ISSUE BRIEF

Medicare Hospice Benefit and Key Considerations for Policy Changes in Medicare Advantage

BY BETTER MEDICARE ALLIANCE

FEBRUARY 2020

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I. INTRODUCTION

The hospice benefit in Medicare covers palliative and support services for beneficiaries who (1) have been clinically assessed to have fewer than six months to live and (2) have elected to receive hospice care. The purpose of hospice care is to allow terminally ill patients to live comfortably during their last few months of life. Hospice patients forgo curative treatment, and instead focus on palliative care, which provides relief from the symptoms, pain, physical stress, and mental stress of illness. Palliative care allows terminally ill patients to receive emotional and medical support comforably at the end of life.

Medicare's hospice benefit covers treatment for both the terminal illness and related conditions. These terminally ill beneficiaries also have access to drugs for symptom control, home medical equipment, and other services, either at the patient's home or in a facility. In 2017, 1.5 million Medicare beneficiaries received hospice from 4,488 providers, a 2.4% increase from 2016.[1]

Hospice care is "carved-out" of Medicare Advantage; that is, these services are not covered under Medicare Advantage. Beneficiaries who choose hospice who are in Medicare Advantage are required to transition to Traditional Fee-for-Service (FFS) Medicare. Similarly, hospice providers receive payment directly from the Centers for Medicare & Medicaid Services (CMS) under Traditional FFS Medicare. In addition, to receive hospice in Medicare, beneficiaries may only receive coverage for services unrelated to the terminal illness from providers who accept reimbursement under Traditional FFS Medicare, not Medicare Advantage.

There has been interest in including hospice care in Medicare Advantage, which could allow patients who elect hospice to remain with providers they know. This would require Medicare Advantage plans to offer hospice services as defined in Traditional FFS Medicare. According to a 2014 report by the Medicare Payment Advisory Commission (MedPAC), the current carve-out of hospice from Medicare Advantage creates a complicated and fragmented system that prevents hospice beneficiaries from receiving coordinated care.[2] The report recommended that hospice services be included in Medicare Advantage. Hospice providers and Medicare Advantage plans have had mixed reactions to this possible change in Medicare policy, while the current Administration has expressed interest in pursuing such a change through a demonstration.

To include a hospice benefit in Medicare Advantage, Congress would need to change current law to include hospice as a required benefit under Medicare Advantage, and hospice costs would need to be incorporated in plan bids. CMS would need to increase capitated payments and modify risk-adjustment to accommodate the risk assessment and cost of hospice services in Medicare Advantage. Medicare Advantage plans would need to develop an adequate

network of hospice providers to ensure that each patient has a choice of hospice providers.[3] In their assessment of hospice care, the Commonwealth Fund wrote that including the hospice benefit in Medicare Advantage would also incentivize plans to advance innovative practices to properly manage the care of terminally ill patients.[4] In addition, because Medicare Advantage can help address socioeconomic factors, Medicare Advantage may be uniquely positioned to improve access to high-quality end-of-life care.[5]

This issue brief provides background on the current hospice benefit in Traditional FFS Medicare and draws attention to the key issues to consider when evaluating a possible policy change to include hospice care in Medicare Advantage.

II. BACKGROUND – HISTORY OF KEY HOSPICE POLICIES

The 1997 Balanced Budget Act included a provision that carved out hospice services from the Medicare managed care benefits package. This provision, along with limited cost data and minimal hospice utilization at the time, is the main reason that hospice is not included in the Medicare Advantage benefit package.[6] In addition to Medicare, while hospice is an optional benefit under Medicaid, most states cover hospice care for terminally ill Medicaid beneficiaries.

In 2000, hospice received national attention when the Senate held two hearings on end-of-life care and barriers to accessing hospice care. This led to the passage of the Benefits Improvement and Protection Act of 2000, which increased Medicare hospice reimbursement rates by 5%. In addition, the Department of Veterans Affairs launched a program in 2002 to increase access to hospice and palliative services for veterans. During that time, many studies were published that showed hospice (1) saved money for Medicare and (2) improved quality of life for patients. These studies confirmed the benefits of the hospice program in Medicare.[7]

In recent years, both Congress and the Medicare and Medicaid programs have made changes to improve hospice care. In 2008, CMS and the Department of Health and Human Services (HHS) finalized major revisions to the Medicare Hospice Conditions of Participation, which detail the requirements for Medicare and Medicaid eligible hospice providers. These changes aimed to improve beneficiary access and provider flexibility. The passage of the Affordable Care Act in 2010 included a provision that required Medicaid programs to allow children with a life-limiting illness to receive both hospice and curative treatments at the same time. In 2014, Congress began to consider including hospice in the Medicare Advantage benefits package following the MedPAC's recommendation of a carve-in. In fact, Congress did include the carve-in provision as part of proposals outlined in the 2015 Chronic Care Act Working Group, but it was not incorporated in the final bill. In 2019, CMS announced that the hospice carve-in would be included in the Medicare Advantage value-based insurance design (VBID) model for 2021, marking growing support for the inclusion of hospice in Medicare Advantage.[8]

In December 2019, the Center for Medicare and Medicaid Innovation (CMMI) released the Request for Applications for a demonstration project, which includes details and requirements for participating Medicare Advantage plans, such as offering broad access to the hospice benefit for all eligible enrollees. Medicare Advantage plans will need to "outline how they will provide palliative care to eligible enrollees, irrespective of the election of hospice, and may make transitional, concurrent care services as well as hospice-specific supplemental benefits available to enrollees who elect hospice through network hospice providers." This is a voluntary demonstration model. Eligible Medicare Advantage plans in all 50 states and territories may apply for the hospice benefit component.[9]

III. OVERVIEW OF THE TRADITIONAL FFS MEDICARE HOSPICE BENEFIT

Currently, the Traditional FFS Medicare hospice benefit covers end-of-life palliative and support services to allow terminally ill patients to live comfortably during the last months of their lives. Medicare beneficiaries electing hospice must forgo curative treatment, and a physician must certify that the patient has a life expectancy of less than 6 months. When a patient elects to enter hospice, the patient's care team and attending physician work with the patient to develop a care plan, which focuses on the required medical services and a treatment regimen to minimize or mitigate pain. Typically, hospice nurses and doctors are on-call 24 hours a day, seven days a week.

Once a patient enters hospice, hospice care is provided in set benefit periods. First, hospice care begins with two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods. At the end of the first 90-day benefit period, the hospice physician must recertify that the patient is terminally ill at the start of each of the next benefit periods.[10]

Eligibility Requirements and Hospice Services

The focus of the hospice program is to provide comfort to terminally ill patients and their families. CMS has outlined criteria that Medicare beneficiaries must meet to qualify for hospice. First, the patient must consult with their hospice doctor and primary physician to certify that they are terminally ill. CMS defines terminally ill as an individual who is expected to live for six months or less. Next, the patient must forgo curative care; however, he or she can continue to receive palliative care. Finally, the patient must sign a statement affirming that he or she is choosing hospice care instead of other Medicare-covered services for the terminal illness and related conditions. Beneficiaries can then work with their doctor or Medicare Advantage plan to find a Medicare-certified hospice provider in their area.

The hospice benefit includes an array of services:

- Physician services
- Nursing care
- Medical equipment (e.g., wheelchairs or walkers)
- Medical supplies (e.g., bandages or catheters)
- Prescription drugs for symptom control or pain relief
- Hospice aide and homemaker services
- Physical therapy services
- Occupational therapy services
- Speech-language pathology services
- Social work services
- Dietary counseling
- Grief and loss counseling for you and your family
- Short-term inpatient care for pain and symptom management
- Short-term respite care
- Any Medicare services needed to manage pain[11]

When selecting care options, the patient and the care team can choose a combination, or all of the services listed, to determine the best course of care.

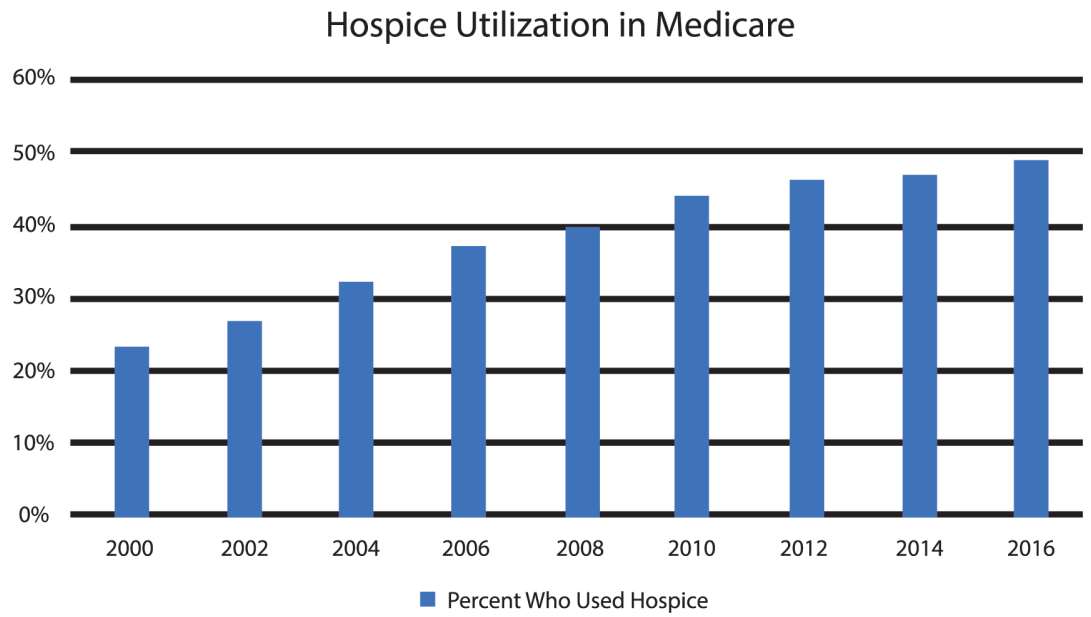
Typically, hospice care is administered in the home, but it may be covered at an institutional facility, such as a nursing facility. In 2016, more than one-half (55%) of hospice beneficiaries received care in the home, and one-quarter (25%) received care in a nursing facility or SNF. [12] The hospice benefit also includes short-term inpatient care for pain management and respite care, which allows the patient's usual caregiver to receive a rest. Respite care may be provided at an inpatient hospice, a hospital, or a nursing facility for up to five days as a time.

Although hospice services do not include curative treatment for the illness, patients always have the option of returning to the Medicare coverage they had before entering hospice. Hospice does not cover any prescription drugs, other than those used for symptom control or pain relief. Further, patients are not allowed to receive care from any provider that was not approved by the hospice team. This includes outpatient services, such as the emergency department or ambulance services not arranged by the hospice provider. However, patients may still visit their primary doctor if supervised by the hospice care team and if all hospice-related treatment is received from the predetermined care provider. Finally, the Medicare hospice benefit does not include room and board if the patient has elected to receive in-home hospice care or care at a hospice facility, outside of the occasional, short-term respite services or inpatient care for pain and symptom management. Hospice patients residing in nursing facilities or other facilities typically have room and board covered through other sources (such as Medicaid or private pay).[13]

Enrollment Trends and Key Statistics

Since 2000, hospice utilization among Medicare beneficiaries has grown. In 2017, 1.5 million Medicare beneficiaries received hospice care, a 4.5% increase from 2016.[14] Overall, Medicare Advantage beneficiaries have consistently utilized hospice services at a higher rate than their Traditional FFS Medicare counterparts. In 2014, 50.8% of Medicare Advantage beneficiaries used hospice compared to 46.8% of Traditional FFS Medicare beneficiaries.[15] With increased enrollment in Medicare Advantage, this trend in hospice utilization will likely grow with the growth of Medicare Advantage.

FIGURE 1



Source: MedPAC Report to the Congress: Medicare Payment

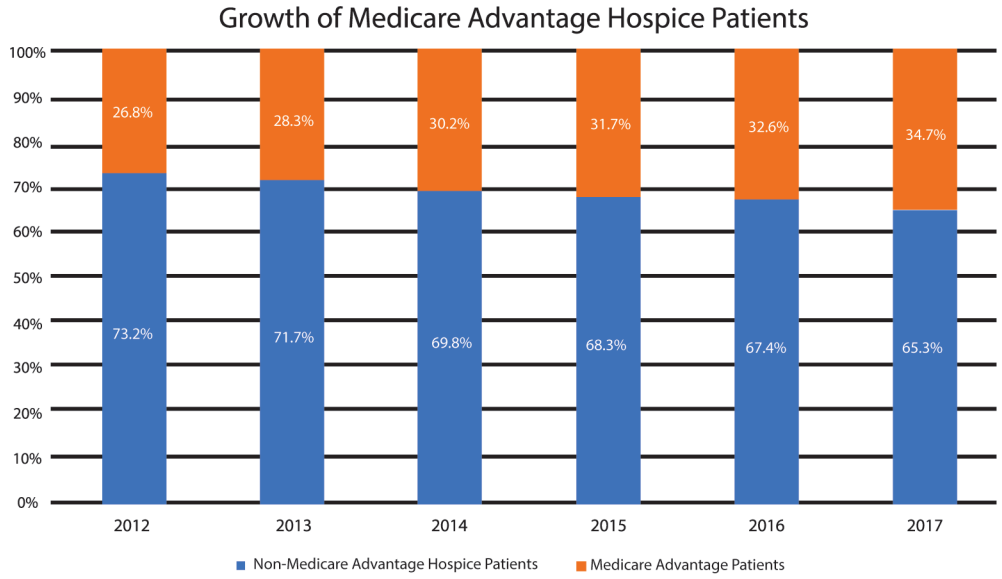
In 2017, more than half of hospice Medicare beneficiaries were female (58.4%) compared to male (41.6%). The majority (64.2%) were 80 years or older when beginning hospice services. Although most hospice patients are Caucasian, use of hospice for Asians and Hispanics increased by 31% and 21% respectively over the past three years.[16]

Further, both the use of hospice services and length of stay have increased over the last two decades.[17,18] Since 2000, average hospice length of stay has increased from 53.5 days to 88.6 days in 2017, a 3.3% increase. Between 2015 and 2017, hospice length of stay increased from an average of 86.7 days to 88.6 days, a 0.9% increase. According to MedPAC, from 2000 to 2017, the hospice length of stay at the 90th percentile

increased from 141 days to 248 days. During the same period of time, those in the 50th, 25th, and 10th percentile have remained around the same at 17 or 18 days, 5 or 6 days, and 2 or 3 days, respectively. In other words, the increase in average hospice length of stay is driven by patients with the longest stays.[19]

Length of stay for hospice services is similar between Traditional FFS Medicare and Medicare Advantage beneficiaries. However, very long stays are slightly shorter among Medicare Advantage beneficiaries (242 days) than Traditional FFS Medicare (250 days).[20] While the length of stay for those with the longest stays has increased, those with shorts stays has remained steady since 2002.

FIGURE 2



Source: NHPCO Facts and Figures. 2018 Edition. [22]

In 2017, 1.1 million beneficiaries died in hospice care. Almost half of those deaths occurred in the patient's home and a third at a nursing facility. Research suggests that hospice care is effective in prolonging life with hospice patients living an average 29 days longer than terminally ill patients that did not receive hospice care. [21]

Payment Structure

Currently, Medicare pays a daily rate to hospice providers and the provider assumes all financial risk for costs and services for the hospice care of the patient. Regardless of whether or not the patient is seen by a health professional, hospice providers receive a per diem payment for each day the patient is enrolled in hospice. The payment structure is designed to cover both the cost of visits by hospice providers and any other costs associated with hospice care such as drugs and medical equipment.

There are four categories of payments based on the type of care the patient received, as seen below (payment rates are associated with Fiscal Year 2019):

- Routine home care: Home care provided for routine care
- Continuous home care: Home care provided during a crisis for a short term (eight hours/day)
  - $42/hour
- Inpatient respite care: Inpatient care for a short period (up to five days) to provide a break for a primary, informal caregiver (e.g., a spouse)
  - $176/day
- General inpatient care: Inpatient care for symptoms that cannot be treated at home
  - $758/day

In 2017, 98% of hospice days were routine home care. MedPAC has expressed concern that routine home care payment rates may exceed providers' costs substantially, while the other, less common forms of care (e.g., continuous home care, inpatient respite care, and general inpatient care) may not be sufficient.[23]

In 2016, CMS implemented differential routine home care rates for days 1-60 and days 61+ to better align payments with the cost of providing care throughout an episode. Hospice services tend to be more intensive at the beginning and end of an episode, so CMS created the dual rate (rather than a flat daily rate) to disincentivize extremely long stays. [24]

Additionally, cost sharing for beneficiaries (amount expected to be paid by the beneficiary) in hospice is intended to be minimal, with cost sharing only associated with some prescription drugs and inpatient respite care. Hospice providers may charge a 5% coinsurance on prescription drugs as long as it does not exceed $5 per prescription. Cost sharing for inpatient respite care cannot exceed the Part A inpatient hospital deductible, which is $1,408 in 2020. However, beneficiaries continue to pay premiums for Part A (if applicable) and Part B. [25]

Hospice Quality Reporting

CMS developed the hospice quality reporting program (HQRP), which was mandated by the Affordable Care Act to determine performance on quality measures. HQRP consists of two reporting requirements: The Hospice Item Set (HIS) and the Hospice Consumer Assessment of Health Providers and Systems (CAHPS) Survey. Hospices that fail to comply with HQRP will incur a 2-percentage point reduction in their Medicare payment rates.

HIS data are used to calculate nine quality measures (including eight National Qualify Forum (NQF) measures and one non-NQF measure). In addition, CMS uses CAHPS data to calculate eight patient experience measures.[26]

Hospice Item Set Measures

- Patients treated with an opioid who are given a bowel regimen
- Pain screening
- Pain assessment
- Dyspnea screening
- Dyspnea treatment
- Treatment preferences
- Beliefs/Values addressed
- Hospice and palliative care composite process (comprehensive assessment at admission)
- Hospice visits when death is imminent (non-NQF)

CAHPS Measures

- Communication with family
- Getting timely help
- Treating patient with respect
- Emotional and spiritual support
- Help for pain and symptoms
- Training family to care for patient
- Rating of this hospice
- Willing to recommend this hospice

HQRP is relatively new, so there is limited publicly available information on hospice quality. Performance on many of the quality measures is relatively high, indicating that hospices are performing well on these metrics.

IV. CURRENT SYSTEM OF HOSPICE CARE FOR MEDICARE ADVANTAGE BENEFICIARIES

The hospice benefit remains entirely carved out of Medicare Advantage and is not included in the benefit package. If Medicare Advantage beneficiaries elect hospice, Traditional FFS Medicare becomes the primary payer for most health care services. Because the hospice benefit is excluded from Medicare Advantage, Traditional FFS Medicare covers hospice, as well as Part A and B services unrelated to the terminal illness.

However, Medicare Advantage beneficiaries may remain enrolled in their plan as long as they continue to pay the monthly premiums. The Medicare Advantage plan continues to cover Part D drugs unrelated to the terminal condition and supplemental benefits, such as reduced cost sharing, dental, or hearing. If the beneficiary continues his or her Medicare Advantage coverage, government payments to the Medicare Advantage plan decrease to reflect payment for Part D and supplemental benefits only, and not capitated Part A and B services.

If the beneficiary disenrolls from hospice, the financial responsibility between Traditional FSS Medicare and the Medicare Advantage plan is shared until the end of the month of disenrollment (up to 30 days). Coverage is divided with Traditional FFS Medicare continuing to cover all Part A and B services, while the Medicare Advantage plan covers Part D drugs and supplemental benefits. On the first day of the following month, the Medicare Advantage plan is paid the full capitation rate again and is responsible for all the benefits.

FIGURE 3

Coverage for MA-PD Enrollees Who Elect Hospice

	FFS Medicare Covers:	MA-PD Covers:
Before hospice enrollment	N/A	• All Part A, Part B, and Part D services, and any supplemental benefits
MA-PD enrollee elects hospice	• Hospice • Part A and Part B services unrelated to the terminal condition	• Part D drugs unrelated to the terminal condition • Any supplemental benefits (e.g., reduced cost-sharing)
MA-PD enrollee disenrolls from hospice	• Until the end of the month, all Part A and Part B services	• All Part D drugs • Any supplemental benefits (e.g., reduced cost-sharing) • Beginning the next month after disenrollment, Part A and Part B services

Source: The Medicare Advantage Program: Status Report. MedPAC, 2014

These coverage rules create a complicated and fragmented system that inhibit beneficiaries in hospice from having access to the coordinated care that they received prior to electing hospice. Because Medicare Advantage plans pay for these services, but the hospice provider is responsible for arranging the care, coverage can be confusing for patients and caregivers. Further, if the beneficiary disenrolls from hospice, their care remains fragmented until the beginning of the following month. The addition of coverage complications can add to the emotional stress of the beneficiary and their family. The chart below demonstrates the division in financial responsibility and accountability for care. [27]

V. PAYMENT AND ACCOUNTABILITY

To include hospice as a required benefit in Medicare Advantage, Congress must amend current law, and then CMS would have to promulgate new regulations governing the addition of hospice to Medicare Advantage. As part of a demonstration, CMMI may now include hospice in Medicare Advantage. Regardless of how the

benefit is included, Medicare Advantage plans would need adequate time to arrange for the necessary services and update the benefit structure of plans with the inclusion of the new hospice benefit.

In addition, several other changes are necessary to implement the inclusion of these new services. These include:

- **Inclusion of hospice services in the annual bid process and arrangement for a network of hospice service providers:** Hospice costs would need to be incorporated in a plan's bid and CMS would need to take into account the cost of this added benefit when determining capitated payments and risk-adjustment. Medicare Advantage plans would also need to develop an adequate network of hospice providers for beneficiaries to ensure that each patient has a choice of hospice providers.[28] This requires identifying and selecting hospice providers, as well as negotiating payment arrangements with each new provider both locally or nationally. If a Medicare Advantage plan enrolls a hospice provider not currently participating in Medicare, the hospice provider would be required to meet Medicare-certification and adhere to the Medicare conditions of participation.

- **A clear definition of the hospice benefit covered by Medicare Advantage:** MedPAC recommends that plans be subject to the complete hospice benefit structure requirements as outlined in the Social Security Act.[29] Medicare Advantage plans would have to follow the same definitions of hospice care and would be expected to contract with Medicare-certified hospice providers similar to Traditional FFS Medicare. The number of providers may need to increase with continued growth in Medicare overall, and particularly Medicare Advantage, to accommodate increased utilization. In addition, hospice providers and Medicare Advantage plans would have to develop and implement appropriate protocols for referrals.

- **Reimbursement for plans at rates that accurately reflect new risk:** Capitated payments to Medicare Advantage plans would have to increase to account for the cost of new services. In addition, Medicare Advantage risk scores would need to be adjusted to reflect the risk for hospice services. Since evidence shows that use of hospice for beneficiaries in Medicare Advantage plans is higher than for beneficiaries in Traditional FFS Medicare, the difference in anticipated utilization would have to be accounted for in the bid process and in the risk adjustment process to account for patients who are sicker than average—and therefore, more costly. Medicare Advantage plans would likely need to include hospice claims in the encounter data reports to monitor hospice services and include the type, number, and length of hospice visits for each beneficiary. [30,31]

- **Quality measures:** MedPAC recommended that claims-based quality measures be used to ensure high quality hospice care. One proposed measure could be the number of skilled visits (e.g., nurse, therapist, or physician visits) a Medicare Advantage beneficiary receives compared to Traditional FFS Medicare. The CHRONIC Care Act Working Group proposed that the Medicare Advantage five-star quality program should be updated to include measures associated with hospice care, as well as additional quality measures that incorporate health outcomes, level of care, and patient satisfaction.[32,33] Further, Medicare Advantage plans may need data from providers to compare the quality and performance of hospice providers in order to select higher quality hospice providers. This type of public performance tool would allow Medicare Advantage plans to establish adequate care networks based on quality to meet the growing demand.[34]

- **A registry of providers and the facilitation of data sharing:** It has been suggested that CMS establish a registry of hospice providers with relevant performance ratings for Medicare Advantage plans. The information could be used to support referrals and partnership development between hospice providers and plans. In addition, CMS could facilitate the exchange of data, particularly encounter data, between plans and providers about patient populations to help health plans and providers better understand and serve patients. Medicare Advantage plans could use the data to evaluate provider performance and hospice providers could use the data to gain market insight. The registry could exist on a "opt-in" basis.[35]

VI. STAKEHOLDER VIEWS

Key stakeholders include Medicare Advantage plans and providers, hospice providers, and beneficiaries and their families. By and large, Medicare Advantage plans have not taken a public stance on whether or not to include a hospice benefit into Medicare Advantage. However, several plans have worked to incorporate programs that address the need for palliative care as part of their delivery of continuous, coordinated care. They have called attention to the disruption that beneficiaries face in the current system when electing hospice, including changing health coverage and providers. Medicare Advantage plans also speak to the value to beneficiaries of being able to remain with providers they know and have cared for them for months or years. In addition, as described above inclusion of hospice would ease the care transitions in the current system, which come at a stressful time for patients and their families. Allowing for a carve-in of hospice benefits would largely eliminate these process and care provider continuity concerns.

PLAN PERSPECTIVE

Plans have expressed openness to including hospice care in Medicare Advantage. They know it would mean new contracts with new providers, but they are open to developing these contracts to achieve greater continuity of care. Medicare Advantage plans expect that these contractual payment arrangements will include quality standards and accountability. They would likely need to vary by geography and care delivery models. While it is expected that there would be defined care and services in a hospice benefit, as well as guidance on implementation, plans have made it clear that they expect the authority to negotiate contracts without interference from CMS; thus allowing the flexibility to create contracts that work best for plans and providers.

Medicare Advantage plans assume that all services included in the current hospice benefit in Traditional FFS Medicare would be included in the new hospice benefit. Plans have some concerns about adequate payment from CMS as part of the benchmark and risk adjustment processes, as well as new measures under the Star Rating System that would need to be established before implementing the new benefit. In addition, network requirements are unknown. Current network requirements for Medicare Advantage plans require at least two providers of every type within specific mileage limits. Requirements for in-home hospice and for facility-based hospice have not yet been defined and remain uncertain. In addition, because palliative care is not well defined, the point when palliative care ends and hospice begins is not clear. In a capitated system, that may matter less than in Traditional FFS Medicare, but it remains an open question.

In addition, both MedPAC and Commonwealth Fund have offered the perspective that if a hospice benefit is included in Medicare Advantage, plans would be incentivized to develop innovative ways to manage the care of terminally ill patients.[36] Stakeholders agree that addressing socioeconomic factors that inhibit access to high-quality end of life care is essential to improving patient care and have acknowledged the importance of addressing social determinants of health in hospice quality measures to provide seamless, high-quality hospice care.[37, 38] Medicare Advantage plans could go beyond Traditional FFS Medicare and concurrently offer both hospice and support care to beneficiaries, which would be unique to Medicare Advantage. Plans could potentially integrate and manage care for terminally ill patients more effectively, thus achieving cost savings for the Medicare program.[39]

Hospice Perspective

Hospice providers and associations that represent them have expressed uncertainty—and in some cases, opposition—to changing the carve-out of hospice. They point to the specialized care they have provided for decades and high satisfaction among patients and families. In addition, some providers argue they would not

be equipped to handle the interdisciplinary approach to care that Medicare Advantage would expect. There are also concerns that the carve-out would undermine the authority of the hospice medical director, threaten the financial stability of the hospice program, and reduce the quality of the benefit.[40]

Hospice providers also express concern about provider networks and possibly being excluded from networks. Smaller hospice providers consider themselves vulnerable to plans giving contracts exclusively to larger hospice providers as a cost-containment strategy and an incentive to limit access to services.[41] Further, they say the hospice benefit in Medicare Advantage would increase administrative burdens on hospice providers, as there would be additional accountability and quality measures to meet that they do not have now.

Conversely, there are hospice groups who support the Medicare Advantage hospice carve-in who say it would benefit patients by integrating hospice services sooner than Traditional FFS Medicare.[42] These groups suggest that Medicare Advantage plans may provide palliative care before the six-month threshold under Medicare. As a result, there would be more streamlined process for beginning palliative care and transitioning to end-of-life care. These groups support testing the inclusion of the hospice benefit in a pilot program before full implementation by all Medicare Advantage plans.

Two convenings were held jointly by the National Hospice and Palliative Care Organization (NHPCO) and Better Medicare Alliance in October 2018 and then in June 2019 on the possibility of hospice being included as a benefit in Medicare Advantage. Hospice providers and plans discussed the likelihood of a demonstration project under CMMI as a valuable way to test models of care management and coordination of hospice care under Medicare Advantage, while maintaining the current hospice care and services as defined in Traditional FFS Medicare. Stakeholders agreed on the importance of adequate payment made by CMS to plans, and subsequently to hospice providers, as essential to continue the quality and personalized care now available to Medicare beneficiaries. CMMI participated in the convenings and a report of the discussion and recommendations were shared with CMMI to inform the development of the demonstration project for 2021.

VIII. CONCLUSION

Given the growing number of older adults and the increasing interest and capacity for providers to deliver palliative and end-of-life care, the need for hospice care will grow. Stakeholders are increasingly considering the impact of carving hospice care into Medicare Advantage. These considerations come amid increasing focus on both care coordination and palliative care. Allowing patients to remain with their providers at the end of life, potentially through the integrated care Medicare Advantage offers, is one main reason to consider this change.

Medicare Advantage plans are seen as well-situated to provide hospice services to those who choose hospice for end-of-life care. For this to happen successfully, two conditions would have to be met. First, plans would need payment adequacy and flexibility to ensure access and quality care. Second, hospice providers would need to adjust to contract payment arrangements and accountability under Medicare Advantage. If these conditions are met, Medicare Advantage plans could work in partnership with hospice providers to advance innovative, value-based practices to manage care for terminally ill patients with compassion and sensitivity. Combining the experience and expertise of hospice providers with integrated care under Medicare Advantage can offer hospice patients and their families a level of continuity and security that does not currently exist for Traditional FFS Medicare beneficiaries. Policymakers should engage with stakeholders as they consider and develop appropriate rules and oversight for a carve-in policy.

High-quality hospice care is important, and the goal is for beneficiaries to have access to quality, accessible end-of-life care in Traditional FFS Medicare and in Medicare Advantage.

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