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Eli's Hospice Insider

Reimbursement: Hospices Question Whether Concurrent Care Demo Pays Enough

Plus: Did CMS drag its feet on the concurrent care pilot?

A larger-than-expected response to Medicare's hospice concurrent care demonstration has led to a ramped up project, but the industry reaction may have been even bigger if pay levels had been higher.

When the **Centers for Medicare & Medicaid Services** announced the program's proposed pay rate of $400 per beneficiary per month last year, multiple hospices voiced concerns about the amount adequately reimbursing for the services covered under the program. One industry expert cites several hospices that "looked at the proposal when it initially came out, and said that $400 per month was way too inadequate to cover the services they would have to provide or would feel obligated to provide."

"My sense is that the concept is good, but the money is lousy," laments **Heather Wilson** with **Weatherbee Resources** in Hyannis, Mass.

Payment adequacy was "a question that many hospices struggled with when applying," agrees **Kathy Brandt of the kb group** in Washington, D.C. "Providers I spoke with, including two that decided not to apply, didn't think it was financially viable."

In comparison, **Partnership HealthPlan of California's** similar pilot will reimburse providers closer to $1,000 per member per month, with incentives built in for quality outcomes, Brandt relates. "I wish that the CMS payment model was more robust," Brandt tells **Eli**.

If the money isn't there, then why did Medicare receive such an enthusiastic response to its proposal? With some encouragement from CMS, at least some hospices that decided to participate believe CMS will raise the rates if necessary, Brandt says. CMS officials have hinted "that the payment rate and costs of care would be monitored and that adjustments could be made," she says.

Beware: But CMS appears to believe that with good care management, proactive advance care planning, caregiver support, and similar practices, "patients who need higher level care will move over to hospice sooner," Brandt says. "They may be right. However I do think some hospices will lose money on this."

Marketing Benefits Figure Into The Equation

Some hospices may participate to capitalize on the opportunity to grow referrals all referrals. For demo patients that will later go off the program and elect full-blown hospice, there's a natural tendency to continue with the provider they already know, experts point out.

And hospices will hope to gain more referrals by offering this valuable service to patients and their referral sources. Many of the selected hospices issued press releases or lined up local newspaper coverage about their new role under the project.

For example: "No other hospice provider in the Miami Valley provides comprehensive concurrent care services to their

hospice patients," **Hospice of Dayton** in Ohio stresses in its release about its MCCM participation.

Hospices also may use the demo as a way to figure out how to furnish community palliative care programs, Brandt expects. "As the hospice builds or expands what is essentially a community palliative care service line, hospices will have to learn how to market this service and develop relationships that can be expanded upon concurrently with the demo or after it ends," she predicts. "It will be interesting to see how many succeed not only in the demo, but overall."

Palliative care programs seem to befuddle providers. "Right now there aren't many hospice-based community PC programs," she observes. "Several hospices have stopped providing home-based palliative care because they were losing money. Making this work will necessitate both systems and cultural changes within each hospice."

More Problems Dog MCCM Demonstration

Money isn't the only concern when it comes to the demo. The MCCM demonstration project "still falls short of a fully-integrated care model for people with severe illness who want to continue curative treatment," judges Forbes. In traditional hospice, the interdisciplinary team handles the patient's care from one focal point. "When hospice works as it should, a patient can get the care she needs with a single phone call," it says.

For the Care Choices model to succeed, "hospice providers, home care agencies, primary care physicians, and specialists will have to work closely and cooperatively on critical issues such as pain management or after-hours care," Forbes notes. "In some cases, hospitals and nursing facilities will also be involved."

Thus far, "the fee-for-service health system has struggled mightily to achieve that level of coordination," it says.

Weatherbee's Wilson also questions the sheer length of time it has taken to get the demo going. After all, it was required by the Affordable Care Act in 2010. "It has taken five years to get rolling," and CMS plans to take another five to finish the project "a whole 10 years," Wilson protests. "The industry is in such need of policy reform that 10 years is insane."