
NAHC Forum of State Associations
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# The Future of Hospice & Palliative Care Policy and Delivery

Theresa M. Forster
Katie Wehri
Davis Baird

HOMECARE & HOSPICE
National Association for Home Care & Hospice

# Hospice under Medicare Advantage & Hospice Payment Reform

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# MA VBID Hospice Component

- Operating CY2021 through CY2024
- Goals of MA VBID Hospice Component model:
  - Eliminate fragmentation
  - Consolidate responsibility (financial, cost accountability, quality, outcomes)
  - Improve care coordination
  - Encourage timelier transition to hospice care when appropriate and preferred

# MA VBID Hospice Component

| GROWTH IN MA VBID HOSPICE COMPONENT PARTICIPATION | CY2023 | CY2022 | CY2021 |
|---|---|---|---|
| MA Plans | 15 | 13 | 9 |
| Plan Benefit Packages (PBPs) | 119 | 115 | 53 |
| States and Territories | 25 | 22 | 14 |
| Counties | 806 | 461 | 206 |

# MA VBID Hospice Component

- First year evaluation report issued October 17, 2022 – initial insights into findings from MA VBID Hospice Component evaluation (covers CY2021 only)
- Benefits:
  - MA benefit package
  - Hospice
  - Palliative Care
  - Transitional Concurrent Care (TCC)
  - Hospice Supplemental Benefits

# MA VBID Hospice Component

- CY2021 – Hospice Component evaluation findings:
  - 9,630 enrollees received hospice
  - 37% from in-network hospices, 62.7% out-of-network
    - In-network hospice median enrollees served -- 16
  - 2,596 enrollees received palliative care (lower than expected)
  - 146 enrollees received TCC
  - 525 enrollees received hospice supplemental benefits

# MA VBID Hospice Component

- Plans' approaches to offering hospice care under model:
  - Used existing referrals and/or algorithms to identify patients eligible for palliative care, TCC, and hospice
  - Palliative care more frequently provided through vendors than in-network hospices
    - Palliative care – no definition but plans all offered many of the same services: Consults, comprehensive assessments, IDT access 24/7, care planning, ACP, pain management, access to social/community resources, med reconciliation, psych/spiritual support, caregiver support
    - Only 2 hospices reported palliative care contracts

# MA VBID Hospice Component

- TCC services
  - included chemotherapy and radiation therapy for cancer patients, dialysis for ESRD, infusion, pain management, CPAP and BIPAP, other services
  - Given lack of definition, participants noted confusion about what was appropriate for TCC
- Supplemental benefits -- most common were elimination of cost-sharing for hospice drugs/biologicals and inpatient respite, as well as in-home respite

# MA VBID Hospice Component

- Plan networks:  from 2 to all hospices in area
- In-network hospices:
  - Generally larger
  - Higher proportion non-profit
  - Higher proportion chains
- Some plans paid FFS rates, others 10-12% lower than FFS
  - Plans used “higher referrals” as rationale for lower rates
  - One “bonus” arrangement
  - Previous plan relationships with hospices served as foundation for networks
  - Limited use of hospice quality measures to select in-network hospices

# MA VBID Hospice Component

- Implementation Experience
  - BOTH Plans and Hospices:  COVID-19 a major competing priority
  - PLANS:
    - SUBSTANTIAL administrative challenges (IT modifications for claims processing, claims reconciliation)
    - Challenges related to data reporting, identification of eligible beneficiaries
    - Communications challenges re conveying benefit info to hospices, other providers
    - Hospices resistant to sharing care plans

# MA VBID Hospice Component

- HOSPICES:
  - SUBSTANTIALLY more administratively burdensome than FFS
    - Reporting of claims/notices, Delayed payments, other oversight requirements
  - Urge model-wide definitions for TCC, palliative care
    - Coordination of care complex for TCC benefits
    - Some plan interference with hospice clinical judgment
  - Need to increase model awareness
    - Model did NOT generate referrals from new sources or earlier admissions
    - Some hospices instructed to “search out” eligible patients

# MA VBID Hospice Component

- Observations
  - Many of the same concerns and experiences expressed by hospice community
  - Too limited participation to judge model based on first year findings
  - Do plans and hospices need more support than is being offered to ensure success of model?

# MA VBID Hospice Component

- Looking Forward
  - Future reports will cover additional outcomes, including associations between the model test and changes in utilization and care quality, and additional stakeholder perspectives (including beneficiaries)
  - To expand nationwide, model must demonstrate that costs do not increase and quality of care either improves or does not diminish
  - Will size of model be sufficient to justify nationwide expansion?
  - Does CMMI have authority to expand nationwide given explicit statutory "carve out" of hospice from MA?
  - Much will hinge on final evaluation findings and political will

# Hospice Payment Issues - Payment-related Reforms Recap

- January 2016
  - Tiers for RHC
    - Days 1 – 60
    - Days 60+
  - Service-Intensity Add-on
    - In-person visits by RN, SW while patient on RHC level of care
    - Up to 4 hours per day (15-minute increments)
    - Paid at CHC hourly rate ($63.42 for FY2023)
- FY2020
  - Rebased levels of care
    - Significant increases for GIP, CHC, IRC
    - Relatively small reductions to RHC
    - Based on hospice cost report data

# Hospice Payment Issues - Payment-related Reforms Recap

- FY2022
  - Revised and rebased “labor shares” of payments
  - Based on hospice cost report data

- Perspectives on reforms to date –
  - Budget neutral relative to hospice outlays
  - Modest redistributional impact
  - Have not addressed hospice “outliers”
  - Policymakers: More must be done

# Pending Payment Policy Recommendations

- MedPAC Recommendations:
  - Freeze update
  - Wage adjust and reduce the Aggregate Cap by 20%
- Options to address spending outside of hospice:
  - Bundle all services into an “end of life” benefit (hospice has full responsibility)
  - Impose penalty on hospices with spending outside of hospice above a certain threshold

# MedPAC Payment Reform Options

- Increase number of RHC payment tiers to better reflect costs over length of service
- Reduce daily payment rate for long hospice stays (home health with medication and DME component)
- Create an episodic payment system for hospice – would need episodes of short duration (30 days)
- In addition to payment changes, create compliance thresholds (high live discharge, long LOS) beyond which payment rates are reduced for all patients

# Program Integrity

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# Margins & Long Length of Stay

Margins

- Projected 2022 – 13%
- “Over cap” hospices in 2019 – 19%

2020 Utilization

- Median LLOS 18 days
- Average LLOS 97 days
  - 25% of patients had stays of 5 days or less
  - 75% had stays of 87 days or less
  - Top 10% had stays of more than 287 days

*LLOS = Lifetime Length of Stay

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# Length of Stay

| 2020 LOS/Diagnosis | | 2020 LOS/Location of Care | |
|---|---|---|---|
| Cancer | 53 days | Home | 90 days |
| COPD | 135 days | Nursing facility | 133 days |
| Neurological conditions | 161 days | Assisted living facility | 172 days |

# Length of Stay

Substantial increase in LOS for hospice patients first receiving care prior to year of death

- 335 days for decedents in 2020
- 321 days for decedents in 2019
- 1/3 of increase occurred in final year of life
- 2/3 of increase occurred prior to final year of life

# Policy Concerns – Length of Stay

What leads to long LoS?

- Uncertainty in establishing 6-month prognosis
- Financial incentives in the payment system
- Where referrals come from
- Variability in interpretations of hospice eligibility criteria

# Policy Concerns - Live Discharge

Live discharge rates

- 2020 – 15.4%
- 10% of hospices have live discharges of 43%+

Do high live discharge rates signal potential

- Quality of care concerns?
- Program integrity concerns?

# MedPAC – Program Integrity Options

- Audit providers with high proportion of long-stay (180+ days) patients
- Investigate long LoS in ALFs
- Investigate long LoS and high live discharge rates in over-Cap hospices
- Audit providers with a high share of payments from patients on hospice prior to year of death
- Compliance threshold – like IRF 60% rule or LTCH 50% rule
- Physician education – how timing of their hospice referrals compares with other physicians

# MedPAC Spending Outside of Hospice

Patients with spending outside of hospice – 47.4%

- Part A or B spending – 34.4%
- Part D spending – 31.6%
- Over cap hospices more likely to have out of hospice spending

*2018

# Spending Outside of the Medicare Hospice Benefit

"Non-hospice spending"

OIG Work Plan – partially completed

- Medicare Improperly Paid Suppliers an Estimated $117 Million Over 4 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Hospice Beneficiaries (2021)
- Medicare Payments of $6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight (2022)

# Program Integrity “Inputs”

DATA

- CMS
- Contractors
  - UPIC
  - SMRC
  - RAC
- Office of the Inspector General
- Predictive analytics

# Palliative Care and Other New Models of Serious Illness Care

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# Hospice Care Takes On Greater Role in Care Continuum

End-of-life care is undergoing enormous change in recent years–spurred by a wave of aging baby boomers, more pe

Hospice News


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The Future of Hospice in the age of Palliative Care

NEWS

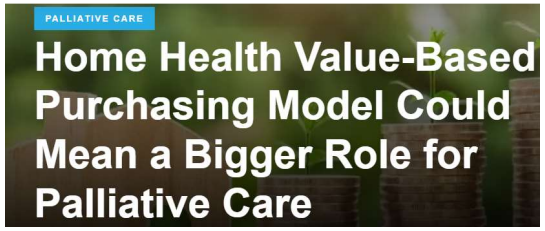
## CMS' innovation arm signals it is moving toward palliative care, capitation payment models

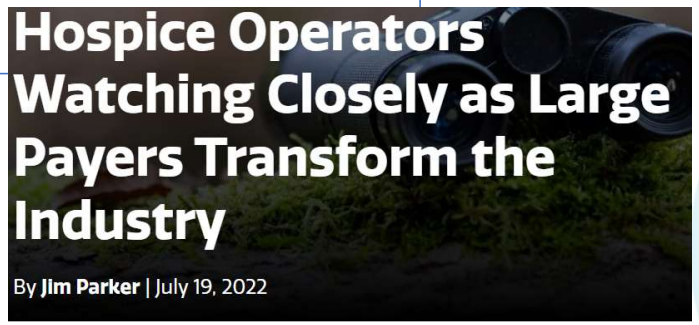
LIZA BER

Home Health Care News

Compl

JUNE 10, 2021

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# What is Behind the Interest in "Upstream" Palliative-like Models?

- It works! – better outcomes, quality of life and cost-savings (in most cases)
- Basic demographics – more people living longer with more symptom and functional burdens
- Current system is siloed and seriously-ill patients often "fall through the cracks"
- Many patients that would benefit from palliative care don't qualify for hospice or do not want to elect hospice
- Increasing government and industry focus on value-based, capitated models – much of palliative care's secret sauce is un-reimbursable in traditional FFS systems

# Policy Driver - Center for Medicare and Medicaid Innovation (CMMI)

- Renewed interest in palliative care
- But…tension btw standalone community-based palliative care demo and a broader strategy that integrates palliative care across all relevant models, primary and specialty alike (this CMMI prefers the “threading” approach)
  - ACO REACH
  - VBID
  - Enhancing Oncology Model (EOM)
  - Other ACO models
- Success of Medicare Care Choices Model (MCCM) concurrent care demo driving a lot of the interest and work
  - MCCM:
    - $26 million in savings
    - Improved patient and family satisfaction and outcomes
    - Facilitated more timely transition to hospice (~83% of enrollees transitioned from MCCM to hospice, which accounted for ~70% of the cost savings).

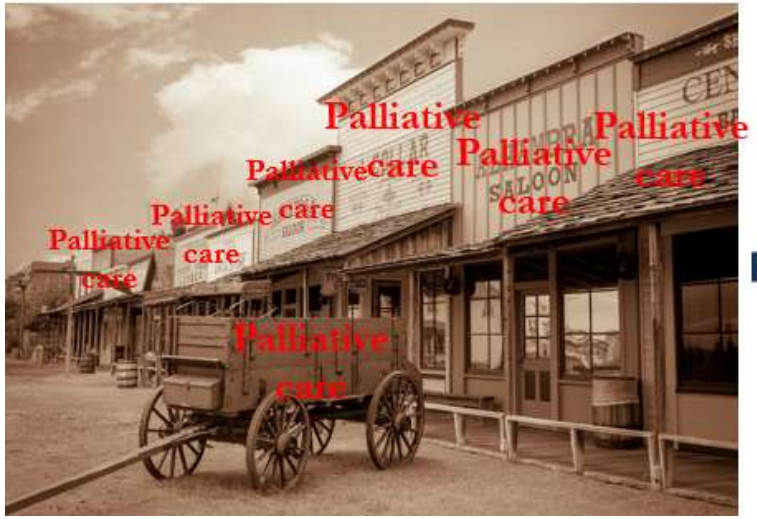
# Policy Driver - Congress

- Recognition of the value of palliative care
- New Models: *Expanding Access to Palliative Care Act* (S.2565)
- Interest in concurrent care
  - Palliative dialysis legislation
  - Potential broader concurrent care efforts
- Specialized workforce: *Palliative care Education and Training Act (*PCHETA) (S. 4260)

# Policy Driver – State Medicaid Benefits

- California SB 1004 – created palliative care benefit in managed Medicaid – first in country; lots of challenges; other states learned from/are learning from Cali and developed or want to develop their own community-based palliative care benefit, program, or regulations:
    - Arizona
    - Washington
    - Oregon
    - Maine
    - Hawaii
    - Colorado
    - Texas

# The Importance of Standardization and Definition




# Key Considerations for Care-in-the-Home Providers

- Partnerships are key (esp with primary care)
- Data/HIT to smooth collaboration
- Training and education in palliative care
- Patient-Reported Outcome Measures (PROMs)
- Willingness to take on risk/participate in value-based models
- Understand and accept that palliative care is not likely to be “owned” by a single type of provider

# Health Equity in Serious Illness Care

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# Policymaker Interest in Advancing Health Equity

- Major push over next few years to formalize equity measurement and accountability in health programs
- Start with improving data collection; then reporting; then reporting tied to quality scores/payment – goal is to incentivize providers to make this a standard and expected part of operations and culture.
- First formal example in hospice & palliative care: health equity questions in FY23 Hospice Proposed Rule and creation of CMS expert group on composite quality measure of "*commitment to health equity*"
  - Making equity part of strat plans; training staff and leaders in equity and culturally appropriate care; outreach to community and using data to understand disparities
- CMMI baking health equity reqs into all new models
- Potential future focus on more robust screening and referral for SDOH challenges

# Look to Other Settings For Potential Future Impact on Serious Illness Providers

- Joint Commission's new health disparities requirements go into effect 1/1/23 (not for hospices or home health, but is applicable to hospitals, ambulatory care providers, and others): https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf

  - "*Although health care disparities are often viewed through the lens of social injustice, they* ***are first and foremost a quality-of-care problem****. Like medication errors, health care-acquired infections, and falls, health care disparities must be examined, the root causes understood, and the causes addressed with targeted interventions. There are many examples of successful efforts to reduce disparities. Unfortunately, most of these efforts have been done as special projects, often with limited external funding, and were not sustained or spread across organizations. A different approach is needed.* ***Organizations need established leaders and standardized structures and processes in place to detect and address health care disparities.***"