Eli's Hospice Insider

Managed Care: Medicare Unveils Medicare Advantage Hospice Carve-In Details

New payment model comes with many worries for hospices.

A first look at how Medicare Advantage plans will include hospice in their programs is failing to reassure many hospices.

Background: About a year ago, the **Centers for Medicare & Medicaid Services** announced that it would test out including hospice in Medicare managed care plans' offerings starting in 2021 (see Eli's Hospice Insider, Vol. 12, No. 3). Now CMS has issued a detailed Request for Applications document for the Value-Based Insurance Design demonstration project, and encourages MA plans to submit applications by March and a final bid by June 1.

While CMS's 44-page RFA document reveals lots of new information, it also leaves out many specifics, including exactly how it will generate reimbursement rates for the so-called hospice carve-in.

Important points the RFA spells out:

- Participating MA plans must provide the full scope of hospice benefits, work with an interdisciplinary care team, and provide the four levels of hospice care.
- Hospice patients must be terminally ill, which includes having a six-month prognosis.
- Plans must cover both hospice care and "have a strategy around access and delivery of palliative care services for enrollees with serious illness who are either not eligible for or who have chosen not to receive hospice services."
- Plans must cover hospice services furnished by both in-network and out-of-network providers, must pay non-contracted hospice providers at a rate equal to the original Medicare Fee-For-Service (FFS) payment for hospice services, and must set cost sharing no higher than the cost sharing in original Medicare for hospice benefits.
- Election and revocation will be entirely up to patients.
- Plans may "identify additional items and services that extend beyond Original Medicare hospice care" and offer them as "supplemental benefits." Examples include adult daycare, caregiver support, and meals.
- CMS will monitor the impact of the model on the following quality domains: (i) Palliative Care and Goals of Care Experience; (ii) Enrollee Experience and Care Coordination at End of Life; and (iii) Hospice Care Quality and Utilization.
- Beginning in 2023, CMS plans to make a quality-related payment adjustment for participating plans. CMS expects the adjustments to be based on: (i) Proportion of Enrollees Admitted to Hospice for Less than 7 Days; (ii) Rate of Lengths of Stay beyond 180 Days; and (iii) Transitions from Hospice Care, Followed by Death or Acute Care, it says. "CMS may consider additional measures such as Days Spent at Home in the Last Six Months of Life and Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life," the RFA adds.

Plans Can Look At Hospice-Provided Doc Services, Weekend Visits

Industry representatives are expressing their reservations over the initial details. The **National Association for Home Care & Hospice** "has long-standing concerns that carving hospice care into the MA benefit package will diminish the integrity of the hospice benefit," the trade group says in its member newsletter. "While this model creates options that have the potential to better support patients with serious illness (including through advance care planning and palliative-type services), inclusion of the hospice benefit in the model is not necessary to take such action, and may work to undermine hospice as the foundation of our nation's system for end-of-life care."

The **National Hospice and Palliative Care Organization** also has doubts about the carve-in. While the trade group "supports innovation that enhances opportunity for access to high-quality, interdisciplinary care, NHPCO continues to

have serious concerns about timing for implementation, the impact on beneficiary access to high-quality care, and lack of beneficiary protections," it says in a release.

Failing to waive the six-month prognosis requirement for eligibility is a big "missed opportunity," NHPCO continues.

Another issue is the short timeframe. "Plans do not have sufficient time to establish provider networks, and providers do not have time to negotiate contracts with MA plans, especially the many smaller programs that provide high-quality care to underserved and rural areas," NHPCO argues.

One helpful change would be adding an ombudsman program to the model, NHPCO suggests in its statement.

Hospices should take note that plans may propose to exclude hospice providers that are "found through publicly available data or sources to pose a risk for beneficiary harm" or "consistently [have] not offered all four levels of hospice care, infrequently provided physician services, or rarely provided care on weekends."

Note: More information, including a link to the RFA document, is at https://innovation.cms.gov/initiatives/vbid.