

## Delivery of Hospice as Part of MA Benefit Package: Concerns and Recommendations

### BACKGROUND

The hospice benefit was the first bundled benefit package authorized under Medicare. Since its inception, the Medicare hospice benefit has been excluded from the Medicare private plan (Medicare Advantage-MA) benefit package. During January 2019, the Centers for Medicare & Medicaid Services (CMS) announced plans to test inclusion of hospice under MA as part of its Value-Based Insurance Design model (VBID Hospice) for four years starting in CY2021.

Under the model, MA plans are required to offer advance care planning (ACP) services, concurrent care for patients choosing an in-network hospice provider to assist with the transition to hospice care, and palliative care services (described by CMS as “largely medical services” already available under Parts A and B of Medicare). In addition to regular supplemental benefits, plans in the model are permitted to offer hospice-specific supplemental benefits that are tailored to the individual’s care needs. Plans are permitted to place a dollar limit on the cost of hospice supplemental benefits, and may also limit their availability to those patients that choose an in-network hospice. Plans are encouraged to provide hospice patient “consultations” to explain benefit limitations should the patient select an out-of-network hospice.

While the model requires that the “full” hospice benefit be provided, it also places a heavy emphasis on management by the MA plan and on utilization controls. CMS and plans (rather than the hospice physician overseeing the patient) will make the ultimate determination of whether services are “unrelated” to the terminal condition and related conditions and would therefore be outside of the hospice benefit package, rather than the hospice

physician. Further, plans are permitted to implement “program integrity safeguards”, suggestions for which include requiring prepayment review of drugs ordered by out-of-network hospices and prepayment review to address long lengths of stay (more than 180 days). CMS also references potential bonus payments for plans that reduce spending outside of hospice while patients are on service (unrelated services) and a quality bonus program aimed at length of stay (reducing lengths of stay over 180 days and increasing short lengths of stay to 7 days or more), as well as live discharge from hospice followed by hospitalization or death.

While it appears that plans will cover services provided by all in-network and out-of-network hospices in an area for the first two years of the model, plans are permitted to exclude hospices based on characteristics that they deem as a potential harm to patients – including that the hospice provides limited physician services or has not consistently offered all levels of care. CMS’ identification of these characteristics as examples raise concerns since these practices by hospices vary widely due to a number of difference circumstances and do not necessarily have a direct link to poor quality care. In the third year of the program, **plans will be subject to a network adequacy standard such that they must contract with as few as one hospice per county.** Plans may not increase their bids to address the costs of palliative care, concurrent care, or hospice-specific supplemental benefits.



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The details for the VBID Hospice model have done little to allay concerns around bringing hospice under MA. If CMS plans to move forward with the demonstration, Congress should:

- Require that the model be revised to:
  - Ensure patient freedom of choice;
  - Eliminate incentives that could result in patient steering toward particular hospice programs;
  - Ensure that in cases where plans exclude hospice providers from their networks due to concern of potential harm to patients that the exclusion criteria used have a demonstrable impact on patient safety and/or quality of care;
  - Ensure that MA plans report all patient visits and services in a comprehensive manner so that service utilization can be compared with hospice care under fee-for-service;
  - Require CMS to expand quality measures to include the percent of patients that die in hospice care;
  - Require that CMS ensure full transparency regarding the benchmarks to be used for each element of the model evaluation and evaluate them against the experience of MA patients outside the model who elect hospice care under fee-for-service and under regular MA; and
  - Require CMS to supply annual updates on the model.

As part of the demonstration, Congress should require CMS to test alternative models, including:

- Allowing MA plans to cover all services (including services unrelated to the terminal illness and related conditions) with the exception of hospice services; and
- Creating an end-of-life services bundle that provides hospices the opportunity to manage all care needs once a patient enrolls in hospice care.

**Finally, Congress should urge the Administration to focus on addressing areas that hold the greatest potential for improvement in end-of-life care, including:**

- Creation of a robust set of cross-setting end-of-life care measures that can be utilized under original Medicare and MA to assess quality of care, adequacy of care coordination and transitions, and patient/family satisfaction;
- Education of stakeholders (plans, hospices, and patients) around the interaction of MA and hospice care coverage to reduce existing confusion and exploration of potential MA coverage modifications, such as the transfer of non-related care at the end of life to MA plans, to reduce coverage complexity and increase plan responsibility;
- Examination of findings from existing innovation models, such as the Medicare Care Choices Model (MCCM) and the Primary Care First-Seriously Ill Population (PCF-SIP) models for useful lessons on appropriate support of advanced illness ways to provide a smoother transition to hospice care where appropriate; and
- Thorough analysis of the impact of developments in end-of-life care and recent changes to the MA benefit package (including the allowance of palliative care as a MA supplemental benefit) on utilization of hospice care.



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