0:20:05	Slide 8	Is everyone else hearing a ton of echoing?
0:20:52	Slide 8	Cathy, you may need to mute your computer speaker if you are also on the phone. That should take care of the echo.
0:31:40	Slide 15	Medicare Advantage is a good program for the Medicare population, but it is very confusing for patients and families when they are enrolling in hospice and must make the switch.
0:34:34	Slide 15	What will the contracting opportunities be if this were to be implemented? We currently do not contract as most plans do not offer the product because they currently revert. Will a window for contracting be designed prior to finalizing?
0:34:35	Slide 15	In Michigan, authorizations are an issue. Some Medicaid HMOs don't recognize the 4 levels of care. Also, they require different billing codes, so there's a lack of consistency for providers.
0:35:22	Slide 15	In Michigan we work regularly with managed care plans for our Palliative Care program, but find they are very challenging to work with as they often don't understand the difference between hospice and palliative care. It will also be burdensome to hospices to contact with all the different plans available in our state.
0:36:22	Slide 16	In Texas all managed care programs through the state revert. Typically, no issues with billing. Regarding the tier model and different coding, we see no issues accept for the Crisis and SIA authorization process.
0:37:06	Slide 16	There are several issues that relate to payment including: lack of consistency re: SIA, CBSAs, 2-tier structure, etc. The inconsistent billing practices make it difficult for providers. Furthermore, there is typically a much longer payment cycle for Medicaid HMOs, so this impacts a provider's cash flow.
0:37:27	Slide 16	Just to clarify - The issues for hospices is that we must have a patient's Medicare number submitted and accepted by CMS. Once a patient is on a MA plan their MA number is used by all other providers. The patient's think their MA # replaces their Medicare and they have no idea where there Medicare card is. or what their number is. With all the numbers changing from SSN to MBI's this is a critical issue for hospices. However, has no impact on other providers of MA patients.
0:40:41	Slide 19	Contracting with providers is difficult. In Utah they don't allow a lot of providers which leaves many of us out of network. Will Medicare advantage plans be required to open their networks?

0:41:14	Slide 19	Is there a correlation n with MA experience with death?
0:42:00	Slide 20	When patients revoke or d/c alive d/t prognosis greater than 6 months, the transition back to Medicare Advantage is very confusing also. We have had patients who ended up paying a lot out of pocket when they revoked because they don't understand that their MA plan doesn't kick back in until the first of the next month.
0:42:23	Slide 20	We compromise care for many patients without a transition window for contracting. Most plans do not currently offer the benefit in the contract terms for hospice.
0:43:25	Slide 20	Will the reimbursement received from MA plans be comparable to the reimbursement received from FFS?
0:44:04	Slide 21	What is not working with how things are currently structured? Are those issues bigger than the issues created by the implementation of carve in for hospice?
0:44:21	Slide 21	Will MA plans be required to offer hospice benefit in their plans and be required to allow hospices to provide the same IDT approach to care?
0:44:26	Slide 21	What is the description of a lower contracted rate? It's going to be difficult to provide the same quality of care at a discounted rate.
0:44:41	Slide 21	Why add a middle man to end of life care? The MHB seems to be working well with built in mechanisms to help us admit patients quickly with few barriers. It's not the same with private payers.
0:44:44	Slide 21	Will LOS be tracked still, how does this impact quality reporting? How is the CAP impacted, are MA patients still counted into that?
0:45:00	Slide 21	It will take time to work on getting contracts in place with MA plans in our area and simplification of the authorization process.
0:45:43	Slide 21	Has Congress considered the impact having the home care benefit in MA, including the financial impact on home health agencies?
0:46:32	Slide 21	Are there alternative ways to solve the problems created by the carve out? Whereas hospice communities can work together to solve by a means different than a carve in.

0:46:48	Slide 21	Hospice is currently covered in full by Medicare, Co-pays will be a burden for Hospice Patients and families
0:48:09	Slide 22	With delays in services particularly for hospices, it decreases the quality of care and satisfaction for our patients. Also, with graduation from hospice services delays in coverage and transitioning back to standardized services makes it difficult and cumbersome to manage for patients.
0:48:57	Slide 22	The idea of a seamless PC to hospice transition in the MA plan is a great idea. Our PC program is becoming much more of a chronic care program to coordinate services such as obtaining DMEs and O2, case management including connections to community resources and emotional and spiritual support to help make decisions about treatment (or not).
0:50:27	Slide 23	In Michigan, we have difficulty in negotiating contracts with commercial payers. They often tell us that they're currently "closed" to discussing rates, etc. and providers sometimes must wait for months or years to renegotiate.
0:55:09	Slide 26	In Utah, we can't even get in network with Medicare Advantage plans. They pick a few providers and close their networks
0:56:10	Slide 26	Contracting is a nightmare.
0:57:45	Slide 26	What will the contracting opportunities be if this were to be implemented? We currently do not contract as most plans do not offer the product because they currently revert. Will a window for contracting be designed prior to finalizing?
0:58:36	Slide 26	For smaller providers it will be an administrative burden as well. We already wear so many hats it's going to be very difficult to have the staff to work on authorization and all the other loopholes.
0:58:36	Slide 26	Currently with the Medicaid contracts we have issues with Prior Authorization requirements that cannot be met.
1:01:04	Slide 26	Even if there was true beneficiary access to any hospice program on the part of the beneficiaries, it is a myth to conclude that this would lead to true open access. Imagine sitting bedside with a patient who is seeking to elect hospice care telling them "Well Hospice A and B are in your insurance's network; hospice C and D are not. But you can choose whichever one you want, but if you choose C and D you will leave your insurance plan that you have been paying in to and will revert to straight Medicare. If you come off hospice, you can go back to your MA plan. All it will take are some phone calls with that insurance company's great customer service call center. Or you can just choose

		Hospice A or B." What percentage of patients will even make it through all that conversation before saying "just call A and B"?
1:01:28	Slide 26	It's not just small hospices that commercial payers won't work with. As large hospice we run into problems.
1:02:33	Slide 26	The 2017-member survey indicated a mean of 18.3 on scale of 10 which many opposed to MA Carve. The 2018 survey mean of 7 on scale of 10 relates more support. What changed to turn attitude?
1:03:35	Slide 26	What caused the huge swing in former opposition?
1:03:54	Slide 26	How the question was worded?
1:07:38	Slide 26	The recent Health Affairs article was on the failure of ACOs to improve access to hospice. What does this say for MA plans that are reliant on ACO model to improve coordinated care?
1:08:58	Slide 26	Beneficiary access and administrative burden of negotiating and maintaining contracts are biggest concerns.
1:09:53	Slide 26	Since MA plans have not covered a full scope of hospice services in the past, will they be capable and knowledgeable on how to properly process the benefits and claims?
1:10:21	Slide 26	Opportunities include working toward a seamless transition from PC to hospice services and hopefully making things easier for patients to understand the hospice benefit if they are currently in a MA plan when considering hospice enrollment.
01:10:46	Slide 26	Have any studies been done to allow MA plans to evaluate hospice costs of their patients?
01:10:59	Slide 26	What happens to the current MA patient volume if this is implemented?
01:12:20	Slide 26	I see many issues with creating contracts that follow the Medicare guidelines and do not put us in jeopardy of not following the conditions of participation for hospice.

01:13:06	Slide 26	If hospice enrollment really does save Medicare money in decrease in hospitalizations, etc. I would hope MA Plans would be willing to reimburse at a comparable rate and allow the same services to be continued.
01:14:09	Slide 26	Administrative burden should include a look at the managed care cycle that can happen with prior authorizations, claims denials, timely filing, resubmission of claims etc.,
01:19:21	Slide 26	Would hospices have to be enrolled in Medicare to provide services to individuals who are in a MA plan? If not, would you run the risk of hospices not taking Medicare patients due to the administrative burdens ... (NOE's, sequential billing, 2%, - audits from various sources)
1:19:54	Slide 26	KK: Thank you for all for your participation!