverage, except in the MA VBIID Hospice Component. In addition, patients who transfer out of hospice are not aware they will have to wait until the beginning of the following month before their MA plan is in effect again.

In regard to palliative care, MA plans should come to a consensus on what is provided by a palliative care benefit for enrollees. CMS should determine the minimum set of services to be provided through palliative care. Without a core set of services for palliative care, both the services offered and how the care is delivered becomes inconsistent across MA plans. Enrollees do not understand what may be included in their palliative care benefit, and providers struggle to meet the various expectations each MA plan considers to be palliative care services. Enrollees also struggle to understand when the transition from palliative care to hospice care is appropriate.

- **Direct mail marketing:** Direct mailers in plain English or in the enrollee's preferred language can be beneficial in communicating the benefits an enrollee will receive. These mailers should have concise bulleted lists, should come from a source recognizable to the enrollee, and with images representative of their community. In addition, MA plans should encourage an enrollee to share the information with a trusted family member or friend to increase the likelihood the information is understood.

4. *How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?*

No comment.

5. *What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?*

- **Benefits of telehealth:** Telehealth can be beneficial in accessing patients and communities who have limited access to transportation and allow check in with patients. Through telehealth, providers can share appointment links with long distances family members so they can, with the patient's consent, be included in care planning and decision making.
- **Audio-only telehealth:** To address broadband access issues in rural and frontier communities, CMS and MA plans should allow audio-only telehealth visits for some services. Although audio-only visits cannot address all issues and are not appropriate in all situations, it is important to provide this minimum standard for some communities.
- **Lack of comfort with technology:** Many patients still find the technology difficult and impersonal. A sizable portion of the current population of Medicare eligible enrollees are not comfortable with the technology necessary for telehealth and require instructions and setup prior to the first telehealth appointment. CMS can support this through resources explaining the benefits and how to get the most from telehealth visits.

- **Telehealth codes or modifiers:** As recommended by MedPAC, CMS should develop codes or modifiers for telehealth visits. Without consistent tracking of telehealth visits, there are limited ways to accurately measure the quality or impact of telehealth on MA.
- **Telehealth best practices:** CMS could improve telehealth services by providing guidance and best practices for both the provider and the patients. Areas of focus should include:
 - Telehealth goals
 - Personnel needs
 - Accessibility and equity
 - Privacy considerations
 - Preparing for and completing a telehealth visit

6. *What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?*

- **Data to inform network development:** When MA plans began to form their networks, they turned to data. This included their existing relationships with providers as well as publicly available data from CMS on utilization, quality, and satisfaction to understand the model and how to optimize care for the plan's members. Typical sources include Medicare Care Compare, which includes quality data from the Hospice Item Set (HIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] Survey, and the Hospice Provider Utilization and Payment Public Use Files (PUF) with information on characteristics of beneficiaries served, service utilization, and payment. Additionally, plans sought to determine the breadth of services available through the hospice provider, including capabilities and inclination of hospice providers to deliver palliative and concurrent care services. Plans also reviewed hospice patient volume for the hospices in the markets identified by the MA plan for the model.
- **Hospice provider outreach to MA plans:** Hospice organizations have reported proactive outreach to MA plans, specifically sharing their quality and performance data, as well as data points of specific interest. Data points included clinical expertise with specific non-cancer diagnoses, percentage of care provided at home, and ability of the hospice to help the MA plan with avoidable hospitalizations. In addition to having positive scores in Care Compare and with Hospice CAHPS[®], hospices can demonstrate to MA plans how the hospice organization can be a strong partner. This includes appropriately utilizing the different levels of care available to hospices, based on patient need, as well as being mindful of overall health care spending.
- **Future networks:** Hospice providers have expressed concern about the future networks for hospice services and whether the enrollee will have a choice of hospice providers as narrow networks are identified in later years of the model.
- **In-network v. out-of-network:** There is still confusion between in-network and out-of-network identifiers for providers. While providers understand each MA plan may have different criteria for in-network providers, it would be helpful to have CMS guidance about how the network adequacy

process works. There are questions on how in-network providers are being selected and what benefits there are compared to out-of-network providers for hospice services.

- **Palliative care network adequacy:** Due to a lack of consistency in how palliative care is defined across MA plans, providers may struggle to meet the expectations of what types of care or services should be provided when multiple plans are available for contracting. MA plans may fail to invite hospice providers to provide non-hospice palliative care services, although hospice providers may already offer this line of service. Instead, MA plans may choose to contract with stand-alone vendors or other providers of palliative care which can impact quality of care delivered to beneficiaries and may delay transition to hospice, when the time for that level of care arrives. Determining a core set of palliative care services and including hospice providers in these networks will strengthen network adequacy and allow for more seamless transitions across the continuum of care. Hospice and palliative care providers alike are deeply embedded in local communities and their service areas are often broader than the zip-code where their main offices are located. To ensure access to high-quality palliative care and an adequate network of providers, we strongly encourage CMS to establish a minimum set of core services for palliative care benefits, and for MA plans to be encouraged to innovate from this baseline.
- **Certificate of need:** There are some states where a state law requires Certificate of Need for hospice services. In many of those states, there are only one or two providers offering hospice services in the service area. How will network adequacy be determined when there is a limited number of providers in the area?

7. *What factors do MA plans consider when determining which supplemental benefits to offer, including offering Special Supplemental Benefits for the Chronically Ill (SSBCIs) and benefits under CMS' MA Value-Based Insurance Design (VBID) Model? How are MA plans partnering with third parties to deliver supplemental benefits?*

- **Better monitoring of SSBCIs:** Supplemental benefits, such as palliative care, are key to increasing support for beneficiaries living with serious illnesses and the addition of the SSBCIs to MA is a welcome addition. However, the reporting on the utilization of such benefits is inconsistent, which makes it difficult to determine if these services are helping beneficiaries. We would recommend improved monitoring of these supplemental benefits by plan and for combined summary of all MA plans so that providers who contract with the MA plan for supplemental benefits will be able to access information on utilization and volume.
- **Minimum set of services for palliative care:** MA plans should provide a minimum set of services provided through the palliative care supplemental benefit. Without minimum set of defined services for palliative care, the delivery of services and the method of delivery, either in person or by phone, is inconsistent between plans and enrollees. In addition, enrollees do not understand the benefit, and providers struggle to define the services.

8. *How are enrollees made aware of supplemental benefits for which they qualify? How do enrollees access supplemental benefits, what barriers may exist for full use of those benefits, and how could access be improved?*

- **Enrollees are unaware of supplemental benefits:** Hospice and palliative care providers are finding enrollees are not aware of the supplemental benefits of their plans and when reaching out to MA call centers, there is limited information or ability to communicate the benefits to the enrollee.
- **Employees across MA plans may not be aware of supplemental benefits:** Hospice and palliative care providers report even MA employees are not fully aware of supplemental benefits being offered to seriously ill patients. We encourage broad education to entire organizations about supplemental benefits so staff can support enrollees access the care they need when they qualify for these additional supports.

9. *How do MA plans evaluate if supplemental benefits positively impact health outcomes for MA enrollees? What standardized data elements could CMS collect to better understand enrollee utilization of supplemental benefits and their impacts on health outcomes, social determinants of health, health equity, and enrollee cost sharing (in the MA program generally and in the MA VBID Model)?*

- **Data collection:** Data on supplemental benefits should have the capability of being analyzed to include the following, at a minimum:
 - Race and ethnicity
 - Gender identity
 - SDOH information
 - Food insecurity
 - Veteran status
 - Transportation needs
- **Sharing of data:** Regardless of what data is collected, it will not be helpful unless shared with providers in a timely manner. Providers cannot address issues with the supplemental benefits if they do not have a comprehensive understanding of the benefits enrollees are receiving and how it might impact the hospice and palliative care delivery of services.
- **Conversion from palliative to hospice care:** Conversion rates from palliative care to hospice services is a key utilization data element. Despite the increased theoretical availability of palliative care, palliative care services are still not provided to many enrollees in different markets and some markets only offer only audio-only palliative care services. Providers are interested in tracking transitions between palliative care, concurrent care, and hospice care. Concurrent care is still limited, but anecdotal reports show these cases result in positive outcomes. Beneficiaries who have elected concurrent care reflect a mix of clinical conditions and personal situations, including people with cancer, people who were looking for additional home health aide and skilled nursing services, and at least one person who used concurrent care as a bridge to hospice while getting the whole family on board with the prognosis.

10. *How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior*

authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

- **Prior authorization:** For hospice services under the VBIID Hospice Component, prior authorization is not allowed. For hospice services provided outside the VBIID model, we strongly encourage the same no prior authorization approach, as care is needed immediately and should not be bureaucratically delayed.
- **CMS utilization management:** CMS should provide additional oversight of post-acute care utilization management.
- **Information to enrollees:** CMS and MA plans should provide enrollees with plain, understandable language about prior authorization requirements, limitations of services (e.g., visit limits, concurrent care), and the enrollee's cost-sharing responsibility. This information should be provided to enrollees before services are initiated. Too often this information is given to the enrollee in a letter after the fact, if at all, and providers are left to explain the issue and process.

11. What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques? How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?

No comment.

Drive Innovation to Promote Person-Centered Care

1. What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program, Center for Medicare and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why?

- **Value of joining:** Many hospices are struggling with the value for patients of receiving the Medicare Hospice Benefit under Medicare Advantage. The current practice, where the enrollee receives hospice services under fee for service Medicare, while MA continues to pay for other benefits unrelated to the terminal illness, is adequate coverage for MA enrollees needing hospice care.
- **Administrative burdens:** Providers must consider an array of administrative factors when deciding whether to participate. These considerations include:
 - Confusion about the MA bid and billing processes
 - Whether the hospice EMR software or other technology is robust enough to manage the requirements of the MA plan
 - In this time of workforce shortages, whether they have the staff available to manage contracts and billing

- **Risk and upfront costs:** Hospice providers receive approximately 90 percent of their payments from Medicare¹ which limits their ability to negotiate prices and minimizes profit margins. The upfront costs and potential risks of participating in value-based contracting are core factors providers consider whether to participate. Providers, especially hospice providers, need additional support for the startup costs of value-based contracting.

2. *What are the experiences of providers and MA plans in value-based contracting in MA? Are there ways that CMS may better align policy between MA and value-based care programs in Traditional Medicare (for example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements?*

- **Adequate payment to meet workforce demands:** Hospice and palliative care providers are seeing critical staffing shortages among nurses, social workers, aides, and other members of the interdisciplinary team. Hospices also generally need staff who have experience furnishing end-of-life care, further limiting the pool of candidates who are qualified to serve in hospice care roles. Additional concerns include burnout and an aging workforce which is plaguing all of health care. Hospices are not well positioned to compete with hospitals, staffing agencies, and other post-acute health care providers to recruit qualified care team members without significantly increasing their compensation costs. This is an issue when establishing value-based contracting amounts.
- **Payments to providers:** Hospice providers have described an additional administrative burden, which was expected and not overly problematic for a new model but has an impact on billing staff for the hospice provider. Duplicate billing, often referred to as “shadow billing,” is when claims are submitted to both the MA plan for payment and the Medicare Administrative Contractor (MAC) as “no pay” or “information only.” Many providers report the duplicate billing is not allowed in their hospice EMR software so the duplicate bill to the MAC must be done manually. Providers also report the hospice Notice of Election (NOE) process has also been a significant pain point for both MA plans and hospice providers. Providers report some MA plans are requiring a different NOE specific to the MA plan and not following the standard form set by CMS for the NOE.

NHPCO strongly encourages CMS to ensure the NOE form be standard among all MA plans serving enrollees with hospice services. Providers are also concerned about the broadening gap between who pays for the services and who regulates the services.

3. *What steps within CMS’s statutory or administrative authority could CMS take to support more value-based contracting in the MA market? How should CMS support more MA accountable care arrangements in rural areas?*

- **Encourage arrangements to serve specific or high need populations:** Through specific and intentional focus on certain populations, providers and plans can work together to improve quality and advance health equity through value-based contracting. These contracting

¹ Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2022. <https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>

opportunities should utilize community-based organizations and providers who have proven to be successful in reaching underserved populations.

- **Encourage industry-level collaboration:** Currently, trade associations for hospice and palliative care providers can reach out to CMS, CMMI, or MACs to address issues but there is not the same connection to MA plans. As MA enrollment is approaching half of all Medicare enrollees, it is imperative for there to be cross sector collaboration and modes of communication between these national level organizations. CMS can be influential in bringing groups together in collaborative forums.

4. *How are providers and MA plans incorporating and measuring outcomes for the provision of behavioral health services in value-based care arrangements?*

No comment.

5. *What is the experience for providers who wish to simultaneously contract with MA plans or participate in an MA network and participate in an Accountable Care Organization (ACO)? How could MA plans and ACOs align their quality measures, data exchange requirements, attribution methods and other features to reduce provider burden and promote delivery of high-quality, equitable care?*

No comment.

6. *Do certain value-based arrangements serve as a “starting point” for MA plans to negotiate new value-based contracts with providers? If so, what are the features of these arrangements (that is, the quality measures used, data exchange and use, allocation of risk, payment structure, and risk adjustment methodology) and why do MA plans choose these features? How is success measured in terms of quality of care, equity, or reduced cost?*

No comment.

7. *What are the key technical and other decisions MA plans and providers face with respect to data exchange arrangements to inform population health management and care coordination efforts? How could CMS better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data? What approaches could CMS pursue to advance the interoperability of health information across MA plans and other stakeholders? What opportunities are there for the recently released Trusted Exchange Framework and Common Agreement³ to support improved health information exchange for use cases relevant to MA plans and providers?*

No comment.

8. *How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?*

No comment.

9. *What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?*

No comment.

10. *Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBI Model that would test how to address social determinants of health and advance health equity?*

- **Expanded caregiver support:** Caregivers play a critical role in providing culturally competent hospice care for beneficiaries. Addressing the needs of caregivers would be a welcome addition to the hospice benefit, including caregiver training and resources, care management services focused on the caregiver, and burden assessments. By providing caregivers with the tools to support their role in the care the beneficiary is receiving, they will be able to communicate their needs and the beneficiary's needs more fully.
- **Health care assistance flexibility:** Flexibility to provide a health care assistance allowance could address health equity and SDOH issues. This allowance could be used to cover items such as housing needs, bills, and improvements in the home environment that all contributed to improving the quality of life for the beneficiary.
- **In-home respite care:** Under the Medicare Hospice Benefit, respite care is currently an inpatient service to provide temporary relief to a patient's primary caregiver. A flexibility to provide in home respite care should be tested as part of the VBI model.

11. *What additional innovations could be included to further support care delivery and quality of care in the Hospice Benefit Component of the MA VBI Model? What are the advantages and disadvantages of receiving the hospice capitation payment as a standalone payment rather than as part of the bid for covering Parts A and B benefits?*

- **Clarify palliative care:** As the benefit currently stands, the minimum core services of palliative care and what is included in the supplemental benefit is inconsistent and unclear. Beneficiaries, providers, and MA plans all struggle to communicate what is included and what can be expected with palliative care. NHPCO supports the flexibility in the current structure, but minimum standards and core services need to be set. In addition, the process and expectations of the transition from palliative care to hospice care needs to be more clearly delineated and explained to beneficiaries.
- **Hospice capitation payment:** For over 40 years, hospices have operated as a revolutionary, risk-based model of care providing quality care through capitation payment. By providing all in care, hospice care has proven to be cost effective for the Medicare program while continuing to provide beneficiaries their choice of Medicare certified providers. Through the capitation payment, the hospice benefit will continue to prioritize beneficiary decision-making authority by keeping extraneous decisions and burdens out of the process.

- **Hospice bundle:** A key part of hospice services is that it is bundled to include all related services for a beneficiary receiving hospice care. By transitioning to a contract process for MA plans, it is likely the hospice benefit will be unbundled, where the value of the interdisciplinary team is minimized, and services are parsed out to meet only minimum service requirements. This could lead to unclear guidance for hospice providers and poor patient outcomes and experiences.

12. *What issues specific to Employer Group Waiver Plans (EGWPs) should CMS consider?*

No comment.

Support Affordability and Sustainability

1. *What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?*

No comment.

2. *What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?*

No comment.

3. *As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?*

- **Standardizing enrollment process for providers:** Currently, providers are struggling with the burden of figuring out how to correctly bill each provider. One provider stated it took seven months to correctly bill the MA plan, despite their leadership team's participation in meetings with the MA plan for five months. Another provider stated they received a payment recoupment review before they ever received a payment. Beyond payments, providers are struggling to understand what documentation is necessary. For example, hospice providers are receiving contradictory information on the requirements for the CMS standardized hospice notice of election (NOE) form. Providers and administrators are stretched thin and with additional administrative burdens from MA plans and referrals coming from a wide variety of MA plans, they will struggle to differentiate between the various enrollment requirements if they are not standardized.

4. *Are there additional considerations specific to payments to MA plans in Puerto Rico or other localities that CMS should consider?*

No comment.

5. *What are notable barriers to entry or other obstacles to competition within the MA market generally, in specific regions, or in relation to specific MA program policies? What policies might advantage or disadvantage MA plans of a certain plan type, size, or geography? To what extent does plan consolidation in the MA market affect competition and MA plan choices for beneficiaries? How does*

it affect care provided to enrollees? What data could CMS analyze or newly collect to better understand vertical integration in health care systems and the effects of such integration in the MA program?

No comment.

6. *Are there potential improvements CMS could consider to the Medical Loss Ratio (MLR) methodology to ensure Medicare dollars are going towards beneficiary care?*

No comment.

7. *How could CMS further support MA plans' efforts to sustain and reinforce program integrity in their networks?*

No comment.

8. *What new approaches have MA plans employed to combat fraud, waste, and abuse, and how could CMS further assist and augment those efforts?*

No comment.

Engage Partners

1. *What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA? More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program?*

No comment.

2. *How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?*

- **Encourage industry-level collaboration:** Currently, trade associations for hospice and palliative care providers can reach out to CMS, CMMI, or MACs to address issues but there is not the same connection to MA plans. As MA enrollment is approaching half of all Medicare enrollees, it is imperative for there to be cross sector collaboration and modes of communication between these national level organizations. CMS can be influential in bringing groups together in collaborative forums.

3. *What steps could CMS take to enhance the voice of MA enrollees to inform policy development?*

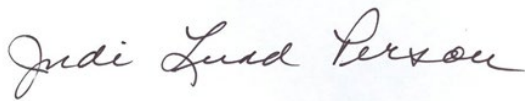
No comment.

4. *What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?*

- **Clear methods of communication:** Providers have shared struggles to communicate with MA plans. Providers are unsure of the best mode of communication for MA plans, and when they do contact MA plans, they struggle with accessing the information they are seeking. CMS can promote better and more detailed contact information for MA plans with distinct communication lines for providers, beneficiaries, and stakeholders.

We appreciate your consideration of NHPCO's comments on the Request for Information: Medicare Program and your commitment to supporting hospice and palliative care providers. We welcome continued engagement with you and your staff. If you have questions or to schedule a meeting, your staff should feel free to contact Judi Lund Person, Vice President, Regulatory and Compliance at jlundperson@nhpco.org.

Sincerely,

A handwritten signature in dark ink, reading "Judi Lund Person". The signature is fluid and cursive, with the first name "Judi" being the most prominent.

Judi Lund Person, MPH, CHC

Vice President, Regulatory and Compliance