Stakeholder Feedback for CMMI on the 2021 Value-Based Insurance Design Model

NHPCO is the largest nonprofit membership organization for providers and professionals who care for people affected by serious and life-limiting illness. Its broad community of members includes local hospice and palliative care providers serving large regional networks representing over 4,300 hospice locations and 58,450 individual professionals caring for more than 1,000,000 patients and their families across the country (nearly 70% of Medicare beneficiaries receiving hospice services).

Better Medicare Alliance is the leading coalition on Medicare Advantage. Their mission is to build a healthy future by advocating for a strong Medicare Advantage. As an alliance of more than 130 organizations – including health companies, community-based organizations, aging services organizations, health care providers, and nearly 400,000 Medicare Advantage beneficiaries – they lead through research, advocacy, and grassroots organization to create a path forward for innovative, modern health care on behalf of seniors and people with disabilities.

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BMA-NHPCO Convening: Stakeholder Feedback for CMMI on Testing Hospice Carve-in to Medicare Advantage Under the 2021 Value-Based Insurance Design

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Introduction and Background

The Centers for Medicare & Medicaid Services (CMS) introduced the Value-Based Insurance Design (VBID) model to encourage innovation in the Medicare Advantage (MA) program. There are currently 13 health plans participating, and the demonstration will be expanded to allow all plans in all 50 states to participate in 2020.

Hospice care is currently not included as a benefit in Medicare Advantage, but beginning in 2021, CMS will leverage the VBID model to test the impact of incorporating the hospice benefit in Medicare Advantage. CMS aims to test whether a hospice carve-in could promote advanced care planning and streamline care across the continuum of care, reduce fragmentation and costs for the health care system, and improve overall quality and consumer experience.

The Better Medicare Alliance (BMA) and National Hospice and Palliative Care Organization (NHPCO) hosted "A Convening on Hospice and Medicare Advantage" ("the convening") on June 25, 2019. This was the second meeting hosted by BMA and NHPCO on exploring the idea of carving in hospice care into Medicare Advantage. The first convening, which took place on October 18, 2018, offered the opportunity to hear perspectives on the rationale for including hospice in Medicare Advantage, as well as explore initial reactions to the potential impact of a possible change in policy. The convenings represent a partnership between BMA and NHPCO formed with the purpose of shaping policy and payment model design. The June 25th convening brought almost 60 for-profit and non-profit health plan and hospice industry leaders together with policymakers to highlight key considerations for the Center for Medicare and Medicaid Innovation (CMMI) to address as the agency develops the 2021 VBID model. There were expert speakers and panel presentations, as well as breakout sessions to ensure participation from attendees.

The June 25th convening focused on the following focus areas:

- Defining the Hospice and Palliative Care Benefits within Medicare Advantage
- Ensuring Medicare Beneficiaries Receive High-Quality Hospice Care
- Ensuring Access to Care through High-Value Networks
- Negotiating Contracts Between Health Plans and Hospice Providers

This report summarizes the insights, key considerations, and recommendations for CMMI in developing the Medicare Advantage hospice carve-in demonstration outlined by participants during the June 25th convening.

Key Takeaways from the June 25th Convening

The following sections outline various options and considerations for carving hospice care into Medicare Advantage. Participants discussed their experiences and provided insights and recommendations on how CMMI

could shape the hospice VBID model to ensure Medicare Advantage beneficiaries have access to high-quality hospice care and continuity of coverage and care.

Focus Area #1: Defining the Hospice and Palliative Care Benefits within Medicare Advantage

CMS has asserted that moving hospice into Medicare Advantage will provide health plans with the opportunity to offer more seamless access to the complete continuum of care. Stakeholders discussed the importance of defining the benefit while maintaining flexibility for health plans on how best to incorporate hospice into the care continuum.

Flexibility in benefit design is important to health plans as they experiment with integrating hospice

To enroll in hospice, CMS requires that beneficiaries have a terminal illness (i.e. a life expectancy of less than 6 months) and discontinue curative treatment for the terminal illness. As there are an array of end of life services, plans and providers need CMMI to clarify what services will be covered under the carved-in hospice benefit. CMS has publicly committed to keeping the hospice benefit intact. Stakeholders also pointed out that CMS should not only provide an array of guidance and specific examples but also allow flexibility in adjusting benefits as plans and providers as they see is necessary for the specific patient or situation. For example, many participants noted that CMMI needs both to define palliative care and to make clear whether palliative care) is being tested in the model. This definition is of particular importance given that CMS recently expanded the supplemental benefits allowed in Medicare Advantage to include non-health related benefits, including palliative care for beneficiaries with more than 6 months to live. CMS must detail what benefits are included in the carve-in demonstration and what will be considered supplemental benefits.

Health plan and provider executives expressed a desire to experiment with new models of care that more seamlessly incorporate hospice into the care continuum. Convening participants described the importance of offering family support services (such as bereavement services) and providing culturally appropriate care. Health plans in particular were excited about potential flexibility but expressed some concern about the financial capabilities. They raised the possibility of implementing a “hold harmless provision” (i.e. loss protection) to ensure that they can innovate within the demonstration without taking on undue financial risk.

The demonstration presents an opportunity to integrate a range of end of life services and leverage lessons learned from the Medicare Care Choices Model

Many stakeholders noted that this model could better integrate curative, palliative, and hospice care. Stakeholders were interested in innovating with broader benefits such as a concurrent care benefit. Medicare Advantage plans expressed concerns about how these benefits would be reimbursed given that it would be an expansion to the current Fee-for-Service (FFS) benefits. In addition, providers described that it could be operationally difficult to administer different benefits for Medicare Advantage and FFS beneficiaries. Finally, Medicare Advantage plans highlighted that the broader benefit may also prevent the model from achieving the statutory requirements to reduce or maintain spending levels in order to expand the demonstration.

Stakeholders also suggested that CMMI should leverage lessons learned from the Medicare Care Choices Model (MCCM), as the model tested the option for Medicare beneficiaries to receive supportive care services from certain hospice providers. CMMI’s model evaluation report suggested that hospice-eligible individuals become more familiar and comfortable with hospice benefits through the program[1], thus stakeholders agree CMMI should build on the successful model and implement early upstream interventions so health outcomes would improve.

[1] Medicare Care Choices Model First Annual Evaluation Report. CMS. September 2018.

Focus on seamless continuation of care across all benefits

Ultimately, stakeholders suggested that the model should promote coordinated efforts between health plans and providers to promote better care continuity for Medicare Advantage beneficiaries. Stakeholders also discussed the importance of identifying patients for hospice earlier. They questioned whether the 6-month life expectancy requirement in the current Medicare FFS benefit was flexible enough asserting that CMS should employ a different standard (e.g., expanding to a 12-month life expectancy requirement).

Regardless of the specific timeframe, many stakeholders advocated for integrating hospice and palliative care into upstream care which would improve access and better identify patients requiring hospice care. Some participants also noted that for each new hospice patient, it is important to have all upstream care experience documented and presented at the point of hospice care so that the best care decision can be made. In addition, participants discussed concurrent care models where hospices become part of the care team and work with the health plan and the patient and their family to ensure shared decision-making along the care continuum. For patients who start from home health and transitioned to hospice, they should be able to carry over their social worker with them during the transfer.

As a part of a more integrated approach, stakeholders discussed the importance of maintaining a good relationship between hospices and referring physicians to ensure care is adequately coordinated and patients can easily move through the care continuum. Participants highlighted successful models where a physician (such as an oncologist) contacts a plan's case managers who can support the care decision process. These models create an opportunity for patient-centered care that is driven by the patient's needs and desires. Despite stakeholders agreeing on the importance of patient-centered care, some participants cautioned that attempts to document and measure this could be overly burdensome, particularly for hospice providers.

Focus Area #2: Ensuring Medicare Beneficiaries Receive High-Quality Hospice Care

CMS currently evaluates hospice provider performance via the Hospice Quality Reporting Program (HQRP) and plan performance through the Medicare Advantage Star Ratings program. Participants discussed the measurement process and measures that CMMI could use in the VBID program to ensure that performance can be quantified and evaluated. Participants stressed the important balance of holding plans and providers accountable while also minimizing reporting burden.

Measurement within the demonstration should be simple and focused on outcomes

Because VBID is a demonstration program, any measures used to evaluate hospice quality should be straightforward and reflective of the actual quality of care provided to the Medicare Advantage beneficiaries. Specifically, stakeholders preferred incorporating measures that are based on existing ones or derived from claims data as these will not require a significant learning curve or additional burden. Stakeholders agreed that CMMI should not discourage participation due to measurement burden but needs to ensure beneficiaries enrolled in Medicare Advantage receive high-quality hospice care.

Plan and provider stakeholders also agreed that measurement should be focused on outcomes. However, some metrics, such as those related to pain management, would be difficult to measure and compare, and may be quite different than outcomes metrics used in acute or post-acute care. Convening stakeholders noted that providing a "dignified death" as a central goal of hospice care and that it is difficult to measure consistently. Health plan and provider stakeholders proposed the following options for measures:

- Patient experience
- Family experience
- Patient satisfaction
- Inappropriate/ unnecessary readmissions
- Earlier access to hospice
- Timely referrals
- Timely authorizations
- Timely admissions
- Access to a range of hospice services
- Responsiveness
- Live discharges
- Patient hospice choice

Measures should focus on the patient and family experience

Plan and provider stakeholders agreed that patient and family experiences are critical measures of hospice quality. There are a host of commonly-used measurement tools that focus on patient experience, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, but some stakeholders discussed their limitations (e.g., the gap in time between when the patient receives the service and when they receive the survey causes inaccuracies). Consideration should also be given to the fact that survey results may only be that of a family member, if attainable at all, and not of the patient.

To streamline reporting, stakeholders suggested that rather than including questions on individual care elements, experience surveys should evaluate whether the patient was treated with dignity and respect. One participant suggested that CMMI use the net promoter score (NPS). The NPS is a measurement system calculates customer experience through a 0-10 scale with three categories, "promoter," "passive," and "detractor" as a framework for assessing patient and family satisfaction.

CMMI should incorporate social determinants of health into hospice quality measures

Health plans and providers agreed that it is critical to consider social determinants of health in any quality measurement program. Patients with greater socioeconomic barriers may have difficulties accessing hospice care and may be less likely to have support in making decisions regarding hospice care. The associated risks are not currently captured in many quality measures. Although this is not unique to hospice, stakeholders agreed that addressing socioeconomic factors that inhibit access to high-quality end of life care are essential to improving patient care. Finally, stakeholders agreed that any quality measures that CMMI develops should be appropriately risk-adjusted. However, there was a general acknowledgement that developing accurate risk-adjustment systems can be operationally difficult with this population, so it may take time for them to be developed.

Focus Area #3: Ensuring Access to Care through High-Value Networks

Medicare Advantage plans will have to develop hospice provider networks that are high-performing and meet the needs of their population. In Medicare Advantage, CMS establishes network adequacy standards to ensure patient access. Stakeholders discussed CMMI's role in developing standards while ensuring access to high quality hospice care.

Providers prefer open networks and open enrollment with limited restrictions

Several of the hospice executives at the convening stated that network restrictions should be minimal. Some stakeholders recommended that CMMI implement an "any willing provider" model, similar to the "any willing pharmacy" provision under Medicare Part D. These rules require Part D plans to allow any pharmacies that meet the standard terms and conditions to participate in the network.

Although some of the provider executives promoted the concept of open hospice networks, they noted that there may be tiering within the network, which may include differential cost sharing and/or preferred networks. Currently, Medicare Advantage members who need treatment unrelated to the terminal prognosis may choose services at the plan cost-sharing level. Some participants discussed that CMMI could outline multiple models to test in the Medicare Advantage hospice carve-in demonstration, but others expressed concerns that this would be operationally difficult for both plans and providers to administer.

Traditional network adequacy standards may not apply to hospice

Stakeholders discussed how provider network adequacy requirements for the Medicare Advantage demonstration would need to change for hospice given its unique role in the care continuum. The stakeholders considered whether network adequacy requirements should be carried out through geographic-area-based licenses, rather than the typical time and distance (T&D) standards. This approach would be similar to the network adequacy requirements for home health which require that health plans contract with at least one home health agency serving each county in the plan's service areas. Others discussed whether adequacy could be established based on response times.

Many hospice providers discussed the importance of responding to needs quickly and initiating care as quickly as possible after a patient enrolls. Stakeholders considered whether these metrics could be used to evaluate a health plan's network and ensure that patients have access to hospice services.

State and local regulations such as networking and contracting requirements and certificate of need (CON) may also influence how the network adequacy requirements are structured in the hospice carve-in demonstration. One issue that was discussed was how the federal requirements would interplay with the state requirements. For example, CMMI would need to determine whether any CMMI standards are the floor or the ceiling to state and local regulations.

Beneficiaries are unlikely to choose plans based on hospice network but should have the option to choose

Stakeholders acknowledged that patients are unlikely to choose a Medicare Advantage plan based solely on a specific hospice provider being in or out of network, but they should be able to make informed decisions. The assembled group also discussed whether CMMI should create a system that allows beneficiaries to switch plans in the event a desired provider is out of network. For example, stakeholders considered whether beneficiaries should be allowed to switch plans on a more frequent or rolling basis once a terminal diagnosis is made (for example through a special enrollment period). Similarly, beneficiaries could disenroll from Medicare Advantage and switch to FFS if the hospice they wanted was not in-network. Although these policies would allow beneficiaries access to out-of-network hospices, participants discussed that they could prevent adequate use of hospice and disrupt the continuity of care.

Health plans should balance utilization management with ensuring timely access to end of life services

Many hospice providers raised concerns that implementing utilization management, particularly prior authorization, could impede access to hospice care, particularly if the patient is admitted outside of normal business hours. Providers pointed to cases where prior authorization took 4-5 days. Given that the median length of a hospice stay is only 18 days[2], 4-5 days can prevent the patient from maximizing the benefit of hospice. One hospice executive pointed out that if a patient is in the emergency department and does not receive timely authorization for hospice care, they would be admitted to the hospital instead. Hospice leaders in attendance

[2] Chapter 11 Hospice Services. Medicare Payment Advisory Commission (MedPAC) Report to Congress. March 2016. Medicare Payment Advisory Commission (MedPAC)

also highlighted that slow authorizations could result in lost revenue if the hospice starts care before the plan has signed off on the hospice admission. From a clinical standpoint, some hospice providers also discussed how the utilization management processes should be structured to ensure that hospice providers maintain control over the care plan.

Health plans agreed that ensuring access to hospice is important; however, they expressed that care will still need to be managed in some way to ensure that hospice is used appropriately. One option explored by the convening stakeholders focused on implementing post-entry utilization management approaches, mechanisms to admit patients and review the services retrospectively, rather than a prior authorization approach. However, this would need to be examined to determine the effects on payment and cost. Others discussed the feasibility of having a complaint reporting system as a mechanism for promoting timely access to vital services.

Focus Area #4: Negotiating Contracts Between Health Plans and Hospice Providers

Under the demonstration program, Medicare Advantage plans and hospice providers will need to develop contractual arrangements governing the provision of services. Although they have negotiated with health plans for other lines of business, some hospice providers do not have experience working with health plans on Medicare Advantage products. Stakeholders discussed CMMI's potential role in these contract negotiations.

CMMI can support contract development, but the agency's role should be limited

Health plans generally agreed that CMMI should not get involved in contract negotiations between health plans and providers under the demonstration. They did not see a reason for CMMI to deviate from the agency's current position of not getting involved with these negotiations and preferred flexibility to develop creative financing arrangements. On the other hand, hospice providers explained that they are not familiar with the Medicare Advantage requirements so wanted some guidance in the negotiation process. Specifically, they discussed that it would be helpful for CMMI to provide education on the Medicare Advantage requirements, such as plan reimbursement, the stars program, and marketing requirements. Similarly, health plans indicated that it would be useful for CMMI to provide information to them on the Medicare hospice benefit.

Beyond general information on Medicare Advantage, hospice providers also discussed whether CMMI could support the contract negotiation process without mandating certain requirements. For example, they suggested that CMMI could identify key contract terms, and provide sample contracts to be used as resources rather than requirements. Similarly, some stakeholders wondered whether CMMI could provide universal contracts that plans and providers could use on an optional basis. Some hospice providers cautioned that allowing too much variability could lead to unfair market dynamics because small hospices may not have the resources to negotiate contracts.

CMMI should facilitate data exchange between hospices and plans

Stakeholders agreed that CMMI should establish a registry of hospice providers and facilitate the exchange of data, particularly encounter data, on their patient population between plans and providers to help health plans and providers understand and serve the patient population. Specifically, stakeholders agreed that the data could be used to support partnership development. Medicare Advantage plans could use the data to evaluate provider performance; whereas hospice providers could use the data to gain market insight. Some expressed that the registry could be on a "opt-in" basis to better connect Medicare Advantage plans and providers willing to collaborate.

Key Considerations for CMMI

Overall, stakeholders were interested in learning more about CMMI's ideas for testing a hospice carve-in for the Medicare Advantage program, and most agreed that CMMI can play a role in developing innovation in benefit design, network development, and contracting.

The health plan and hospice leaders who attended the June 25th convening agreed that CMMI should consider the following in crafting the demonstration and engage directly with stakeholders throughout the design process:

1. High-quality hospice care is important to all stakeholders, but the current quality measures may not adequately capture quality in hospice care. Improving current measures and applying easy-to-implement measures from other settings (such as claims-based measures) may be necessary in the near-term while new hospice measures that focus on clinical outcomes and patient / family experience are being developed.

2. CMMI should clearly define the benefit structure, particularly whether the carved-in benefit will be expanded by including palliative care, define palliative care, and how CMMI will reimburse plans for the additional benefit to ensure adequate resources.

3. Stakeholders agree on the importance of ensuring access to hospice, but it must be balanced with ensuring that hospice is used appropriately, potentially through some form of utilization management (e.g., post-entry review). However, the ultimate goal should remain to ensure that all beneficiaries have access to high-quality hospice care. This tension is not unique to Medicare Advantage, but the demonstration may be able to test different ways of achieving this balance.

4. The model should be structured to promote participation by health plans and hospice providers, but CMMI needs to balance this goal with providing adequate protections to ensure that the model improves patient access and care quality. CMMI should focus on establishing simple procedures and easy-to-understand measures that minimize the barriers to participation while ensuring high-quality care.

5. The VBID model is seen as an opportunity to test innovative care delivery approaches, including better integration of hospice into upstream care. Stakeholders stressed the importance of supporting innovation while requiring some consistency across all CMMI models to ensure that the program is not operationally difficult to manage and evaluate.

6. Stakeholders acknowledged the importance of addressing social determinants of health to provide seamless, high-quality hospice care.