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WHO WE ARE

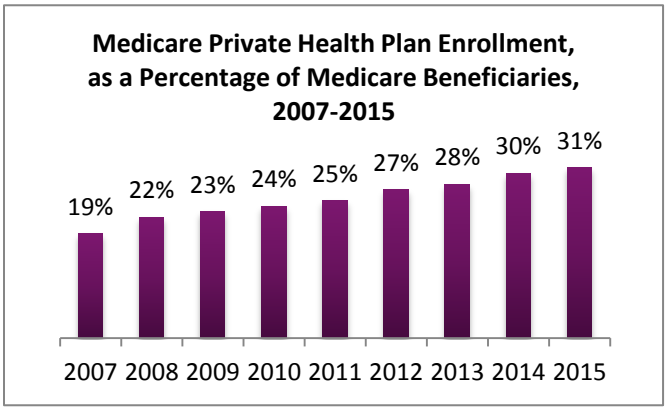
The National Hospice and Palliative Care Organization (NHPCO) is the largest membership organization representing hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice programs that care for the majority of hospice patients in the US. NHPCO is committed to improving end-of-life care and expanding access to hospice so that individuals and families facing serious illness, death, and grief will experience the best care that humankind can offer.

Issue Briefing: Hospice and the Medicare Advantage "Carve-In"

Background

In 2015, 31% of Medicare beneficiaries were enrolled in a Medicare Advantage Plan, although enrollment rates vary greatly by state and locale. This is up from 19% in 2007.[1] Once a beneficiary elects to receive hospice care, the hospice is responsible for all medical care related to the beneficiary's terminal prognosis—their primary diagnosis and related conditions—as well as coordinating unrelated care.

Currently, Medicare Advantage Plans do not cover hospice care. When an individual with Medicare Advantage coverage decides to elect the Medicare Hospice Benefit, he or she typically disenrolls from the MA plan, and can then select any Medicare-certified hospice, without any network restrictions. All Medicare-covered services a beneficiary receives while in hospice care are covered by fee-for-service Medicare. This includes any Medicare-covered services for conditions unrelated to the terminal prognosis. If the beneficiary's Medicare Advantage Plan includes additional services not covered under fee-for-service Medicare (such as vision and dental benefits) and the patient does not disenroll from the Medicare Advantage Plan, the MA Plan will continue to cover those additional services.



Source: Kaiser Family Foundation. Medicare Advantage 2015 Spotlight: Enrollment Market Update.

Potential Changes to the Medicare Advantage Hospice "Carve-Out"

The Medicare Payment Advisory Commission's (MedPAC) March 2014 Report recommended that Medicare Advantage (MA) plans assume both the clinical management of and financial responsibility for the hospice benefit. This proposal is rooted in an effort to promote coordination of care management between MA plans and hospices. In December 2015, the Senate Finance Committee's Chronic Care Working Group (CCWG) released a similar proposal.

Implications for Hospice Patients and Families

In choosing a hospice provider, patients often take into consideration their faith, their unique personal and family needs, referral to a particular hospice from a friend or family member, the reputation and familiarity of the hospice programs in their community, and other factors. It isn't simply a medical decision. If hospice is carved-in to MA, however, beneficiary access could be severely limited. Additionally, MA plans could also assign additional co-pays, deductibles, or prior-authorizations for both in-network and out-of-network hospice utilization. For individuals and families facing terminal illness, these restrictions and financial requirements create an additional burden during an already stressful time.

Network adequacy requirements call for plans to contract with a bare-minimum number of providers based on statistical formulas and geography. Small, community-based providers, faith-based providers, and others might be left by the wayside.

Hospice patients do not have the luxury of waiting several months for an open-enrollment period to change plans to elect the hospice of their choice – more than one-third of hospice patients die within a week of electing hospice. More than half of all hospice patients die within two weeks of electing hospice care.[2] The limited networks with potential pre-authorization requirements are a bad fit for hospices and patients alike.

[1] "Medicare Advantage 2015 Spotlight:Enrollment Market Update." The Henry J. Kaiser Family Foundation. http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/. June 30, 2015.
[2] 2014, NHPCO National Data Set and/or NHPCO Member Database.

The hospice interdisciplinary team (IDT) includes physicians, nurses, social workers, chaplains, volunteers, and other professionals. The IDT ensures that the whole patient and family are treated – not just the physical illness. Many hospice providers have witnessed managed care organizations in other markets asking them to offer a subset of services, such as pain management or in-home care, but at a reduced fee-for-service rate. NHPCO is concerned that a "hospice lite" model may undermine the integrity of the hospice benefit.

Implications for Hospice Programs

A "carve-in" of the Medicare Hospice Benefit into MA plans would have a significant impact on the hospice community. NHPCO is concerned that MA plans would undermine the autonomy of the hospice medical director, and require hospices to pay for services/care that is unrelated to the terminal prognosis. Hospices are not designed to assume risk for these costs; a shift of this nature could threaten the financial sustainability and viability of hospice programs.

Finally, an MA carve-in would likely undermine the financial viability of many hospice programs. The current MA carve-out allows hospices to focus staff time and resources on delivering high quality patient care. Unfortunately, the proposal to carve-in hospice under MA would significantly increase hospices' administrative burden. Hospices would be required to negotiate, manage, and process claims from each MA plans with whom they contract.

It is presumed under current proposals that MA plans would be able to set their own reimbursement rates for hospice care. This would come at a time when hospices have already faced multiple Medicare reimbursement reductions, a series of costly regulatory changes, and more recently, a complete overhaul of the Medicare hospice payment system.

> "The success of our program [the Aetna Compassionate Care program] – and other MA programs – has been supported by efficient administration and broad access to local hospice services. **Eliminating the carve-out would diminish patient access, program impact and satisfaction.**"– Randall Krakauer, MD, former Vice President, National Medical Director, Medical Strategy, Aetna

What Would the "Carve-In" Cost?

Hospice is already a managed benefit. Hospices manage patient care related to the terminal condition for a fixed daily rate, just as MA plans manage medical care for their enrollees for a monthly capitation. The MA carve-in would seemingly add another layer of 'managed care' to what is essentially a managed hospice benefit. In doing so, this creates redundancy, complexity, and increased administrative cost for both hospices and MA plans, but adds very little value – either in terms of quality or cost of care – to the consumer or the taxpayer. In fact, an estimate prepared by Avalere Health suggests that **making this change would cost the Medicare program more than $895 million over ten years.**

Policy Recommendations

If Congress enacts legislation creating a carved-in benefit, safeguards must be in place to protect patient choice and the integrity of the hospice benefit. In addition**, a pilot or demonstration phase**, coupled with a robust evaluation, would allow us to better understand the unique impact this change would have and make modifications to ensure the sustainability of hospice. NHPCO seeks to ensure the following in the event of a carved-in benefit:

- **Beneficiary Access:** Patients must have access to the hospice of their choice; a carve-in must allow patients the flexibility to go outside of the MA plan network to receive hospice services from the hospice of their choice, taking into account the specific desires of the patient, such as specialized or faith based providers, without financial penalties.
- **Integrity of the Hospice Benefit:** The program design of the full hospice benefit must remain unchanged and serve as the model of care; MA plans should not be able to diminish the full depth and breadth of services provided by the hospice's interdisciplinary team.
- **Autonomy of the Hospice Medical Director:** The hospice Medical Director should continue to determine if care is "related" or "unrelated" to the terminal prognosis; MA plans should have the option to appeal these decisions to CMS.
- **Financial Sustainability:** The reimbursement framework of a carve-in must mirror that of the existing Medicare Hospice Benefit; the same per diem rates should be paid for all hospice beneficiaries under Medicare or MA. Further, MA plans should be required to reimburse hospice providers in a timely manner.
- **Administrative Burden:** Contracts between MA plans and hospices should be standardized nationwide based on guidance from CMS. If MA plans are allowed to impose preauthorization requirements for hospice care, there needs to be uniformity in the processes, forms, and documentation requirements.
- **Accountability and Options for Plans:** Many MA plans lack the capacity and expertise to effectively manage a carved-in hospice benefit. MA plans should be able to opt out of including hospice in their MA plan's benefit package. For MA plan members without a carved-in hospice benefit, the original Medicare Hospice Benefit would be available. Further, CMS should engage a group of stakeholders in developing a new five-star domain under Medicare Advantage (similar to domains for preventive and chronic care) to address coordination of advanced illness care including transition to hospice.