REFORMING THE MEDICARE HOSPICE BENEFIT

MODERNIZATION POLICY PROPOSALS

SPRING 2022
INTRODUCTION

The Medicare Hospice Benefit (MHB), having remained largely unchanged over its last four decades, is due for an upgrade. While the hospice marketplace is evolving rapidly – with the growth of for-profit and private-equity-backed providers – the original, holistic hospice care model continues to provide great value to beneficiaries and play an important role in advanced illness and end-of-life care.

It is time to re-imagine the MHB in order to preserve the holistic hospice care model as an element of a comprehensive approach to advanced illness care. If this model is to thrive, we must reduce incentives in the per diem hospice payment that encourage payment abuse and unbundling of the original model, and that attract an undue government focus on program integrity that burdens providers who meet and exceed program standards. At the same time, we must provide opportunities for advanced illness providers to move "upstream" from hospice care to better support patients and adapt to the changes that are occurring in the marketplace.

BENEFIT DESIGN AND REIMBURSEMENT

NPHI proposes three alternative payment approaches for hospice and advanced illness care. The first approach would apply for beneficiaries who remain enrolled in Original Medicare and would require amending current MHB statute. The second and third approaches would provide alternative payment models (APMs) for hospice providers who choose to assume risk either through delegation from MA plans or accountable care organizations (ACOs), or through arrangements with CMS directly. These hospice and advanced illness care APMs could be established through contract with MA plans, ACOs, or demonstrated as part of the CMS Center for Medicare and Medicaid Innovation (CMMI’s) testing of APMs. All three of these alternative payment approaches would pursue a common set of objectives.
Common Reform Objectives

- **Remove Six-Month Prognosis:**
  - Eliminate diagnosis of a terminal illness with 6-month prognosis as the basis for hospice eligibility. Base eligibility on progression of an advanced illness and assessment of frailty.

- **Cover Upstream Palliative Care:**
  - Reimburse upstream, community-based palliative care (CBPC) under Medicare and base eligibility on clinical progression of illness with no regard for decline or prognostication utilizing comprehensive assessments as trigger points along the continuum of advanced illness care.

- **Allow Concurrent Care Coverage:**
  - Provide coverage of concurrent curative care through Medicare Parts A & B.

- **Enable Providers to Assume Partial or Full Risk:**
  - Provide a set of alternative payment approaches to enable hospice and palliative care providers to assume varying degrees of risk for providing more comprehensive advanced illness care.

Track One: Reformed Fee-for-Service

- **Comprehensive Advanced Illness Benefit:**
  - Design a cost-neutral reform that would offset the cost of expanded advanced illness coverage with savings from increased hospice use and modified hospice payment that is less prone to abuse.

- **Six-Month Prognosis:**
  - Eliminate the diagnosis of terminal illness with a 6-month prognosis that now serves as the basis for eligibility for the hospice benefit. Instead link eligibility for hospice care to measured functional decline and increases in frailty.

- **Palliative Care:**
  - Provide coverage for limited pre-hospice palliative care with eligibility based on a diagnosis of advanced illness and a level of frailty based on a frailty screening.

- **Concurrent Care:**
  - Allow coverage for concurrent care through Medicare Parts A & B.

- **Per Diem:**
  - Modify the per diem hospice payment by exploring:
    - Risk-adjusting the per diem based on diagnostic categories (e.g., cancer, heart failure, stroke, COPD, dementia).
    - Combining the four per diem rates into a single rate adjusted for proportion of census in each level of care.
    - Replacing it with a risk adjusted PMPM payment.

- **Long Length of Stay (LLOS):**
  - Eliminate provider-initiated live discharges. Step-down PMPM or per diem rate after 180 days.
**Track Two: Partial Risk-Based Model (PCF-SIP)**

- **Value-Based Payment:**
  - Provide for alternative value-based payment to advanced illness providers who want to contract with payers to assume partial risk and share savings.
- **PMPM Payment:**
  - Develop a single monthly per capita payment combining a basic hospice payment plus a supplement for palliative care, concurrent care, and prescription drugs (when applicable).
  - Risk adjust the PMPM payment for the patient mix in the provider’s census, adjusting for diagnosis, frailty, care intensity, and service area.
- **Quality Bonuses:**
  - Provide a percentage increase in the PMPM rate for providers based on previous year’s performance on process, experience of care, and outcome measures.

**Track Three: Full Risk-Based Model (ACO Reach-Advance Payment)**

- **“Total Cost of Care” (TCOC) Payment:**
  - Credit advanced illness providers with a total per beneficiary amount that is based on the TCOC for a comparable Medicare beneficiary with advanced illnesses in Original Medicare.
  - Pay the credited amount to the provider in monthly installments over a specified number of months (based on disease-specific expected care pathways) regardless of the actual course of illness of the individual beneficiary. Advanced illness providers would continue to provide services through the end-of-life without regard to payment.
- **Cover All Medical and Non-Medical Services:**
  - The credited TCOC amount would cover all medical and non-medical care to be provided over the beneficiary’s course of illness from a specified “trigger” point through end-of-life, reduced by a fixed percentage (e.g., 10%) for Medicare’s share of savings.
- **Risk Adjust Payment by Disease Pathway:**
  - Risk-adjust the TCOC to reflect the costs of treatment in Original Medicare for specific diagnoses and care pathways of the primary diagnosis, with adjustments for co-morbidities.
Track Three: Full Risk-Based Model (ACO Reach-Advance Payment) (Cont.)

- Reinsure Longevity Risk:
  - Provide for stop-loss coverage or re-insurance to protect providers from the unexpected “long-tail” of risk resulting from unpredictably long lengths of stay for patients with terminal illness. Adjust fees for stop-loss or re-insurance based on experience.

OTHER LEGISLATIVE PRIORITIES

In addition to the payment reform proposals described above, NPHI proposes policies in the interim that would promote equitable access to care and improve delivery of care by addressing workforce challenges, embracing new technologies, managing the continued impact of COVID-19, and ensuring all providers are operating on a level playing field.

Workforce and Technology

- Make permanent the ability to provide the routine home level of care and to recertify patient eligibility via telehealth.
  - Require CMS to collect telehealth visit data (as recommended by March 2022 MedPAC Report to Congress).
- Distribute Medicare grants to serious and advanced-illness providers for the purposes of expanding the capacity of the workforce.
- Allow Physician Assistants (PAs) to perform the certification and recertification of terminal illness (unnecessary with proposed benefit reform proposals).
- Provide training and certification for “hospice aides”, pursue opportunities to enable hospice aides to provide higher levels of care in the home, including adjustments in state scope of practice laws related to nursing.

Innovation and Equity in Care Delivery

- Encourage CMMI to continue work on a payment models that would enable hospice and palliative care providers to receive payment for upstream, community-based palliative care as part of a continuum of advanced illness care.
- Provide funding to providers to advance and improve health equity by removing structural barriers to end-of-life care and by building trust through education and community engagement with underserved populations.
Program Integrity, Quality Improvement, and Managing the Impacts of COVID-19

- Apply quality bonuses to the MHB payment structure that rewards providers based on their previous years’ Hospice Quality Reporting Program (HQRIP) and Consumer Assessment and Healthcare Providers and Systems (CAHPS) survey data.
- Encourage CMS to develop an audit and enforcement mechanism to redistribute the burden of focused medical reviews and audits per the proposals included in the NPHI Reforming Hospice Audits brief.
- Ensure current flexibilities related to the COVID-19 Public Health Emergency (PHE), specifically telehealth, are extended as necessary and appropriate.
- Ensure continued economic support for providers by protecting provider relief funding and minimizing the impacts of Medicare sequestration.

ABOUT NPHI

The National Partnership for Healthcare and Hospice Innovation (NPHI) is a collaborative of 80+ not-for-profit, community-integrated hospice and palliative care providers dedicated to ensuring patients and their families have access to care that reflects their individual goals, values and preferences. Representing providers from 34 states and the District of Columbia, NPHI and its members help design more innovative and effective models of care, advocate for comprehensive and community-integrated care customized to meet each person’s unique needs, and build collaboration between national thought leaders, decision-makers, and other healthcare stakeholders to improve hospice care. www.nphi.info