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Submitted electronically via email to VBID@cms.hhs.gov

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:

On behalf of the more than 5,400 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment in response to Request for Information (RFI) on the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have timely access to high-quality, equitable palliative and hospice care.

Overview

Our comments below reflect our deep concerns around the potential implications of restricting access to hospice care under the MA VBID model, including through the imposition of provider network restrictions and prior authorization requirements. We are particularly concerned about the risk of such policies reducing patients' ability and willingness to access high quality hospice care in a timely manner if appropriate safeguards are not put in place.

We believe that such outcomes would compromise the success of the MA VBID model and its ability to meet the quality criterion for expansion of CMS Innovation Center models.

As CMS is aware, patients who require hospice are at a particularly stressful and vulnerable point in their lives. The hospice benefit is intended to ease many of their stressors, including pain and other symptoms, thereby contributing to increased comfort and improved quality of life in their final days, weeks, or months. Rather than supporting patients' smooth transition to the hospice benefit, the changes that CMS is contemplating would increase burden for patients, families, and caregivers, restricting access to patients' preferred hospices and requiring patients to jump through administrative hoops to obtain prior authorization for services to which they are entitled. In many cases, the added difficulty could result in patients' death prior to hospice admission. Indeed, one Academy member recounted how 64 percent of her hospice's non-admissions – that is, patients who were referred to her hospice but not admitted – were not admitted because they died prior to a first hospice visit, despite an average referral-to-visit time of 24 hours. If more hurdles are placed in front of patients as they seek to elect hospice, we fear that the proportion of patients who desire hospice but cannot access this vital service will see a troubling rise.

While we understand that network restrictions and prior authorization requirements are customary tools that Medicare Advantage organizations (MAOs) and other health plans implement to manage costs and utilization, we highlight that the application of these tools in the context of hospice care is not comparable to other services for which MAOs apply these tools. Hospice patients may be at imminent risk of death, with half of patients enrolled in hospice for 17 days or less in 2021, 25 percent of patients enrolled for 5 days or less, and **10 percent of patients enrolled for 2 days or less.**¹ This means that, for a substantial proportion of these patients, time is of the essence, and ready access to hospice care must be prioritized. Too often, election of hospice occurs because patients and their families or caregivers are aware of imminent death, and they have a strong desire to choose where the patients will be located when they die – most often in their homes. Honoring their decision-making at this stage is, therefore, of the utmost importance, particularly given the outsized impact of hospice election decisions on the emotional, psychological, and spiritual well-being of patients and their families and caregivers. Unnecessary barriers to patient- or caregiver-directed hospice election decisions, however, would place these considerations lower on the priority list, and increase the risk of negative – and even harmful – end-of-life experiences for affected beneficiaries.

We provide additional details on our concerns in our comments below. Notably, our comments reflect the input of a wide range of hospice and palliative care stakeholders, including hospice medical directors – inclusive of a hospice participating in the MA VBID program, hospice attending physicians, referring palliative care practitioners, and hospice and palliative care researchers. We believe their breadth of experience provides comprehensive understanding of the impact of CMS' contemplated changes on beneficiaries and their families and caregivers, as well as the hospices and practitioners who manage their care.

At the same time, we recognize that our comments only provide a starting point for CMS' further work on these issues. We note that, given the short comment window, reaching consensus on detailed

¹ National Hospice and Palliative Care Organization. NHPCO Facts and Figures: 2023 Edition. December 2023. Accessed from <https://www.nhpco.org/wp-content/uploads/NHPCO-Facts-Figures-2023.pdf> on January 20, 2024.

recommendations for addressing our concerns was not feasible. *We therefore request that CMS continue to engage in dialogue with AAHPM and other hospice and beneficiary stakeholders in order to translate our high-level comments to actionable network adequacy standards and other related MA VBID requirements.* We would be happy to engage our experts in such ongoing dialogue in order to secure the best possible outcomes for MA VBID hospice beneficiaries.

Responses to Questions

Question 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?

AAHPM has serious concerns with CMS' plan to permit participating MA VBID organizations more flexibility to require their enrollees to only receive hospice services from hospice providers in their network. We believe that, without significant guardrails, such a policy change will create significant barriers for patients to access medically necessary hospice care and ultimately reduce affected beneficiaries' ability to access high-quality hospice care in a timely manner. Barriers include the following:

- **Confusion among referring practitioners.** AAHPM is concerned that the imposition of network restrictions will result in significant confusion among practitioners, who are accustomed to referring Medicare hospice patients to any available hospice. This will be particularly true if – given the need that CMS highlights in questions 2 and 3 – there will be different rules for different patients depending on if the patient requires urgent or emergency care. Referring practitioners will have difficulty keeping track of which patients are enrolled in the MA VBID model, whether hospice network restrictions apply for a specific plan benefit package, and which hospice are contracted or non-contracted. Determining each of these factors, and more, will each take time, cumulatively adding more and more delay to getting a beneficiary an appropriate referral.
- **Limited scope of services among in-network hospices.** As CMS has highlighted,² many hospices are not furnishing certain specialized palliative therapies such as dialysis, chemotherapy, radiation, and blood transfusion. Likewise, CMS has clearly documented that a high percentage of hospices that provide little to no continuous home care (CHC), inpatient respite care (IRC), or general inpatient care (GIP). For some beneficiaries, access to these services will be critical for ongoing palliation during their hospice election, and referring providers will need to find hospices that can provide such care. If network restrictions are put in place, it will be much more difficult for referring providers to match patients to hospices that can meet their care needs in a timely manner or at all, if in-network providers do not offer these appropriate but more advanced palliative therapies.
- **Limited in-network availability, including as a result of geographic location, staff shortages, and more.** AAHPM is concerned that CMS' historic approach to establishing network adequacy standards under the MA VBID model will result in insufficient access for model enrollees if network restrictions are put in place. Our members report that hospices have been experiencing significant staffing shortages, which limit their ability to admit new patients in a timely manner. For example, one member reported experiencing wait times of 1 month and longer among some

² See CMS' discussion in the Fiscal Year 2024 Hospice Wage Index and Payment Rate Update proposed rule (88 FR 20022-20057).

hospices in her service area for admitting new patients. Likewise, we note that average daily census, on its own, does not fully reflect hospices' capacity or their ability to admit a new patient in a timely manner. Separately, as CMS has not been applying time and distance standards to hospice network adequacy standards, and the minimum number of provider (MNP) standard is determined at the MAO level, rather than a more granular level, it is possible that hospices may be unwilling or unable to serve beneficiaries located within the MAO service area due to travel time and distance constraints, including on an emergency basis. Without network adequacy safeguards to protect against these types of risks, beneficiaries may struggle to access the hospice care they need.

- **Personal preferences of patients, family members, and caregivers.** In our members' experience, patients (or their families or caregivers) often choose a hospice based on their own positive prior experiences with a hospice or the recommendations of family members, caregivers, and/or friends. Likewise, in many cases, patients may be amenable to hospice election, but not from a particular hospice program that they feel did not meet their loved one's needs or expectations. The role of emotion and personal preference in making a hospice election should not be discounted, and we are concerned that inability to access a preferred hospice due to network restrictions will deter patients from electing and benefitting from hospice care.

Further, even after beneficiaries have been admitted to an in-network hospice, we believe network requirements could pose ongoing challenges for patients and families, and in particular, we are concerned that patients could experience quality and continuity of care challenges. For example, it is not clear what protections patients will have if the MAO terminates its contract with a hospice provider while it is actively managing the MAO enrollees' hospice care. Likewise, it is not clear how patients – or the practitioners they call upon for assistance – will navigate circumstances when their hospice needs change and they require services like GIP or a palliative transfusion that the in-network hospice is unable to furnish, or when there is evidence otherwise suggesting the in-network hospice is furnishing substandard care. At the same time, members also reported concerns that referring practitioners could experience difficulty maintaining ongoing contact with hospice beneficiaries if they are not familiar or have relationships with in-network hospices, which can lead patients to feel abandoned. While patients in such scenarios could theoretically petition to be transferred to out-of-network hospices, it is not clear that such changes could happen in a timely manner, and if patients are denied, there is a significant risk that they would not have the time or wherewithal to navigate multiple levels of appeals. These requirements would increase stress in an already stressful period and would require significant energy and time from patients and their families who often have limited amounts of both.

We are also concerned that the contracting practices of MA organizations (MAOs) could undermine the financial viability of hospice providers, and in particular disproportionately harm small, rural, and not-for-profit hospices. One member who participates in the MA VBID model reported that their hospice accepted MA VBID payment rates that are lower than fee-for-service (FFS) hospice rates. While their hospice is large enough to accommodate the payment reductions at this time, they note that their hospice's ability to provide specialty interventions would be harmed if the payment reductions were spread across a larger proportion of the patient population. Of course, small, rural, and not-for-profit hospices with small margins will also face challenges staying viable if they are compelled to accept lower rates, and/or they are shut out of network models that do not provide adequate reimbursement.

For the above reasons, we urge CMS to exercise the utmost caution as it considers plans to impose provider network restrictions on MA VBID enrollees' ability to access hospice care. We believe numerous safeguards will be needed to ensure beneficiaries' ability and willingness to access hospice services is not

compromised, and that their experience participating in the hospice benefit is commensurate with beneficiaries receiving hospice care on an FFS basis. *In implementing any network restrictions, AAHPM urges CMS to adhere to the following principles:*

- *Beneficiaries should have timely and equitable access to hospice care across all participating geographies and communities, consistent with what should be available under Medicare FFS.*
- *Hospice services should be furnished in a manner that meets the individualized care needs of hospice patients and their families to ensure optimal care experience.*
- *Hospice services should be consistent with services that should be available under Medicare FFS, including with respect to the quality and intensity of services that hospice beneficiaries receive. Beneficiaries should have access to higher levels of hospice care – that is, GIP or CHC – when needed.*
- *Beneficiaries should have the right to petition for out-of-network hospice care, including higher level appeals, and all requests for out-of-network care should be reviewed on an expedited basis.*

We note that, rather than implement network restrictions, CMS could continue to utilize an approach that is currently in place under the model that provides supplemental benefits for patients who choose in-network hospices. We believe that an approach that utilizes “carrots” instead of “sticks” will support CMS’ and MAO plans’ interest in increasing in-network utilization while at the same time ensuring that patients can access medically necessary hospice services when and where they choose.

We also recommend that MAOs engage in extensive outreach and communication efforts with hospice and palliative care stakeholders in their service areas. Referring providers should receive regular updates about MAOs’ plans to limit access to network providers (including for standard versus urgent admissions), which hospices are in-network, and how to address access questions and concerns in a timely manner.

Additionally, CMS should implement a robust monitoring program to determine the effects of network restrictions on patient access. Such a monitoring program would track a range of indicators and, as applicable, compare performance of contracted hospices relative to the FFS experience in the same service area. Indicators should include, but not be limited to:

- Rates of hospice admission for each participating plan benefit package
- Median hospice length of stay
- Average star rating of MAOs’ contracted hospices
- Provision of higher levels of hospice care (GIP and CHC)
- Provision of respite care
- Quality performance indicators, including claims-based indicators and responses to hospice CAHPS surveys
- Requests for out-of-network hospice services, along with timeliness of determinations, approval and denial rates, and rates of overturned denials
- Rates of conversion from hospice referral to hospice admission
- Timeliness of hospice referral to hospice admission
- Rates of out-of-network utilization
- Rates of transfer from out-of-network to in-network hospices, and vice versa.

Finally, we also believe that CMS must include additional access protections and network adequacy standards, as further detailed in response to questions 3 and 4 below.

Question 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? Additionally, how could such protections be operationalized by participating MAOs?

AAHPM believes that it is imperative for safeguards to be put into place for patients that are in crisis and need immediate hospice support. As noted above, we are concerned that any type of network restrictions would be harmful to beneficiaries, but we believe that is particularly true in the case of patients needing urgent or emergency hospice care. Particularly given the short median hospice length of stay, we believe that more often than not, admissions to hospice would be considered urgent or of an emergency nature.

While we appreciate that existing regulations require MAOs to ensure access to covered benefits under urgent or emergency hospice care, we are concerned that that this requirement could be easily disregarded or by MAOs given lack of historic understanding about what may qualify as urgent or emergent with respect to the need for hospice. For example, MAOs may only consider a case to be an emergency if the patient seeks care from an emergency department, or may determine that in emergency situations, seriously ill patients at the end of life should simply seek emergency care, rather than seek admission to an out-of-network hospice. Such an approach could subject beneficiaries to harmful, unnecessary, and expensive medical intervention when they instead would prefer a palliative approach to managing their well-being in their final days. The risk of such an outcome is exacerbated by the lack of clear or objective criteria for determining when the need for a hospice admission case would be considered urgent or emergency, and therefore fall under statutory protections. Indeed, we do not believe that current MA definitions for emergency medical condition and urgently needed services at 42 CFR 422.113 (b) adequately capture the potential risks to hospice beneficiaries. For example, it is not clear that a pain crisis would meet the current regulatory criteria for being considered an emergency medical condition. Likewise, patients may experience a range of urgent or emergency social, psychological, or spiritual needs – as could caregivers who may also experience crisis in their ability to provide the necessary care – that could be managed by hospice providers when beneficiaries make a hospice election. Additionally, the current definition for urgently needed services requires the beneficiary to be out of the plan’s service area, but we would not expect that the beneficiary would necessarily be out of the service area in the scenarios we are envisioning for urgent hospice care – for example, if in-network hospices cannot admit patients in a timely manner. We also note that, even if objective criteria more applicable to hospice patients were to be established, dying patients might not always fall neatly into such criteria.

We are concerned that lack of clarity about access to hospices on an urgent or emergency basis would place patients and their families and caregivers in the middle – potentially at risk of either non-payment by health plans or non-receipt of services by out-of-network hospice providers. For example, would patients be responsible for payment of hospice services if plans determine that the admission did not reflect an urgent or emergency need? Under what conditions could plans determine that an admission is not urgent? This lack of certainty and risk of liability could result in tragic delays in patients’ access to hospice care, including risking the patient’s death before hospice admission, or patients’ decisions to forego hospice care altogether, potentially resulting in preventable suffering and unwanted hospitalizations.

And even if plans agree that a hospice admission reflects an urgent or emergency need, will patients have

to transfer to in-network hospices once they are considered to be stabilized, which will require patients to face the burdens and risks of shifting care teams and changes in contracted durable medical equipment and oxygen providers, as well as to undergo repeat admissions procedures? Given the short median length of stay of hospice patients, AAHPM is concerned that a required transfer will create unnecessary stressors that will harm patients' end-of-life experience, including by increasing the risk that patients will not have the opportunity to develop therapeutic relationships with the new hospices before dying. A required transfer would also not support patients' choice in the selection of a hospice provider in their last days of life.

To address these concerns, we urge CMS to adhere to the following additional principles when considering safeguards to ensure beneficiary access to urgent and emergency out-of-network hospice care:

- *CMS should establish clear definitions that apply across the MA VBID program for what constitutes an urgent or emergency need for hospice services. Definitions should include a holistic understanding of need that incorporates the many dimensions of individual well-being addressed by hospice care, including medical, physical, social, psychological, spiritual, and caregiver needs.*
- *Patients should be allowed to access out-of-network urgent and emergency hospice services even if they are in the MAO's service area.*
- *MAOs should defer to physicians' judgement regarding patients' need for urgent or emergency hospice care, consistent with the definitions CMS has established, and prior authorization should never be applied.*
- *Hospice beneficiaries admitted to an out-of-network hospice on an urgent or emergency basis should not be required to transfer to an in-network hospice during the course of their hospice election and should not be penalized for continuing care with an out-of-network hospice in any way. However, beneficiaries should be allowed to voluntarily elect to transfer to an in-network hospice once they no longer meet the definition of having an urgent or emergency need for hospice services, if consistent with their preferences.*
- *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. MAO denial of ongoing coverage or payment should only be applied prospectively for dates of service after beneficiaries have exhausted all appeal rights. All appeals should be reviewed on an expedited basis.*

We also recommend that, in addition to the indicators noted in response to question 1, CMS further track the following indicators specifically related to use of urgent or emergency hospice services:

- *Rates of out-of-network utilization for urgent or emergency hospice care*
- *Rates of transfer from out-of-network to in-network hospices, and vice versa, specifically related to urgent or emergency hospice care.*

Question 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?

In order to protect patients' rights to urgently needed out-of-network hospice services and to protect patients and hospice providers against improper payment denials, AAHPM believes the best approach would be to adhere to the principles and recommendations outlined in response to Questions 1 and 2 above. AAHPM would be pleased to work with CMS to translate these principles into more specific requirements that would apply for the MA VBID model.

Question 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?

As detailed above, *AAHPM is concerned that CMS' current Model-specific network adequacy standards (as reflected in the 2024 MA VBID Phase 2 Network Adequacy Requirements Policy and Technical Guidance³) would not provide assurance of a sufficiently robust hospice provider network to meet beneficiary needs and believes that modifications are needed to align with the principles listed above.* For example, we believe that CMS should apply network adequacy standards that consider the projected need of the patient population holistically, not simply based on a calculated minimum number of providers. That is, *network adequacy standards should ensure that contracted hospices have sufficient capacity to meet the projected need, including based on the size and staffing level of the contracted hospices.* Furthermore, we are concerned that CMS' decision not to apply a time and distance standard will also compromise the robustness of the hospice provider network and patients' ability to access and receive timely hospice care. While hospice providers may most often travel to patients' homes to deliver hospice care, the lack of a time and distance standard may mean that hospice locations are significant distances from patients' homes. This 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. Hospices would also experience greater difficulty traveling to patients' homes quickly in response to urgent or emergency situations. To avoid such outcomes, *we believe that CMS' network adequacy standards should be updated to ensure that hospices are located within a reasonable proximity to patients' homes – for example by applying time and distance standards or by assessing network adequacy at a more granular level such as by census tract.* To be sure, CMS' current approach of determining the minimum number of providers at the MAO level rather than a more granular level will inevitably lead to disproportionate geographic allocation of hospices across MAOs' service areas. *Furthermore, where there are insufficient Medicare certified hospices that would enable the MAO to meet time and distance standards for a given service area, MAOs should be required to ensure access to the closest available hospice providers.*

AAHPM also encourages CMS to consider network adequacy standards that ensure that network hospices meet quality and service standards comparable to what is available in the same service area for Medicare FFS beneficiaries. For example, CMS should incorporate assessments of quality performance and availability of higher levels of hospice care (e.g., GIP or CHC) when determining if an MAO's hospice network is sufficiently robust.

With respect to certificate of need (CON), we note that the variability in CON laws by state will result in significant disparities regarding the number of hospices that may be available to participate in an MAO's hospice network. We are therefore concerned that a single set of network adequacy standards will not be able to bridge the whole continuum, while still ensuring ready access to hospice services. *However, we do not believe that hospice availability in strict CON states should serve as a floor for network adequacy requirements across all states. Rather, we believe our principles and the network adequacy standards they support should apply wherever practicable; exceptions to robust network adequacy requirements should only be allowed when unavoidable based on strict CON limits.*

³ <https://www.cms.gov/priorities/innovation/media/document/vbid-cy2024-hospice-phase2-ntwk-adq-guidance>

Question 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?

AAHPM believes that CMS should fully maintain its Model-specific requirement to not allow any prior authorization requirements for in-network hospice care, nor for urgent or emergency hospice services.

Similar to our concerns with the network restrictions, we believe that implementation of prior authorization requirements could have detrimental effects on patients' ability to access medically necessary hospice services in a timely manner. Prior authorization requirements to access hospice services or to receive higher levels of hospice care could significantly impair patients' ability to receive care they need when they need it. For hospice patients in crisis, this could mean that patients experience excruciating pain or other distressing symptoms for hours or days before a prior authorization request is approved, or even that they die before being admitted to a hospice. Patients may also decline to elect hospice if prior authorization delays lead to concerns regarding potential financial liability.

As the Office of Inspector General has shown, MAOs regularly deny medically necessary services to which beneficiaries are entitled, and their denials are disproportionately overturned.^{4,5} We are concerned that extending this poor track record to hospice benefits would result in tragic consequences, particularly given reports that demonstrate lack of MAO capacity to accommodate unique hospice needs. For example, one member reports that prior authorization requirements for transitional concurrent care and supplemental benefits under the model has resulted in significant delays in care for hospice beneficiaries, including because MAOs do not staff their utilization management offices on a 24/7 basis, despite the fact that hospices admit patients around the clock. Even when utilization management teams are available to receive requests, delays in reviewing cases and issuing determinations could be significant, as beneficiaries can experience significant decline over a 72-hour period that may elapse before a plan responds to an "expedited" request (as required when CMS' new prior authorization timelines are effectuated) for a hospice admission. Additionally, in our members' experience, health plans do not have appropriate staff reviewing prior authorization requests or providing oversight of prior authorization denials: rather than utilizing peer-to-peer review, MAOs may rely on clinicians without expertise in hospice and palliative medicine.

In order for beneficiaries to have timely and equitable access to hospice care – both for initial admissions and access to higher levels of care – in a manner consistent with what is available under Medicare FFS, prior authorization requirements cannot be allowed.

We further highlight that the Medicare hospice benefit already has a built-in process that addresses risk of inappropriate admissions. That is, two physicians must certify that patients meet hospice eligibility criteria before enrollment into a hospice program. Applying prior authorization requirements would simply increase burden while delaying patient access and increasing the risk for patient harm.

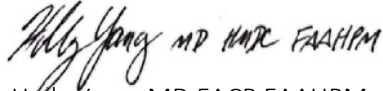
⁴ HHS Office of Inspector General (2018). Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials. OEI-09-16-00410. Downloaded from <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf> on January 24, 2024.

⁵ HHS Office of Inspector General (2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care. OEI-09-18-00260. Downloaded from <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf> on January 24, 2024.

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Thank you for considering our feedback on the future direction of the MA VBID Model hospice component. As noted above, AAHPM would be happy to continue to work with CMS to consider policy options that address both CMS' goals for the future of the model as well as our substantial concerns about the risks that network restrictions and prior authorization requirements would pose for beneficiary access to timely, high-quality hospice care. If you have any questions, please feel free to reach out to Wendy Chill, Director, Health Policy and Government Relations, at wchill@aaahpm.org or (847) 375-6744.

Sincerely,



Holly Yang, MD FACP FAAHPM
President