

February 16, 2024

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure,

Since 1982, the National Association for Home Care & Hospice (NAHC) has been the largest organization representing hospice, home health, and home care providers across the nation. Our members include a wide array of provider types, including nonprofit and proprietary, urban and rural, hospital-affiliated, public and private corporate entities, and government-run agencies. We are 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). Our comments are specifically focused on the questions about the hospice demonstration component of the VBID model ("*Expanding Access to Higher Quality Hospice Care*" RFI section).

**General Comments**

While NAHC appreciates CMMI's desire to drive innovation for seriously and terminally-ill patients and their families, we have long had major concerns about the very idea of incorporating hospice into the Medicare Advantage program<sup>1</sup>. Anecdotal reports from model-participating hospices and MAOs, and evaluation data from the first few years of the demonstration, have not alleviated these concerns. Based on the low overall participation rate, lack of impact on key metrics to-date, reports of confusion and administrative burden from both hospices and MAOs, and recent research and policymaker focus on the negative impact of widely used MA tools such as prior authorization, we remain skeptical that the VBID hospice component will result in improved care and quality of life for hospice beneficiaries and their families compared to how they currently receive care under the FFS model.

In the context of this particular RFI, we are extremely worried about how the imposition of provider network restrictions and/or prior authorization requirements would likely limit beneficiary access to timely and high-quality hospice care. Given that hospice is a care model built around the unique preferences, goals, and values of terminally-ill individuals and their loved ones, we believe that policies that restrict patient access to preferred hospices run counter to the very spirit of the Medicare hospice benefit. These changes could result in real patient and family harm, including scenarios where the red tape and additional administrative burden associated with navigating closed networks or prior authorization processes result in beneficiaries dying before ever even being admitted to hospice.

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<sup>1</sup> NAHC's Dombi: 'Balance Business with Mission'. April 1, 2019. <https://hospicenews.com/2019/04/01/balance-business-with-mission/>

Moreover, these outcomes could denigrate the public perception of hospice as a concept, potentially reducing patient interest in this type of care, both under the FFS system and as potentially offered by MAOs.

Another reason we believe CMMI's contemplation of closed networks and prior authorization is misguided at this time is due to the lack of robust participation in the model to-date and associated lack of high-quality data on how MAOs and hospices in the demonstration are collaborating to improve access to and care for hospice-eligible patients. According to the most recent evaluation data, only 1.9% of all beneficiaries enrolled in plans participating in the hospice component received any hospice care<sup>2</sup>. Model evaluators found that *"Beneficiary uptake of the Hospice Benefit component has been low to date, and we found little evidence that the model affected beneficiary-level measures of hospice enrollment, care patterns, or care experiences in the first year of implementation (2021)."* Given this low number of those receiving care under the hospice model, we feel that it is premature to begin pursuing restrictive network access policies. Much more data needs to be made publicly available to understand how the model is currently being implemented and how it is impacting beneficiaries, their families, and hospice providers. This data should include which MA beneficiaries are accessing hospice services through VBID, how plans are formally operationalizing current networks under the model, and what the patient, provider, and financial impacts are of those early attempts to develop hospice networks.

More specifically, CMMI should share baseline comparison data for VBID hospice patients and FFS hospice beneficiaries receiving care outside of the demonstration. This comparison data should support evaluation of whether the model is meeting CMMI's stated goals for the demonstration to drive greater care continuity and higher quality hospice care for beneficiaries and families. Examples of measures/data that could help illuminate the goal of care continuity include:

- Hospice Length Of Stay (LOS) less than 7 days & less than 14 days
- Rates of admission direct from the hospital to the General Inpatient level of hospice care (GIP)
- Specific Hospice Care Index (HCI) sub-measures
  - Early live discharge
  - Live discharges from hospice followed by hospitalization and subsequent hospice readmission
  - Live discharges from hospice followed by hospitalization with the patient dying in the hospital
  - Gaps in skilled nursing visits
  - Visits near death
- Whether a hospice has a contracted relationship or joint venture with an existing provider or provider entity (ex. physician group or hospital partner) that is in-network with the MAO.

Examples of measures/data that need to be more transparent that could help determine the model's impact on improving quality of care include:

- Hospice Care index (HCI)
- Hospice visits in the Last Days of Life (HVLDL)
- Hospice Length Of Stay (LOS) less than 7 days & less than 14 days

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<sup>2</sup> <https://www.cms.gov/priorities/innovation/data-and-reports/2023/vbid-2nd-eval-report>

- CAHPS Star Ratings

Additional data that CMS should make publicly-available and more transparent includes:

- The number of hospices providing care to model beneficiaries that are owned by participating MAOs, as well as the experience of these hospices, and the experiences and outcomes of beneficiaries served by these hospices compared to non-MAO owned hospices
- Information and/or data shared by participating MAOs related to the specific implementation check-in call questions “*How does your organization work with enrollees to ensure access to out-of-network hospice where requested?*”, and “*Are there any differences in timeliness of claims payments btw in and out-of network hospices? In receiving NOEs and/or NOTRs?*”
- Data related to MAOs hospice and beneficiary outreach and education activities, and any outcomes or metrics of success associated with these activities
- Data related to the voluntary disenrollment of MA beneficiaries receiving care under the model who choose to revert back to FFS
  - A 2021 GAO report found that MA beneficiaries in the last year of life disenrolled to join Medicare fee-for-service (FFS) at more than twice the rate of all other MA beneficiaries<sup>3</sup>. Stakeholders told GAO that, among other reasons, beneficiaries in the last of year life may disenroll because of potential limitations accessing specialized care under MA as a result of limited networks.

This list of important demonstration data is not exhaustive, and NAHC would be happy to work with CMS to further explore the kind and types of data and information that would be helpful in supporting a better public understanding of the model’s impact from the perspective of participating hospices and the patients and families they serve.

### **RFI Questions**

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?*

Current MA program policies” related to network access for other kinds of providers should not simply be translated to the hospice VBID demonstration. These existing policies are ill-suited to terminally-ill patients that receive care predominantly in their own homes. Hospice is a unique Medicare benefit that serves a unique population, one whose goals, wishes and expectations for care are often of a different nature than those of patients who are not terminally-ill. Network access approaches for this population must honor and respond directly to the needs and goals of seriously and terminally-ill beneficiaries and their families. Notably, the only Medicare experience for hospice is under FFS hospice; MAOs have no prior experience managing a hospice benefit.

Additionally, for many hospice patients, timely access to care is literally a matter of life-and-death. According to the Medicare Payment Advisory Commission (MedPAC), between 2020 and 2021, length of

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<sup>3</sup> <https://www.gao.gov/assets/gao-21-482.pdf>

stay among decedents with the shortest stays remained the same (**2 days at the 10th percentile and 5 days at the 25th percentile**)<sup>4</sup>. Unfortunately, there has been no improvement in recent years in reducing the proportion of hospice users with very short lengths of stay. That means that for this large contingent of hospice beneficiaries who are only on the benefit for a short period, getting connected to hospice services without any delay at all is critically important for their quality of life during their last days. Because so many hospice elections happen when a patient is extremely ill and/or imminently dying, any restriction of hospice choice or additional administrative utilization or prior authorization approvals patients and families are subjected to during this time could have a profoundly negative effect on their well-being.

Unfortunately, the imposition of closed-network requirements will only add to the confusion and stress amongst patients, families, hospices, and referring providers. Patients and/or their caregivers often select a hospice based on their own prior experiences with a certain provider or the recommendations of family members, friends, or other community connections. Likewise, in many cases, patients may be open to hospice election in general, but would resist signing-up to receive care from a particular hospice that they believe provided poor care to their loved one or friend. Patients and families have come to expect that they will be able to receive care from the hospice of their choosing based on their unique circumstances, beliefs, and experiences, and we are concerned that inability to access a preferred hospice due to network restrictions would deter patients from electing and benefitting from hospice care. Any policy that diminishes interest in hospice and results in less access and lower utilization could also have the unintended consequence of increasing overall Medicare spending, given the financial savings the hospice benefit drives to the overall Medicare program by helping avoid unwanted and very expensive acute, disease-focused treatments at the end of life. A seminal 2023 analysis of the MHB's financial impact found that in 2019 alone, utilization of the MHB was associated with \$3.5 billion in savings to Medicare<sup>5</sup>.

In addition to creating confusion amongst patients, restricted network policies will also make it harder for referring providers to make appropriate and timely recommendations for hospice. In the current FFS environment, those that commonly make referrals to hospice, including practitioners at physician groups, hospitals, skilled nursing facilities, etc are used to being free to refer to any Medicare certified hospice. Under a closed network structure, referral partners will struggle to accurately track which patients are enrolled VBIID-participating MAOS, the specific hospice network restrictions for separate plan benefit packages, and the network status (in-network vs out-of-network) of many different hospice providers. The added cognitive load and administrative challenges associated with keeping current with each of these factors will add time to the referral process, which could ultimately increase the delay to hospice admission and care initiation. Problems could also arise if referring practitioners do not have relationships or familiarity with in-network hospices. On top of the confusion referenced above, and a hesitancy to refer to a provider whose quality profile a referral partner is not familiar with, the absence of a referrer-hospice relationship could result in the referring clinician losing contact with the patient and family. This could cause serious emotional strain for patients who have long-standing relationships with those who referred them to hospice, many of whom may want to serve as the patients' attending physician.

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<sup>4</sup> [https://www.medpac.gov/wp-content/uploads/2023/03/Ch10\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch10_Mar23_MedPAC_Report_To_Congress_SEC.pdf)

<sup>5</sup> [https://nahc.org/wp-content/uploads/2023/03/Value-of-Hospice-in-Medicare\\_032023\\_FINAL3.pdf](https://nahc.org/wp-content/uploads/2023/03/Value-of-Hospice-in-Medicare_032023_FINAL3.pdf)

We also fear that mapping traditional MA network policies onto the hospice demonstration does not account for certain structural challenges hospice providers currently face, especially those related to workforce shortages that are impacting access and capacity. NAHC hospice members, including those in high MA penetration areas, continue to struggle to rebuild their staffing and volunteer levels to pre-pandemic levels. Restricting access to hospices amidst such shortages could exacerbate problems of timely access to hospice for patients and families. And because CMMI has not been utilizing time and distance standards to hospice network adequacy under the model, and the minimum number of provider (MNP) standard is being determined at the MAO level as opposed to the unique PBP level, some staff-constrained hospices may be unable to serve beneficiaries located within the MAO service area due to extremely onerous travel time and distance constraints. This would, again, threaten timely and appropriate access to care.

Finally, as it is regular practice for MAOs to demand payment rates that can be significantly lower than traditional FFS reimbursement, and hospices participating in the demo as in-network providers are already being asked to take large discounted rates, we worry that the expansion of this practice to a broader standard closed-network structure could jeopardize the financial stability of many hospices, especially smaller organizations that deliver care to rural and underserved communities. The latest VBID evaluation report cited in-network hospices' reports that they were being paid between 5-15% less than FFS hospice rates by the MAOs. NAHC has heard of hospices feeling pressured to accept even lower levels of payment. This reimbursement erosion could further reduce access to timely hospice care, as well as have the effect of driving patients and families to lower-quality providers. This pressure imposed by the MAOs is compounded as a result of the fact that the FFS hospice payment rates already do not account for all of a hospice's costs, including the extensive and required use and management of volunteers. The discounted rates required by plans will require subsidization from the hospices, and it is foreseeable that this subsidization will require hospices to reduce services to traditional Medicare patients to stay financially viable. As a cautionary example from another provider setting, recent research found that patients enrolled in MA – even in “high quality” MA plans – receive lower quality home health services, which the authors posit is due to the low reimbursement rates offered by MA plans, which may discourage participation by higher quality home health agencies as part of MA networks<sup>6</sup>.

Illustrating the difficulty of remaining in-network under the hospice demo, one anonymous in-network hospice leader in the most recent VBID evaluation report lamented about the low payment levels:

*“I think my next step is going to be to sit down with [PO representatives] . . . and just say: “Hey, can you work with us? Can we make this viable? Because it’s not.” And if that doesn’t go anywhere, then I think we have to take a hard look at just saying we’re not playing in the VBID space any longer. I hate to do that because there’s a chance that this becomes law, and then we’re going to be forced into that space. And we want to be able to influence that in a way that’s going to be best for patients and families. But I’m only going to take a financial beating for so long to be able to do that. And if we can’t get value by taking this loss, by working with [PO], then why am I taking that? There’s just no reason to go through that if we can’t see value for patients and families and if we can’t get actual change.”*

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<sup>6</sup> <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2749236>

For the many reasons stated above, we recommend that CMMI maintain the current “any willing provider” network standard in place under the model that maintains beneficiary choice of out-of-network hospices and sets the floor of out-of-network hospice payment at no less than the prevailing FFS rates. We also urge CMMI to require MAOs to engage in more frequent and proactive outreach to hospice and palliative care providers in their service areas to convey important network and model changes and/or guidance that could impact providers’ ability to appropriately serve their hospice-eligible enrollees.

*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?*

We have major concerns with the implication in the framing of this question that only some hospice admissions or potential admissions are “medically necessary and immediately required”. We believe that all appropriate hospice admissions would meet this criteria, and that all hospice beneficiaries’ choice and right to timely access to care be protected and maintained under the hospice demonstration. It is worth stating however, that in the event of a patient referred to hospice who is extremely ill and possibly close to death, the negative consequences of potential delays and confusion associated with closed networks would be especially devastating, up to and including having the patient die in pain or while experiencing some kind of symptom crisis before they ever are able to access any hospice services at all.

Further, we have questions about how a determination of “medical necessity” and “immediately required” would be defined and by which entity or individual. If CMMI were to allow the MAO to make these determinations, there could be serious negative ramifications for patients and families, given plans’ lack of experience with and understanding of seriously and terminally-ill beneficiaries’ clinical, psychological, emotional and social dynamics. We have not seen evidence or data that provides confidence that MAOs would be able to appropriately determine what might constitute an “urgent” need for hospice, a problem that is exacerbated by the lack of any set of consensus standards or guidance to identify when a patient meets “emergency” hospice need criteria. Certifying physicians seeing a patient in-person are in the best position to ascertain the severity of a patient’s illness and “urgency” of their need for hospice.

Beyond the most pressing concerns related to access interruptions, additional issues would arise from treating some hospice cases as “urgent” in the context of closed networks. For example, should a patient want to choose an out-of-network hospice in an emergency situation, there would be plausible risk of either non-payment by the MAO, or non-receipt of services by the out-of-network hospice provider. These positions, on both the plan and the hospice side, could delay timely access to care, resulting in needless suffering for the patient and family. Similarly, if a patient does receive “urgent” hospice care at an out-of-network provider, would there be a requirement that sometime after that admission they would have to transfer to an in-network hospice? This would cause undue stress and burden on patients and families, and could result in poor care and quality outcomes for both the plan and the hospice.

For the above reasons, we urge extreme caution if CMMI intends to classify some hospice admission scenarios as “medically necessary” or “immediately required”. Patients should be allowed to access out-of-network urgent and emergency hospice services even if they are located in the MAO’s service area, and MAOs should bear full financial liability for admissions to out-of-network hospice providers that are

determined by the certifying physicians to reflect urgent or emergency situations.

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

The same factors, considerations and recommendations referenced above in question #2 apply to this question, as we interpret “immediately required” and “urgently needed” to be similar in nature and aimed at the same goal of developing a hierarchy of hospice need. As previously stated, we disagree with the premise of the questions that not all hospice care is urgent to some degree, given the implicit vulnerability of someone who is terminally ill.

*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?*

We do not feel confident that CMS’ current model-specific network adequacy standards would guarantee access to a hospice provider network comprehensive enough in scope to meet beneficiary needs and expectations for consistent high-quality care. CMMI’s current focus on centering a network around a minimum number of providers does not align with the person-and-family centered nature of the hospice benefit. A better framing for building a network adequacy approach is to have it ensure that contracted hospices have the capacity to meet the projected need for hospice care, and can respond adequately to certain specific care preferences of hospice patients and families, including for care providers that match their unique cultural or ethnic backgrounds, or those that have special training or expertise in disease-specific care (ex. heart failure expertise).

We also have concerns that the lack of time and distance standards could negatively impact the reach, scope, and nature of the hospice provider network and patients’ ability to access and receive timely hospice care. Absent these standards, network hospices could be located far from patients’ homes, which could increase burden and costs for hospice providers to travel to remote homes and/or increase the likelihood that a hospice could not accept a patient into its care. We urge CMMI to re-assess its network adequacy standards to ensure that hospices are located within a reasonable proximity to patients’ homes. CMS could address these concerns by developing, in conjunction with hospice experts, MA stakeholders, and other outside experts, appropriate time and distance standards. Additionally, CMS could modify its network approach to assess adequacy at a more localized, as opposed to MAO service area, which may result in an underestimate of the number and spread of hospices necessary to deliver timely care to all enrollees.

We recognize that MAOs, as part of their network development, should strive to contract with high-quality providers that can adequately and consistently deliver appropriate levels of care to beneficiaries and their families. At the same time, plans should seek to avoid partnering with fraudulent, abusive, exploitative or very low-quality hospices that present a risk to enrollees’ safety and well-being. To that end, we support the development of network credentialing criteria and processes to help plans discern hospice quality more effectively. CMMI should not, however, leave it up to the MAOs alone to create their own credentialing criteria that does not meet minimum standards or expectations of what

constitutes high-quality hospice care and appropriate and compliant business and operational practices. CMMI should instead convene a diverse group of individuals and entities with expertise in hospice, MA, network development and evaluation, and quality measurement to collectively develop guidelines for model plans to use to help inform their capacity to contract with high-quality providers. Potential areas that may be appropriate for consideration in this potential matrix of quality criteria could include provision of all four levels of care, measurement of timely initiation of care, and consistent reporting of all required quality metrics to CMS.

We recognize that in recent years there have been major concerns raised about fraud and abuse within the Medicare hospice benefit. This is an important consideration for potential MAO network development practices, especially if a participating plan serves a county or area that is regarded as being at high-risk for hospice fraud or abuse. In 2023, NAHC, in partnership with the other national hospice associations, submitted a list of recommendations to CMS for actions to take to improve hospice program integrity.<sup>7</sup> These same recommendations can be employed by MA plans to identify potentially fraudulent hospice operators upfront, preventing them from becoming part of their networks. Examples of the kinds of criteria that might help a plan's ability to flag a "bad actor" hospice include whether the hospice is co-located at the same address as many other hospices, or if the hospice administrator, medical director, or other leadership staff are responsible for overseeing many different hospices.

With regard to CON states, we understand that the variable CON laws and regulations across different states make it difficult to speak in blanket terms about CON-specific policies. That said, we do not believe there should be any special dispensations or exemptions for MAOs serving states with CON designations for hospice. Currently only 13 states and Washington DC have CON laws for hospice and VBID hospice-participating plans only serve 7 of those states. Given the limited number of CON states and the even smaller number of VBID MAOs in those states, CMS should not allow any flexibility for provider networks in CON states.

*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?*

NAHC strongly urges CMS to maintain the current prohibition on any MA prior authorization requirements for hospice care. As highlighted in the previous responses, the hospice care model and the unique vulnerability of hospice patients and families require timely and seamless connection to services as soon as is feasible. Especially given the aforementioned high number of hospice patients who are only on service for a few days before they die, imposing prior authorization in this setting could delay needed care and result in prolonged pain and suffering at a time that is already extremely difficult for patients and their loved ones. Prior authorization should not be allowed for either initial admission to hospice, or for transitions across the four levels of hospice care. As under FFS, any need for hospice care or level of care change should continue to be determined based on patient needs and the physician/team assessment of what level of care is required to most effectively meet those needs. Both state regulations and Medicare Conditions of Participation (COPs) require that the hospice interdisciplinary team (IDT) plan and assure the delivery of care. Additionally, Congress made clear in the *Benefits Improvement and Protection Act of 2000* (BIPA) that hospice certification of terminal illness "shall be based on the

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<sup>7</sup> [https://www.nahc.org/wp-content/uploads/2023/01/Hospice-Program-Integrity-Recommendations\\_Jan-2023.pdf](https://www.nahc.org/wp-content/uploads/2023/01/Hospice-Program-Integrity-Recommendations_Jan-2023.pdf)



physician's or medical director's clinical judgment regarding the normal course of the individual's illness."<sup>8</sup> These are basic foundational tenants of the hospice approach to care, and should continue to be honored and protected under the VBID model.

Recent government data from HHS' Office of the Inspector General (OIG) has validated many providers' longstanding concerns about the negative impact tools like prior authorization have on access to necessary and appropriate care. In a 2022 report, OIG found that MAOs' prior authorization practices frequently delayed or denied Medicare Advantage beneficiaries access to services that met Medicare coverage rules<sup>9</sup>. In their findings, OIG estimates 13% of the prior authorization denials met Medicare coverage rules. Alarming, OIG found that MAOs both used clinical criteria that are not contained in Medicare coverage rules to deny appropriate care, and argued that many prior authorization requests did not have enough documentation to support approval, even though OIG's reviewers did find that these requests for care were appropriately supported by beneficiary medical records. These findings should raise major red flags when considering prior authorization for a hospice population. Considering the urgency of end-of-life care, inflicting a problematic prior authorization process on an already vulnerable population could have severely negative consequences for the quality of care and quality of life for beneficiaries and families.

Some NAHC members' experience providing hospice care for commercial insurance patients further illustrates the challenge of prior authorization for this population, and serves as a cautionary tale for deliberations about its appropriateness for the VBID demonstration. For example, dealing with some commercial insurance plans' burdensome authorization requirements has resulted in hospices not getting paid for care provided due to untimely follow up from the plans, or in some cases patients not receiving timely hospice care because the provider is waiting to hear back from the plan regarding its decision to approve the hospice request. Some commercial plans require extensive medical record review or multiple layers of internal reviews, which slows down the hospice transition and adds stress and strain to patients, families, and hospice providers. Timely connection to care is critical in order to serve patients appropriately, and hospices often will have to coordinate services and equipment prior to their ability to obtain insurance authorization. Some plan response times for prior authorization decisions for hospice can be up to 14 days for routine home care. The time constraints and implications of delays due to prior authorizations are especially intense for referrals that are received by hospices after hours, on holidays or weekends, when insurance plans often do not have prior authorization representatives working around the clock, which exacerbates challenges with obtaining approval. Indeed, we have also heard from member hospices participating in the demo that MAOs in the model do not staff their utilization management offices 24 hours a day, despite the fact that hospices admit patients at all times throughout a day. Additionally, MAOs can have even more complicated and burdensome prior authorization systems than commercial plans, so the frustrations and negative impact the process has on privately-insured patients could be exacerbated for hospice patients if it were allowed under the VBID model, especially without additional safeguards. CMS recently finalized a requirement for shorter prior authorization response timelines for specified payers, including MAOs, requiring decisions to be made within seven days for standard requests and within 72 hours for expedited requests.<sup>10</sup> These parameters, while intended to serve as beefed-up safeguards in the

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<sup>8</sup> See 42 CFR 418.22(b)

<sup>9</sup> <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>

<sup>10</sup> <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.>

traditional MA program, would be dangerous to adopt for a hospice population, given the large number of patients who are only on service for two days or less.

CMS should also understand that the challenges associated with imposing prior authorization for hospice under the model could lead to patients and families in the community developing more negative opinions about hospice as a care model, which would likely deepen mistrust and fear, and reverse the many years of hard work and effort it has taken to cultivate high levels of public goodwill and acceptance of the hospice philosophy and experience. This could lead to greater hospice avoidance, which could have an enormous unintended consequence of increasing emergency room visits, increasing hospital mortality as beneficiaries are unable to transition to an alternate level of care for end-of-life, and increasing total cost of care at end-of-life as beneficiaries are unable to access their hospice benefit without an authorization.

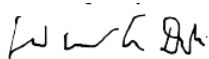
Beyond the implications for timely access to hospice, the additional administrative burden commercial prior authorization imposes on hospices adds major costs, time, and organizational resources that further strain financial stability, which unfortunately can impact an organization's capacity to continue delivering high-quality and responsive care in the way they want to. Most plans today have their own unique prior authorization systems, and expectations and rules around what kind of care is covered, how long a patient should be on service, and who should be eligible. Navigating the varied and sometimes shifting systems and requirements is extremely burdensome and difficult for hospices, and nearly impossible for small providers that are located in rural or under-resourced areas that lack the technological infrastructure or staff capacity to deal with multiple, uncoordinated plan approaches.

Simply put, applying MA prior authorization requirements to hospice patients would increase burden while delaying patient access and increasing the risk for patient harm.

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NAHC appreciates the opportunity to provide feedback on the above questions, and to share our thoughts on the evolution of the VBID hospice demonstration. We are grateful for our existing work with CMS on these important issues, and welcome the chance to deepen the engagement to ensure this model protects hospice patients and families. If you have any questions, please feel free to reach out to Davis Baird, Director, VP of Hospice Policy & Advocacy at [dbaird@nahc.org](mailto:dbaird@nahc.org).

Sincerely,



William Dombi  
President, National Association for Home Care & Hospice (NAHC)