Eli's Hospice Insider

Payment: Prepare For More Departures From Traditional Medicare Reimbursement

CMS pushes alternative payment models.

As Medicare talks about ramping up hospice participation in alternative payment models and managed care, hospice providers are enumerating the problems with an APM they already are a part of.

At the **National Association for Home Care & Hospice's** March on Washington conference, a top **Centers for Medicare & Medicaid Services** official told attendees about the agency's push to switch Medicare payments away from fee-for-service models. CMS hopes to tie 50 percent of payments to non-FFS models by 2018, noted CMS Deputy Administrator and Director of the Center for Medicare **Sean Cavanaugh** in an April 4 talk. And that percentage will only go up. CMS has already met its goal for 2016 of tying 30 percent of Medicare spending to APMs.

Hospices' APM participation has been more limited than home health agencies' involvement with APM programs including Value-Based Purchasing, the Comprehensive Care for Joint Replacement (CJR) model, and the Bundled Payments for Care Improvement initiative (BPCI). Under BPCI, hospice services are excluded from the calculations that compare an episode's cost to a target price.

But hospices have their own dedicated APM too the Medicare Care Choices Model demonstration project. Under MCCM, hospices receive $200 or $400 per month, based on days of service, for furnishing supportive palliative services to beneficiaries who would qualify for hospice but don't want to give up curative care. Participation is limited to benes with "advanced cancers," chronic obstructive pulmonary disease, congestive heart failure and HIV/AIDS, CMS notes on its website. Half of the 141 participating hospices began in January, and the other half will begin in January 2018.

The problem: Finding an eligible MCCM patient is like "finding a unicorn," one conference attendee told Cavanaugh in the question-and-answer session after his talk. His hospice had yet to admit a patient under the restrictive eligibility criteria.

It has taken **Neighborhood Health** in West Chester, Pa., more than four months to enroll its first MCCM patient, CEO **Andrea Devoti** tells **Eli**. Of three potential MCCM enrollees it had identified earlier, one died and two decided to enroll in the regular hospice benefit, Devoti explained at the NAHC meeting.

Barriers: "The biggest issues for us are being on a Medicare Advantage plan, or not having part D drug benefits," Devoti says.

Cavanaugh admitted that part of testing new payments models may be finding out that they don't work, and urged hospices to furnish feedback on MCCM experiences to CMS's Innovation Center.

More APM Concerns

Quality: Presumably, as in other provider types' APMs, hospices eventually would be paid or included in programs based on their quality scores. This is a problem because CMS doesn't yet have publicly reported quality measures, conference attendees told Cavanaugh. CMS uses outdated and inaccurate data, providers said in a separate session.

Evaluation: Ellen Bolch, CEO of the **THA Group** in Savannah, Ga., whose HHA participates in BPCI, asked Cavanaugh how CMS will assess a provider's effectiveness under the model.

It boils down to cost effectiveness and care improvement, Cavanaugh responded. Some models may work in certain geographic areas, while others don't, he offered.

Medicare Advantage Threat Looms

NAHC's **Theresa Forster** noted in a separate session that hospices soon may grapple with another payment structure Medicare Advantage. Currently, when patients elect hospice, they are disenrolled from their MA plan and receive hospice services under FFS Medicare. Policy- and lawmakers ranging from the **Medicare Payment Advisory Commission** to congressional committees of jurisdiction have broached the idea of including hospice in the MA benefit.

Problems: The downsides of including hospice in MA plans include taking away the patient's choice of provider and paring down the services offered to patients at end of life, providers say.

Irony: If lawmakers proceed with this change, the hospices who would have the financial resources to agree to low-cost contracts with MA plans would be those who are currently the most profitable, Forster pointed out. That would most likely be hospices with long lengths of stay, which Medicare is trying to discourage.