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December 2nd, 2014

Martique Jones, Deputy Director
Regulations Development Group
CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attn: Document Identifier/OCN 0938
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-10538; Prior Authorization Form for Beneficiaries Enrolled in Hospice

Dear Ms. Jones:

On behalf of Cambia Health Solutions, thank you for the opportunity to comment on the proposed standardized prior authorization form for hospice beneficiaries. As a total health solutions company, Cambia takes person-centric care very seriously. In fact, we consider all decisions under the guidance of our Cause: "To serve as a catalyst to transform health care, creating a person-focused and economically sustainable system." Keeping these values in mind, we respectfully submit our comments in regard to this proposal.

We have a unique perspective on hospice and end-of-life care in that Cambia's health plans provide the industry's most comprehensive integrated palliative care program, a holistic system of serious illness care and services to our more than 2.2 million members. Through specialized case management, coordinated care, caregiver support and community outreach Cambia is transforming palliative care. We offer this benefit because we believe that all health care should be patient-centered and humane, especially for those suffering from serious illness and approaching end-of-life.

Palliative care, as defined by the Institute of Medicine, is care that "provides relief from pain and other symptoms, that supports quality of life, and that is focused on patients with serious advanced illness and their families."[1] Hospice is integral to quality palliative care. For patients nearing terminal stages, hospice provides a comforting and cost-effective alternative to hospital stays or other medical interventions. The management of emotional stress, pain and other symptoms at end-of-life are core elements of hospice. Palliative care shares these basic tenets.

We at Cambia have common goals with Centers for Medicare and Medicaid Services. CMS expressly states the desire to "improve the quality of life and care received by

[1] IOM (Institute of Medicine). 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life.* Washington, DC: The National Academies Press.

Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures"[2] through hospice. CMS is not alone in this endeavor. Cambia strives to reach these same goals by providing health care that focuses on the member and is economically sound. Our palliative care program embodies these pillars.

While we respect the effort being made by the CMS to improve the coordination between prescribers, hospices and Part D sponsors, we are concerned with the suggested remedy of a standardized prior authorization. Along with many others in our industry, we support the use of prior authorizations when they include a front-end reimbursement to providers. We oppose, however, the proposed rule's post-authorized reimbursement structure because it has a detrimental effect on consumers, providers and the health system as a whole.

Impact on Consumers

Individuals at end-of-life have an increased prevalence of medical bankruptcy due to extensive out-of-pocket costs associated with unreimbursed services provided, loss of wages, and lack of social subsistence. Under the prior authorization process introduced by CMS, in some instances the member may have to pay out of pocket for non-reimbursable drugs that are not part of the palliative care for the member. This requirement would put an administrative burden on hospice providers to make the member and/or their family aware of the drugs that are no longer covered on Part D and are not covered on Hospice so that the member/family can make an informed choice about their treatment options. Drugs required to go through prior authorization will be denied automatically, increasing likelihood that patients would forego needed medications. The rate of hospice election is underutilized. In fact, according to studies done by the Medicare Payment Advisory Committee[3], the median stay in hospice is approximately 19 days. The proposed prior authorization process will only further reduce hospice utilization which is an outcome of that is diametrically opposed to our shared goals. Hospice is a vastly preferable, less costly and more humane service delivery model.

Impact on Providers

We consider the administrative burden of completing and processing the proposed prior authorization by hospice providers as a financial cut. Already spread thin, hospices are impacted by the cuts imposed by the Affordable Care Act and the budget sequestration to CMS payments. Under the Affordable Care Act, beginning in 2013, the hospital market basket index used to update payment rates is reduced by a productivity adjustment. The Hospice Action Network proposes that due to the labor-intensive nature of hospice care, this adjustment may not be appropriate for hospices. There may be additional reductions to the market basket update tied to targets for health insurance coverage among the

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[2] "Medicare Care Choices Model." *Centers for Medicare and Medicaid Services*. Web. 21 Nov. 2014. <http://innovation.cms.gov/initiatives/Medicare-Care-Choices/index.html>.

[3] Medicare Payment Advisory Committee. 2013. Report to Congress: Medicare Payment Policy.

working age population. Under sequestration, in 2013 there was a reduction of 2% to most Medicare spending, including hospice payments. This reduction is still in effect. Adding an additional burden places more limitations on the provider, while diminishing the capacity to provide care. Further, requiring pharmacists to track down hospice information in order to acquire the prior authorization in advance of releasing medications creates a delay for the patient while placing an undue responsibility on the pharmacy.

Impact on the Health System

For the population of people approaching end-of-life stages, hospice is a comforting alternative to major medical intervention. Hospice addresses the psychological, spiritual, and emotional need of the individual while administering skilled care. When a patient opts out of the hospice benefit in order to obtain medications covered by Part D, disruption to the system spans both cost and quality of care. The recently released Institute of Medicine report *Dying in America* is a strong resource attesting to these disruptions. It is well-documented that individuals nearing end-of-life outside of a hospice setting have a higher rate of hospital readmission and emergency department visits. Additionally, these types of transitions are often mismanaged and confusing for beneficiaries and family members, with referrals unmade, psychological needs unmet, and a higher rate of medication error. The costs associated with these events are significant. Providers paid by Medicare are incentivized by the fee-for-service platform as opposed to the per diem rate hospices receive; physicians are practiced to provide high-cost services, tests and procedures. Most 911 calls near end-of-life are from pain or mismanaged symptoms that would be better treated through palliative care or by a physician visit, as opposed to an emergency department trip, but EMS workers are required to transport Medicare beneficiaries to a hospital in order to receive payment. These factors contribute to higher costs associated with beneficiaries opting out of hospice, as well as disjointed care without significant benefit at late-stages of life.

We strongly support improving coordination across the health care system to ensure Part D medications are being swiftly accessed and properly appropriated. Unfortunately, a standardized prior authorization form makes an already complex process more difficult to manage and coordinate. In addition, it places a financial burden on providers and delays key medications for hospice beneficiaries.

We urge the Centers for Medicare and Medicaid Services to revisit the proposal in its entirety. A standardized prior authorization form requirement will do more harm than good and decrease coordination rather than improve coordination. We seek a remedy that fosters support of providers and creates a more patient-friendly process for this vulnerable end-of-life population while successfully achieving the CMS goal of increasing hospice utilization and decreasing expensive, unnecessary hospital stays. As an alternative to the proposed rule, we support allowing payers to address this individually to meet the needs of hospice patients and the providers who care for them.

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To that end, our Deputy Chief Medical Officer, Dr. Csaba Mera, and I welcome further conversation regarding this process and improvements that can be made.

Best,

Mark Ganz
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