Discussion Draft:
Hospice Care Accountability, Reform, and Enforcement (Hospice CARE) Act
Representative Blumenauer (D-OR-3rd)

Comments Submitted by The Coalition to Transform Advanced Care (C-TAC)

Introduction:
On behalf of The Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to comment on the *Hospice Care Accountability, Reform, and Enforcement (Hospice CARE) Act* as envisioned and drafted by Representative Earl Blumenauer (D-OR-3rd). C-TAC commends Representative Blumenauer for this important work and for his decades of support for compassionate end-of-life care and for bringing policies to the national stage with bi-partisan support.

We have had the privilege to work with the Congressman, his staff, Ways & Means Committee staff, and other stakeholders during the past several years on efforts to secure greater oversight and administrative policy changes to address reports of increased awareness of fraud within Medicare's hospice benefit, and this draft legislation is an important starting point for ideas that lead to modernizing the hospice program and improving the lives of people with serious illness and their family caregivers.

Established in 2010, C-TAC pursues a comprehensive policy agenda with the goal of ensuring that all Americans living with advanced or serious illness receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. Our work has influenced many issues in the field of serious illness, including palliative care, hospice, advance care planning, community-based supports and services, preference-driven care, caregiver and consumer support, and health system delivery and payment reform. Our focus on health equity informs our work in all these areas. With 200+ member organizations, C-TAC collaborates with key legislators and decision makers to shape policies that deliver more comprehensive, equitable, and consistently funded care.

C-TAC supports the dual approach to hospice reform that Representative Blumenauer takes. The first addresses the integrity of the industry amid concerns of fraud and C-TAC has focused on the negative impact on patient and family experience and needed protections in its work to address needed improvement in efforts to address provider fraud. The second approach targets improvements in the hospice benefit that build on the success of the hospice program in providing access to patient centered care and how benefit change should improve the lives of more individuals with serious illness and their family caregivers. C-TAC has developed the attached ***Core Principles Applied to Hospice Modernization*** to provide clear guideposts that can be used to evaluate hospice care and modernization.

Hospice is a holistic approach to care, and any changes to the Medicare Hospice Benefit should continue to ensure that all individuals living with serious illness have access to equitable care reflecting those core principles, regardless of who pays for that care. Because this is a particularly at-risk population, all efforts should be made to support providers' capability to provide equitable, informed, quality care to meet the needs of these individuals. Consistent with these core principles, C-TAC also suggests hospice modernization ideas that would address:

- Access limitations caused by the six-month prognosis rule.
- Expanding successful team-based approach to provide care earlier in the course of serious illness.
- Allowing concurrent curative care coverage; and
- Covering upstream palliative care services and supports.

We also believe that an early comprehensive assessment is important to enable the right care at the right time, especially for timely access to palliative and hospice care. A comprehensive assessment should assess, on an on-going basis, each person's physical, social, psychological, and spiritual needs, as well as the needs of the family caregiver(s). This assessment and subsequent care coordination is essential to ensuring that the necessary resources are made available to the individual based on their care preferences and that the most efficient and often also the most-cost effective service delivery is used.

C-TAC is pleased to provide the following preliminary comments on the *Hospice CARE Act.* We also look forward to engaging the C-TAC membership in discussions about this legislative proposal and their viewpoints on addressing the future of the hospice program. We will provide additional feedback on the bill as the legislative process moves forward.

Section 2. Ensuring the Integrity of Hospice Care Furnished Under the Medicare Program
Subsection (a). Mandatory Temporary Moratorium on Enrollment

- C-TAC supports the use of a temporary moratorium on enrollment of new hospice programs and revalidating the enrollment information of each hospice in Medicare. We support the collection and analysis of ownership information, as well.
- We suggest that the Secretary should have the flexibility to consider targeting states, particularly where there is evidence of fraud, and adjusting the length of the moratorium if justified.
- We believe that there must be common sense exceptions to the moratorium that provide access for those living in areas without sufficient access to hospice and providers. Adequate flexibility should be provided to the Secretary to modify the moratorium and reduce the administrative burden for good programs.
- The Secretary must work to make sure that this tool does not stifle innovation or reduce access to quality hospice programs.

Subsection (b). Authority to Extend Oversight of Newly Enrolled Hospice Programs

- We support extending the ability of the Secretary to establish provisional periods of enhanced oversight for hospice programs to two years and believe it will improve program quality.
- We support providing the needed resources for CMS to report on the impact of the current requirements.
- We are also concerned about the regulatory burden for good hospice providers.

Subsection (c). Increase in Survey Frequency for Certain Hospice Programs

- We support the Secretary surveying new hospices more frequently and believe that the Secretary should work to develop an approach that ensures that those programs without enforcement actions are treated fairly and not overburdened.

Subsection (d). Prohibition on Payment for Failure to Meet Quality Data Reporting Requirements

- We support this subsection which prohibits payment to hospice programs that do not submit required quality data to the Secretary. From a consumer point of view, this data collection and reporting is critical to quality measurement and oversight.

Subsection (e). Independence of Attending Physician

- C-TAC supports measures to address fraud by physicians in the hospice program and understands the potential use of certain financial interest prohibitions. These must be used carefully in order not to limit access to hospice services or providers. Advocates have pointed out that the right of patient choice must not be forgotten in developing these program integrity protections.
- The Secretary and CMS must develop ways to monitor the use of any prohibitions.

Subsection (f). Allowing Nurse Practitioners to Certify Terminal Illness

- C-TAC supports this subsection which allows nurse practitioners acting as the patient's designated attending physician to certify terminal illness.

Subsection (g). Allowable Use of Supporting Material in Medical Review of Hospice Care

- We support policy that promotes the use of appropriate documentation for medical review but look to providers and policymakers to work through how this could be implemented for real world circumstances.
- We are concerned about delayed access for beneficiaries.

Subsection (h). Inclusion of Hospice Care as a Designated Health Service

- C-TAC supports adding hospice care to the "Stark" law on self-referral, but again cautions. The provider burden and effect on patient access should be assessed.

Subsection (i). Prohibition on Certain Changes in Majority Ownership

- C-TAC supports this provision, which addresses "churn and burn" schemes by prohibiting the hospice provider agreement and billing privileges to convey to a new

owner within 60 months of initial certification (or the last majority change in ownership), rather than 36 months. Analysis of the 36 months rule is also needed.

Subsection (j). Medical Review of Hospice Outliers and Care Unrelated to Terminal Condition

- C-TAC acknowledges the complexity of the long length of stay and discharge alive problem. C-TAC supports efforts to better understand situations where an individual receives hospice care for more than 180 days, particularly if there may be fraud involved and or patients that were discharged alive.
- We support efforts like prepayment reviews for any claims submitted by providers and suppliers (not the hospice) that indicate that such claim is for an item or service unrelated to the terminal condition, but we also know that patients often need care provided by other practitioners, as well as supports and services in the community.

Subsection (k). Required Provision of Addendum of Non-Covered Services

- C-TAC is aware of a potential burden but believes in well-informed patients and families. We support efforts to ensure that hospices provide good explanations for what items and services will and will not be provided early in the hospice enrollment process. We do not have a preference on how this is done successfully.

Subsection (l). Provision of Explanation of Benefits Upon Hospice Election

- C-TAC supports having the Secretary, within 15 days of an individual's hospice election, provide notice of such election so that beneficiaries can identify any mistakes or fraud in such an election and report such instances to the hospice, Centers for Medicare & Medicaid Services (CMS), or the OIG. CMS must be provided the necessary resources to do this.

Subsection (m). Medical Review of Hospice Care Contractor Requirements

- We support appropriate specialized instruction and training for contractor staff and that medical review activities be reported to Congress.

Subsection (n). Requiring Face-to-Face Encounters Before Recertifications of Terminal Illness

- C-TAC does *not* support a requirement for a face-to-face encounter to occur before each recertification of terminal illness that cannot be conducted via telehealth. We understand the benefits of performing a physical exam in-person but believe that there are many circumstances where this is not feasible and could limit access in some cases.

Subsection (o). Ensuring Medical Director and Physician Availability

- We support the idea of having the hospice medical director or physician member of the interdisciplinary group available for immediate consultation (which may be through telehealth) when hospice care is provided in an individual's home. It is our understanding that this is already required.

Section 3. Payment Reforms for Hospice Care Furnished Under the Medicare Program

- C-TAC supports efforts to modernize the payments and methodology used for reimbursement for hospice care.
- We believe that payments should be bundled or episode-based, available to qualified organizations of any size, and should include risk adjustment, upfront investment, accountability, standardized metrics, and cover both clinical and social services. This would build on the current hospice bundled payment system and apply to the full continuum of care as well and improve the outcomes for patients.
- We support changes that would enhance payments for transitional concurrent care including palliative chemotherapy, radiation, blood transfusions, and dialysis. We would add intravenous inotropes for heart failure to this list.
- We have some concerns regarding the removal of coverage for home health aide services from the hospice benefit for individuals living in skilled nursing or nursing facilities. This has the potential to harm patients in situations where the facility does not provide the needed care.
- We support plans to provide additional payments for unusual variations in the type of routine care provided if sufficient evidence supports it.
- C-TAC believes that the respite care proposal could significantly benefit hospice patients and their caregivers. We also support the discharge planning requirements and the in-home respite benefit.

In addition, C-TAC supports a consumer/patient/family caregiver-oriented approach to hospice reform including the following:

- *Consumer information* - Individuals and their family caregivers should have access to understandable, unbiased, accurate information to help them understand their care, provider, and treatment options.
- *Quality assurance* - Systems should be in place to monitor and improve the quality of services delivered to individuals with serious illness.
- *Consumer rights* - Rights should be clear, explicit, and known to all. Problems, grievances, and appeals regarding benefits, services, and quality should be addressed quickly and fairly.

Overall, The Coalition to Transform Advanced Care appreciates the *Hospice Care Accountability, Reform, and Enforcement (Hospice CARE) Act* as a much-needed legislative initiative and positive step forward, and we look forward to working with Representative Blumenauer and Congress to address issues regarding the quality and integrity of the Medicare Hospice Program and its modernization. If you have any questions, please contact me at jbroyles@thectac.org or Brian Lindberg at 202-306-6126 / blindberg@healthsperien.com.

Sincerely,

Jon Broyles
Chief Executive Officer, C-TAC

C-TAC's Core Principles Applied to Hospice Modernization

The principles below were created to help develop and evaluate care and payment models for serious illness. They are used here as aspirational guides to help evaluate revisions to the hospice benefit that could also provide care earlier in a serious illness.

Goal

Hospice is a holistic approach to care, and any changes to the Medicare Hospice Benefit should continue to ensure that all individuals living with serious illness have access to equitable care reflecting the core principles below, regardless of who pays for that care. Because this is a particularly at-risk population, all efforts should be made to provide equitable, informed, quality care to meet the needs of these individuals.

Overall

Unit of care- Care should be person- and family-centered, improving quality of life throughout the trajectory of a serious illness. This means delivering quality care and support to both the person and those who matter most to them, throughout the course of an illness and including bereavement services.

Inclusivity- Care should be inclusive – reducing inequities and disparities and removing barriers to access and to quality care. This means ensuring that under-resourced communities are empowered and safeguarded from low-quality services.

Care Model Elements that Expand the Existing Hospice Benefit

Comprehensive assessment- Any program should assess each person's physical, social, psychological, and spiritual needs and the needs of their family caregiver(s) on an ongoing and standardized basis. While already true of hospice, this would also apply to anyone living with serious illness and help identify appropriate services when needed.

Care planning- A care plan is developed, using shared decision making, based on those needs and the person's individual goals and preferences. Again, while this is currently required of hospice, there is the opportunity to ensure that individuals with serious illness are fully informed throughout their illness as to the services they could receive and fully engaged in planning their care.

Interdisciplinary team- Care should continue to be provided by a qualified core interdisciplinary team, with additional team members as needed.

24/7- Care is accessible 24/7 (using technology as appropriate) and available throughout the continuum of a serious illness (including in the home when appropriate). This means that any program should have this capability and especially for those later on in a serious illness.

Coordinated care- Care is comprehensive, coordinated, with seamless transitions, and with integration of clinical and community-based services and supports for the person and family caregiver(s). This should be required of all programs providing care to those with serious illness and especially when curative or disease-modifying treatment is also being pursued.

Payment - Payment is bundled or episode-based, available to qualified organizations of any size, and should include:

- Risk adjustment
- Upfront investment
- Accountability, standardized metrics
- Quality improvement
- Both clinical and social services

This would build on the current hospice bundled payment system and apply to the full continuum of care as well.

Consumer Protections

- *Consumer information* - Individuals and their family caregivers should have access to understandable, unbiased, accurate information to help them understand their care, provider, and treatment options.

- *Quality assurance* - Systems should be in place to monitor and improve the quality of services delivered to individuals with serious illness.

- *Consumer rights* - Rights should be clear, explicit, and known to all. Problems, grievances, and appeals regarding benefits, services, and quality should be addressed quickly and fairly.

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