



February 14, 2024

Chiquita Brooks-LaSure
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Subject: Request for Information for the Value-Based Insurance Design Model Innovating to Meet Person-Centered Needs

Dear Administrator Brooks-LaSure,

On behalf of our more than 5,400 nonprofit and mission-driven aging services providers from across the continuum of aging services and our 36 state partners in 41 states, LeadingAge is pleased to offer the following comments in response to the Center for Medicare and Medicaid Innovation's (CMMI) Request for Information (RFI) for the Value-Based Insurance Design Model (VBID).

We would like to start by strongly advising CMMI to exert extreme caution regarding closed networks for hospice providers. The history and uniqueness of hospice services is undeniable. Since the beginning of the concept of hospice as a community-based, volunteer-driven service, to its incorporation into the Medicare benefit as a bundled service, hospice has a unique frame of reference different than other services provided in Medicare. The act of giving up traditional curative care is a deeply personal choice, and so it follows that any integration into alternative payment models, whether it is Medicare Advantage (MA), Accountable Care Organizations, or other alternative payment models must be done in full support of each person and family's choice of when, where, how, and from whom they receive their hospice care. Creating any opportunities or perverse incentives to drive individuals to a Medicare Advantage Organization (MAO's) preferred provider over the person and family's preferred provider is simply anathema to the goal of hospice.

1. How can CMS implement network access policies for hospice providers in line with current MA program policies (e.g., the ability for health maintenance organizations (HMOs) to limit access to in-network providers) while minimizing confusion among enrollees/patients, caregivers, and hospice and non-hospice providers?

The uptake of the current hospice component of the VBID demonstration is relatively low. According to the last evaluation published in 2023, only 1.9 percent of all beneficiaries enrolled in plans participating in the Hospice Benefit Component, received hospice care. The argument for creating a network of providers is to allow beneficiaries more access to the supplemental benefits and additional services allowed under VBID including transitional concurrent care (TCC) which is only provided by in-network hospices. But the evaluation found that less than 1 percent of beneficiaries electing hospice actually received TCC. We believe that it is simply too early in this demonstration to begin implementing network access policies. More data needs to be made publicly available to understand which MA beneficiaries are accessing hospice services through VBID.

As stated earlier, hospice is a unique Medicare benefit that is often accessed at the most difficult and personal time in an individual beneficiary's life. Complicating these already difficult and often urgent situations with whether a hospice is in or outside of a plan's current network of providers could further burden beneficiaries and families as well as complicate existing referral networks of providers. Additionally, participating MAOs are already responsible for communicating to enrollees the limits imposed on coverage of hospice supplemental benefits or concurrent care services furnished by out-of-network hospice providers.

As LeadingAge noted in comments regarding other MA regulations,¹ we remain concerned that providers have an oversized burden of navigating multiple plan portals or websites to obtain the needed data. In the evaluation released in 2023, hospices stated that the additional administrative processes, especially claims submission and insurers reporting requirements raised concerns about continuing in the program.² We urge CMS to continue to pursue efforts to reduce the administrative burden of these processes on providers. We believe one such way to achieve this goal is to establish a standardized process in cases where all payers must follow the same regulations without deviation especially with regard to submission of documentation.

2. How should statutory protections ensuring access to covered benefits, even out of network, where services are "medically necessary and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization" be potentially applied in the context of the hospice benefit?³

While we appreciate CMMI's intent with this question, we reiterate that hospice is a unique benefit within the Medicare framework of services and we reject the premise that only some hospice services are medically necessary and immediately required. All hospice services should be protected regardless of whether a provider is in-network or out-of-network. We believe that the current requirements --that any out-of-network hospices should be paid 100% of Medicare fee-for-service and that MAOs should never be allowed to unbundle the current services provided under the hospice benefit -- should continue unchanged.

The treatment of out-of-network providers is critically important for hospice services. Many hospice beneficiaries travel outside their hospices service area to achieve their end-of-life goals such as attending a wedding, graduation, or birth of a grandchild. In traditional Medicare, these personal choices are treated with respect and supported by current regulation. We have heard from members that when they supported travel outside service area of a VBID hospice for a participant it was extremely difficult to get support from another provider at the patient's destination. Additionally, because the hospice receiving the beneficiary during their travel was not part of the plan of care, the payments were denied by the plan. CMS should require plans to pay for hospice services outside the

¹ LeadingAge Comments on Advancing Interoperability and prior authorization CMS-0057-P. March 13, 2023. <https://leadingage.org/wp-content/uploads/2023/03/LeadingAge-Comments-on-Advancing-Interoperability-and-prior-authorization-CMS-0057-P-FINAL.pdf>

² Evaluation of Phase II of the Medicare Advantage Value-Based Insurance Design Model Test. September 2023. <https://www.cms.gov/priorities/innovation/data-and-reports/2023/vbid-2nd-eval-report>

³ Existing regulatory requirements regarding this obligation include, but are not limited to, requirements under 422.100(b)(1) for an MAO to make timely and reasonable payment to providers or suppliers that do not contract with the MAO for emergency and urgently needed services. Additionally, how could such protections be operationalized by participating MAOs?

plan's geographic area for a limited duration (e.g. 3 weeks) regardless, if a specific hospice is named in the plan of care. The beneficiary and hospice should be crystal clear as to when they would have to inform the plan if a permanent switch in geography is made that results in the need to transfer hospices permanently.

3. To what extent should CMS implement new or additional access safeguards specifically in the VBID Model Hospice Benefit Component to address situations when an enrollee may want to elect hospice in situations when hospice care is urgently needed?

Again, due to the unique nature of the hospice benefit within the Medicare framework of services, we reject the premise that only some hospice services are urgently needed as opposed to all hospice services being urgent. We also have strong concerns regarding who is allowed to define what is "urgent" in the case of hospice. Is it a clinician certifying hospice during the in-person face-to-face visit or an administrator at the plan simply conducting a chart review? Hospice is a beneficiary choice and should be protected regardless of any definition of "urgency". By definition, these individuals are in their last 6 months of life and evidence shows that those who access hospice services reduce costs in the last two years of life.⁴ Therefore, utilization management of these services should be unnecessary from an appropriateness or cost standard. There should be no delay for any beneficiary to access hospice services.

According to the Medicare Payment Advisory Commission (MedPAC), between 2020 and 2021, length of stay among decedents with the shortest stays remained the same (2 days at the 10th percentile and 5 days at the 25th percentile).⁵ While long length of stays decreased by five days over this time period, there has been no movement in the short length of stays, meaning the bottom two quartiles of patients receive less than one week of hospice care and are arguably less likely to receive the full benefits of the comprehensive, interdisciplinary service. Any access safeguards implemented in the VBID program should have the sole purpose of protecting beneficiaries from delays in care which could reduce the days spent in hospice.

4. To what extent should CMS modify the current Model-specific network adequacy standards, including the minimum number of providers requirement and the comprehensive network development strategy? For example, should CMS include any special consideration for states with certificate of need for hospice providers or use alternative datasets to set and implement the network adequacy standards?

In the current comprehensive network development strategy, CMS states they will review VBID Hospice Benefit Component applications to assess a MAO's process to ensure their hospice provider networks deliver care in a timely manner across all four levels of hospice care. It is a requirement of the hospice Conditions of Participation for Medicare that all hospices be able to deliver care across all four levels of hospice. There is currently some publicly reported information on each hospices use of each level of care through the Hospice Care Index. However, the way that the current level of care components of this measure is calculated, an agency could provide 1 day of general inpatient care or continuous home

⁴ Aldridge MD, Moreno J, McKendrick K, Li L, Brody A, May P. Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018. *JAMA Health Forum*. 2022;3(2):e215104. doi:10.1001/jamahealthforum.2021.5104

⁵ MedPAC March 2023 Report to the Congress: Medicare Payment Policy. Chapter 10: Hospice Services. https://www.medpac.gov/wp-content/uploads/2023/03/Ch10_Mar23_MedPAC_Report_To_Congress_SEC.pdf

care and earn a point for the component. Regardless a plan would need to dig deep into publicly reported data to identify this.

Unfortunately, the hospice quality reporting program and its measures are relatively new compared to other long- standing programs in hospitals, skilled nursing facilities, and home health. CMS within the last two years launched a hospice five-star program and only a third of hospices are eligible for a rating. CMS is also in the process of finalizing the Hospice Outcomes & Patient Evaluation (HOPE) tool which will be the first standardized hospice patient assessment. This implementation could lead to further opportunities for MAOs to understand potential hospice partners, but the timing of implementation is not yet known and will most likely not occur prior to Request for Applications are due for the 2026 VBID Hospice Benefit Component, when the in-network flexibilities are set to begin. Given the current state of quality measurement, we would strongly recommend CMS require plans to allow any willing hospice provider to participate as long as the provider meets the threshold for quality reporting or has been identified as having numbers too low to report. As part of the publicly reported measures on Care Compare, there are multiple footnotes that would indicate a provider did not comply with reporting requirements rather than having too few cases to report.

Footnote Number ⁶	Footnote as displaced on Care Compare	Footnote details	Data Source
2	Data not available for this reporting period.	The provider has been Medicare-certified or less than 6 months for HIS measures / 1 month for claims measures OR there wasn't data to submit for this measure for this reporting period.	HIS and claims
4	Data not submitted for this reporting period.	The provider didn't submit required data for this quality reporting period.	HIS
9	There were discrepancies in the data collection process.	There were deviations from data collection protocols.	CAHPS®
10	None of the required data were submitted for this reporting period.	The agency didn't submit any required data for this quality reporting period.	CAHPS®

⁶ Data Dictionary for Hospice Quality Reporting Program Data on Care Compare Version 14.1. November 2023. https://data.cms.gov/provider-data/sites/default/files/data_dictionary/hospice/HOSPICE_Data_Dictionary.pdf

This leads to a much more significant concern of the industry, protecting patients from fraudulent providers. In 2023, LeadingAge and three national hospice association partners submitted a list of recommendations to CMS for actions to take to improve oversight of the program.⁷ These same recommendations can be used by MA plans to eliminate potentially fraudulent hospice operators from their networks. In particular, the four red flags identified in the 34 recommendations would help eliminate bad actors from being included in any future MAO networks:

- Co-location of multiple hospices at single address;
- Hospice administrator overseeing multiple hospices;
- Other hospice leadership staff or patient care manager serving multiple hospices; and
- If hospice company appears to be hidden behind a shell company.

In the current comprehensive network development strategy, CMS states it will review VBID Hospice Benefit Component applications to assess an MAO's process to ensure their hospice provider networks have adequate capacity and provide three examples of adequacy including staffing. No other Medicare settings has staffing as a measure of adequacy. Additionally, data on staffing is not publicly reported by hospice organizations. Hospice providers should be able to manage their own business which includes adding staff to meet demand. Perhaps it would be better to ask the hospice what their average number of patients served in the prior year was, which is publicly reported data. It is concerning that the health plans would be given the power to regulate staffing if federal regulations do not. Also, adequacy is going to vary quite frequently in hospice as people pass away. This is not like a hospital with a certain number of beds.

In 2023, CMS conducted a comprehensive research study on staffing ratios in skilled nursing facilities which stated there was "no obvious plateau at which quality and safety are maximized or 'cliff' below which quality and safety steeply decline."⁸ To date, this is the only post-acute setting that was studied for what would constitute adequate staffing. Without evidence-based research to define staffing adequacy, allowing MAOs to define staffing expectations for contracted hospices would be irresponsible and potentially lead to access issues in the long term.

We do not believe there should be any special considerations for MAOs serving states with Certificate of Need designations for hospice. Currently only 13 states and the District of Columbia have Certificate of Need laws for hospice⁹ and plans currently participating in the VBID Hospice Benefit Component only serve 7 of those states. Given the limited number of CON states and the even more limited number of VBID MAOs in those states CMS should not allow any flexibility for provider networks in CON states. If a plan serving a county with two hospices that meet the state's CON, and the minimum number of providers for that county is two, then the plan should be required to contract with the two hospices in that county.

⁷ Hospice Program Integrity Ideas Hospice Industry Consensus. January, 13 2023. https://leadingage.org/wp-content/uploads/2023/01/Hospice-Program-Integrity-Ideas_Hospice-Industry-Consensus-Final-1.13.23-.pdf

⁸ Nursing Home Staffing Study: Comprehensive Report. June 2023. <https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>

⁹ National Conference of State Legislatures. Certificate of Need State Laws. <https://www.ncsl.org/health/certificate-of-need-state-laws>

5. To what extent should CMS maintain its Model-specific requirement to not allow any prior authorization requirements for hospice care? If CMS should change the policy, what would the alternative look like and how could it be operationalized?

LeadingAge strongly opposes any change to current prior authorization restrictions for the VBID Hospice Benefit Component. As we have outlined above, hospice is a unique and personal decision. Any change to the current process of election could have significant impacts on access to necessary and urgent services at the end-of-life. Additionally, adding prior authorizations could further reduce the days spent in hospice by patients with the shortest stays. Are short stay hospice patients no less worthy of reason this end-of-life care?

In January 2024, CMS finalized a requirement for shorter prior authorization response timelines for specified payers, requiring decisions to be made within seven days for standard requests and within 72 hours for expedited requests.¹⁰ Even if these parameters were adopted for the VBID Hospice Benefit Component, this would be negligent and irresponsible for the bottom quartile of patients with the shortest length of stay, only two days.

A 2023 report for the Office of Inspector General found that MAOs sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules.¹¹ In their findings, OIG estimates 13 percent of the denials met Medicare coverage rules. This meant delays in necessary services for beneficiaries. Considering the urgency of end-of-life care, implementing this flawed process on an already vulnerable population could have considerable consequences for the quality of care for beneficiaries and families. Additionally, creating more layers of administration is counter to the cost savings CMS is attempting to achieve with this demonstration. CMS and Congress are also looking at prior authorization policy within the larger Medicare Advantage program – CMS is more forcefully overseeing plans to ensure that beneficiaries are actually getting access to the same services as in Medicare fee for service, including the same course of treatment. These policies are new and there could be lessons learned or new parameters to be explored when there is some learning on barriers from CMS.

CMMI also has an opportunity here to, rather than seek to emulate what is in the rest of the Medicare Advantage for hospice – could CMMI use its authority to drive plans toward utilizing tools like case management and data analytics that are shared between plans and providers, and other mechanism that could lead to partnerships that promote high value care at the right time? Instead of assuming that mechanisms like prior authorization and traditional network adequacy requirements are what is needed just because that is what plans have been using to date – we encourage CMMI to think bigger about the tools that plan has and how a three way partnership between plans, providers, and the government could lead to better care delivery. Could CMS support creating standard contracts and billing procedures to reduce administrative burden? We ask for similar imagination with regards to oversight of payment – as more beneficiaries enroll in Medicare Advantage, non-interference in MAO rate setting and

¹⁰ Centers for Medicare and Medicaid Services. Fact Sheet: CMS Interoperability and Prior Authorization Final Rule CMS-0057-F. <https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f#:~:text=In%20the%20CMS%20Interoperability%20and,via%20that%20Patient%20Access%20API>.

¹¹ Department of Health and Human Services, Office of Inspector General. High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care. <https://oig.hhs.gov/oei/reports/OEI-09-19-00350.asp>

contracting is going to meant that CMS loses much if not all of its oversight leverage. Could CMMI explore waiving certain aspects of non-interference to explore quality incentives in network adequacy? A payment floor?

Thank you for the opportunity to provide feedback on this RFI. We are available to discuss these or other issues. Please contact Katy Barnett, Director of Home Care and Hospice Operations and Policy at kbarnett@leadingage.org with any questions or to follow up with the LeadingAge team.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Katy Barnett', with a large, sweeping flourish at the end.

Katy Barnett
Director, Home Care and Hospice Operations and Policy
kbarnett@leadingage.org