

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

On January 1, 2021, the Centers for Medicare & Medicaid Services (CMS) began testing the inclusion of the Medicare Part A hospice benefit within Medicare Advantage (MA) through the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model.¹ Nine Medicare Advantage Organizations (MAOs) are participating in the VBID model in 2021 in portions of 14 states and Puerto Rico. CMS reports that “when a patient enrolled in an MA plan participating in the Hospice Benefit Component of the VBID Model (or the “Model”) elects hospice, the plan generally covers all of their Medicare benefits, including hospice care. Each participating MA plan must include all the services covered by the Part A hospice benefit under Fee-For-Service Medicare.”²

Seven months into the test, the National Hospice and Palliative Care Organization (NHPCO) gathered stakeholders as part of a series of convenings held over several years related to the MA VBID model. This report shares the learnings from that convening.

Background and History

For several years, numerous stakeholders, including the Medicare Payment Advisory Commission (MedPAC), have recommended testing hospice in an MAO model. MedPAC first recommended that Medicare Advantage consider “carving in” the hospice benefit in the March 2014 Report to Congress, Chapter 13: Medicare Advantage Program, Status Report.³ Many of the recommendations first published in the MedPAC March 2014 Report to Congress, Medicare Advantage chapter, were the seeds for the design of the Hospice Benefit Component in the MA VBID model.

Throughout the design of the Hospice Benefit Component of MA VBID, the National Hospice and Palliative Care Organization (NHPCO) has been actively involved in dialogue with CMMI, with MA plans and with hospice providers, hosting three convenings to discuss the conceptual design of the hospice benefit component and the details of offering hospice as a service under the MA VBID model.

First Convening

To encourage dialogue and for hospices and MA plans to meet together and learn more about hospice and the proposed “carve in,” NHPCO held its first convening on the subject on October 18, 2018. It brought together nearly 70 plans, hospice providers and stakeholders. It offered the opportunity to hear perspectives on the rationale for including hospice in Medicare Advantage, as well as to explore initial reactions to the potential impact of a possible policy change. The convening was a partnership between the Better Medicare Alliance (BMA) and NHPCO, formed to shape policy and payment model design.

Second Convening

NHPCO held a second convening on June 25, 2019, where almost 60 for-profit and nonprofit health plan and hospice industry leaders met together with policymakers to highlight key considerations for the Center for Medicare and Medicaid Innovation (CMMI) as the agency developed the 2021 VBID model. There were expert speakers and panel presentations, as well as breakout sessions to ensure participation from attendees. NHPCO’s 2019 convening focused on the following 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

Third Convening

NHPCO hosted its third convening on August 5, 2021, where MAO plans and hospice providers shared their learnings from the first seven months of experience with the model. Over 50 health plan and hospice industry leaders, as well as policymakers from CMMI, shared observations, reactions, and suggestions for future considerations of the model. The convening provided an opportunity for stakeholders to explore treatments and services available to seriously ill individuals and their families, including palliative and hospice care. The convening was a forum to learn what is working and what still needs improvement to maximize care coordination and collaboration and minimize unintended consequences for vulnerable consumers.

NHPCO’s 2021 convening focused on the following areas:

- **Beneficiaries and Families** – Quality Measures & Consumer Impact

1 <https://innovation.cms.gov/innovation-models/vbid-hospice-benefit-overview>
2 <https://innovation.cms.gov/innovation-models/vbid-hospice-benefit-coverage>
3 http://www.medpac.gov/docs/default-source/reports/mar14_ch13.pdf?sfvrsn=0

- **Seamless Transition of Care** – Palliative Care Core Services
- **Network Adequacy**
- **Innovative Contract Arrangements**

The model's aim, as defined by CMMI, is to enable a seamless care continuum that improves quality and timely access to palliative and hospice care in a way that fully respects beneficiaries and caregivers and honors their choices. CMS has identified seven design elements:

- Maintains the full scope of the current Medicare hospice benefit
- Focuses on improved access to palliative care
- Enables transitional concurrent care for enrollees
- Introduces additional hospice-specific supplemental benefits
- Promotes care transparency and quality through actionable, meaningful measures
- Maintains broad choice and improves access to hospice
- Utilizes a budget neutral payment approach to facilitate all the above⁴

The convening sought to observe and capture how well the implementation is meeting these design elements. While several positives have emerged from the early months of the model, many opportunities for improvement exist to achieve the aim of a seamless care continuum.

Significant Learnings and Key Considerations for CMMI

Mutual respect and collaboration across CMMI, MAOs, and hospice providers were essential for the convenings, along with a recognition of what is and is not known about the successes and failings in the early days of the model. Several key themes emerged that stakeholders, including CMS, MA plans, and hospice providers, should consider as the model continues:

- The data needed to effectively test outcomes are missing.
- There is no defined required set of core services for palliative care.
- There is no data on rates of palliative care use or conversion to hospice.
- Access to palliative and hospice care can be accomplished outside the Hospice Benefit Component of VBID.
- The model can promote health equity through the use of concurrent care and health-related benefits.

This report summarizes the discussions of the four topic areas as well as insights, key considerations, and recommendations from the August 5 convening. NHPCO hopes to identify refinements and improvements in the Hospice Benefit Component of VBID for CMMI and interested stakeholders for use in the future.

The data needed to effectively test outcomes are missing.

The current model design does not require the level of data collection necessary to measure and evaluate utilization outcomes among hospice-eligible beneficiaries. Identification of measures related to beneficiary and family satisfaction across the model and types of care should be included in the reports. CMS should require frequent detailed reporting by both MAOs and hospice providers as a key part of their monitoring activities; timely reporting would enable real-time improvements and course corrections. While developing agency-specific data points and metrics may be helpful for individual hospices or MAOs to evaluate their progress, CMS should develop a set of data points that all VBID MAOs and hospice participants should collect so that consistent data is available to make changes in the model.

Three quality domains are currently monitored for the model:

- Palliative Care and Goals of Care Experience
- Enrollee Experience and Care Coordination at End of Life
- Hospice Care Quality and Utilization

The current measures rely on existing CMS and plan-reported data sources. Participants at the convening questioned whether these measures are being collected in a way that the information can be used for timely

4 <https://innovation.cms.gov/webinars-and-forums/vbid-hospice-benefit-component>

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performance improvement and policy changes by CMS, MAOs, and hospice providers. Participants sought to gain a clearer picture of the CMS process for obtaining data, how the agency will act on that data, and the lag time between reporting and availability of data. Both health plans and hospice providers noted that they develop their own specific intermittent data points, since relying on the timeframes of CMS reporting of the identified measures makes it too late to react or course correct.

Measures recommended for development and inclusion

With the existing 19 transparency and monitoring measures published by CMMI in their Hospice Benefit Component Monitoring Guidelines and found in Table 1 below, only one addresses palliative care: *Access to, and use of, Palliative Care*. Missing from the list of measures being monitored is a measure for identifying conversion from palliative care to hospice services.

Table 1. Transparency and Monitoring Measures by Domain and Source of Data⁵

Transparency and Monitoring Measures	Source of Data: CMS	Source of Data: Plan Reported	Frequency of Monitoring Review
Palliative Care and Goals of Care Experience			
Development of WHP, including Advance Care Plans (ACPs)		X	Annually
Access to, and use of, Palliative Care		X	Bi-annually
Proportion of Enrollees Admitted to Hospice for Less than 7 Days	X		Quarterly, beginning Quarter 2 2022
Enrollee Experience and Care Coordination at End of Life			
Days Spent at Home in Last Six Months of Life	X		Annually
Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life	X		Annually
Hospice Care Quality and Utilization			
Pre-Hospice Consultation Process		X	Bi-annually
Availability of and Access to Hospice Providers		X	Bi-annually
Hospice Utilization	X		Quarterly, beginning Quarter 2 2022
Delivery of Transitional Concurrent Care		X	Bi-annually
Hospice Supplemental Benefits		X	Bi-annually
Part D Duplicative Drug Utilization	X		Annually
Unrelated Care Utilization	X	X	Annually for CMS-sourced data & Bi-Annually for Plan Reported
Proportion of Lengths of Stay beyond 180 Days	X		Quarterly, beginning Quarter 2 2022
Visits in the Last Days of Life	X		Annually
Transitions from Hospice Care, Followed by Death or Acute Care	X	X	Annually for CMS-sourced data & Bi-Annually for Plan Reported
Experience of Care Measures	X		Annually
Appeals and Grievances Processes	X	X	Rolling basis for CMS-sourced data & Bi-Annually for Plan Reported
Provider Complaints and Disputes	X	X	Rolling basis for CMS-sourced data & Bi-Annually for Plan Reported
Timeliness of Claims and Payments		X	Bi-Annually

⁵ CMMI Hospice Benefit Component Monitoring Guidelines <https://innovation.cms.gov/media/document/vbid-hospice-cy22-monitoring-gl>

Participants sought benchmarks or a baseline measure to evaluate the rates of conversion between palliative and hospice care. It was noted that in several markets represented there is not a strong or identifiable relationship between the palliative care provider and hospice provider for a beneficiary. Another identified omission is the lack of member and caregiver satisfaction measures in each domain. Participants also noted that these measures should be consistent across MAOs and providers. Finally, participants observed that the list of measures struck them as unbalanced with a larger number of hospice utilization measures compared to other domains.

Patient experience

Participants appreciated the opportunity to share their experiences in the first seven months of the model. It is important to consider what data elements should be considered for patient experience so that there are opportunities to determine the difference between VBID and non-VBID patient experience for hospice services. For example, hospice CAHPS scores may not provide enough detail about VBID enrollment to compare VBID and non-VBID patient experience. Other data points should be considered now, so that length of stay and transitions from palliative care comparisons can be collected and compared at specified timeframes in the future, e.g., quarterly, or annually.

Additionally, some of the data elements, like advance care planning, have qualitative, manual processes for data collection and aggregation. This adds administrative burden on providers and health plans, such as joining a common database, transforming data to meet common formats, and developing benchmark comparative data that is meaningful. From the perspective of MAOs, this can extend the time for submission, synthesis, and report-out, which can again delay actionable changes for providers.

There is no defined required set of core services for palliative care.

VBID has not defined a required set of core services for “comprehensive palliative care” that a Medicare Advantage plan can offer to effectively implement concurrent care. Though “transitional concurrent care” should be available to beneficiaries who could benefit from palliative care for serious illness concurrent with a transition to hospice care for those nearing the end of life, absent a well-defined set of services to support their care, beneficiaries may be denied access to the care they need.

Defining palliative care core services

One significant opportunity within the Hospice Benefit Component of VBID is the ability to make palliative care and concurrent care more accessible and integrated for MA enrollees and providers. A question from the group was, “What constitutes palliative care core services?” Participants in the convening reported that palliative care services are not consistent across MAOs, and beneficiaries find it challenging to navigate, given that the services available are not clear and consistently defined or delivered.

Concurrent care

A breakout group discussed how concurrent care is offered, delivered, and billed. One example from a participating plan is that the MAO develops a contracted rate for up to 31 days of concurrent services after the election into hospice. It allows the opportunity to transition from curative care without specific parameters about what form that curative care takes. Other MAOs have found concurrent care to be more easily offered with integrated systems where the providers are already in value-based arrangements, e.g., a health system already participating in Medicare Shared Savings Program (MSSP) or an Accountable Care Organization (ACO).

Hospices reported that there is an expectation that providers take on 100% risk, with adjustment based on the average patient profile to deliver concurrent care from MAOs. It has been more challenging for many hospice organizations to deliver the innovative pieces of the model, such as concurrent care, supplemental benefits, and palliative care, in contracts with MAOs as these services are often separate. Conversations are ongoing and MAOs and providers are developing partnerships, but additional education continues and is needed to deliver care beyond the traditional Medicare fee-for-service hospice benefit. The non-traditional services, such as palliative care and concurrent treatment, are not clearly

defined. Given this lack of clarity, it is uncertain how beneficiaries in the model access the new benefit offerings. MAOs are working to educate beneficiaries, hospice providers, and referring providers of the new benefits, but seven months in, more education and time are needed.

There is no data on rates of palliative care use or conversion to hospice.

CMS has offered no visibility into the rates of palliative care use or conversion rate of palliative care to hospice services. Given the model's aim to enable a seamless care continuum, CMS must address concerns related to palliative care services being offered through separate contracts by non-hospice providers and collect data to fully understand the components of the care continuum.

Palliative care and conversion to hospice

Participants shared initial observations that the conversion rates are low from palliative care to hospice services. Despite the increased theoretical availability of palliative care, some participants noted that palliative care services are still not provided to many enrollees in different markets and some markets only offer telephonic palliative care services. Both MAOs and hospice providers are interested in tracking transitions between palliative care, concurrent care, and hospice care. At this point, attendees at the convening reported that there have been very few concurrent care cases to date, but these cases seem to result in good outcomes. Beneficiaries who have elected concurrent care reflect a mix of clinical conditions and personal situations, including people with cancer, people who were looking for additional home health aide and skilled nursing services, and at least one person who used concurrent care as a bridge to hospice while getting the whole family on board with the prognosis.

Separate contracts for palliative care services

Hospice providers raised a concern regarding plans that are contracting separately for palliative care providers who do not deliver hospice services. This practice can limit the ability to provide the seamless care continuum that the model is intended to create and test. Some hospice providers reported that although the hospice had a robust palliative care program, delivered in person, the plan opted for a third-party palliative care provider that delivered all care telephonically from a remote location. Hospices reported very few or no referrals to hospice from the palliative care provider, further diminishing the opportunities for hospice providers to partner fully with MAOs in the model.

Impact on Utilization

According to feedback from participating plans, early data indicates that overall healthcare utilization has decreased for beneficiaries utilizing palliative care and hospice services. It is too early in the model to note variation between those who utilize palliative care and transition to hospice and those who stay on palliative care to end of life. Items such as emergency department and inpatient hospital use are particularly reduced in hospice, as expected. At this point in the model, plans noted that hospice length of stay is still short, but it is expected to increase as the model matures.

Access to palliative and hospice care can be accomplished outside the Hospice Benefit Component of VBID.

The goal of improving quality and timely access to palliative and hospice care in a way that fully respects beneficiaries and caregivers can also be accomplished outside of the VBID model. The potential exists for health plans, referral sources, and hospice providers to increase their communication and collaboration related to the benefits of palliative care and hospice services for patients and their families. CMS/CMMI should implement a Community-Based Palliative Care model demonstration to improve timely access to high-quality care and seamless transitions of care for seriously ill individuals and their families.

The model can promote health equity through the use of concurrent care and health-related benefits.

The model does show promise in addressing some social determinants of health through the interdisciplinary model offered through hospice. There are valuable lessons to be learned about the flexible approach that plans and providers are taking to meet the housing, nutrition, and transportation needs of beneficiaries enrolled in the model through supplemental benefits. The model also offers the opportunity for concurrent care. Currently, hospice is limited to patients with less than six months

to live and requires that both the patient and the family acknowledge impending death, “a concept that often runs counter” to the spiritual beliefs of people of color. Replacing the “or” with “and” in the choice between the hospice benefit and curative treatment restores a sense of dignity to those beneficiaries with a terminal illness.

Supplemental benefits

Within the Hospice Benefit Component of the VBID Model, MAOs can offer not only supplemental benefits to all enrollees as a typical MA plan but can also offer hospice supplemental benefits to those participants who elect hospice. A variety of supplemental benefits of both types are offered depending on the plan. Examples discussed included a healthcare assistance allowance that has been used flexibly to cover items such as housing needs, bills, and improvements in the home environment that all contributed to improving the quality of life for the beneficiary. Other examples included medically tailored meal delivery services and in-home respite care.

Additional Topics Discussed

Two additional key topics were discussed, informed by the initial seven months of the program: network adequacy and innovative contract arrangements.

Network Adequacy

It has been noted that time and distance do not offer the same adequacy standards for hospice services as compared to other types of health care. The geographic location of the hospice office does not define where hospice care is delivered. During the discussion, an emphasis was placed on the primacy of the location of the patient’s home as that is the main place where most services are provided.

Data to inform network development

When MAOs began to form their networks, they turned to data. This included their existing relationships with providers as well as publicly available data from CMS on utilization, quality, and satisfaction to understand the model and how to optimize care for the plan’s members. Typical sources include Medicare Care Compare, which includes quality data from the Hospice Item Set (HIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, and the Hospice Provider Utilization and Payment Public Use Files (PUF) with information on characteristics of beneficiaries served, service utilization, and payment. Additionally, plans sought to determine the breadth of services available through the hospice provider, including capabilities and inclination of hospice providers to deliver palliative and concurrent care services. Plans also reviewed hospice patient volume for the hospices in the markets identified by the MAO for the model.

Hospice outreach to MAOs

Hospice organizations in attendance reported proactive outreach to MAOs, specifically sharing their quality and performance data, as well as data points of specific interest to the MAO. Data points included clinical expertise with specific non-cancer diagnoses, percentage of care provided at home, and ability of the hospice to help the MAO with avoidable hospitalizations. In addition to having positive scores in Care Compare and with Hospice CAHPS, hospices can demonstrate to MAOs how the hospice organization can be a strong partner. This includes appropriately utilizing the different levels of care available to hospices, based on patient need, as well as being mindful of overall healthcare spending.

Future networks

Hospice providers in attendance expressed concern about the future networks for hospice services and whether the enrollee will have a choice of hospice providers as narrow networks are identified in later years of the model. While the experience in the first year is uniform with all plans in phase 1, the landscape grows more complex in 2022 with new plans entering in phase 1 and continuing plans moving to phase 2.

In-network and out-of-network hospice providers

MAOs in the convening reported that there was variation among plans about whether more in-network providers are being selected compared to out-of-network providers for hospice services. Plans also reported that the use of the voluntary consultation process is still relatively low but growing. MAOs are developing a variety of resources to educate their members and providers about the opportunities available within the Hospice Benefit Component of VBID.

Innovative Contract Arrangements

The Hospice Benefit Component of VBID presents an opportunity to integrate a range of end-of-life services as a Medicare Advantage plan option and leverage lessons learned from the Medicare Care Choices Model through payment innovation and service delivery design.

Payment to providers

Participants noted that claims and billing processes for out-of-network payments to providers have been “clunky.” Hospice providers describe additional administrative burden, which was expected and not overly problematic for a new model, but it has an impact on billing staff at a hospice provider. Duplicate billing is often referred to as “shadow billing” when claims are submitted to both the MAO for payment and the Medicare Administrative Contractor (MAC) as “no pay” or “information only,” and the hospice Notice of Election processes have been significant pain points for both MAOs and hospice providers. COVID-19 has also created additional challenges with implementing the operational side of the model. Resources and attention have been diverted to addressing COVID-specific needs that could have otherwise been expended on the Hospice Benefit Component of VBID.

Innovative payment arrangements

Several providers have not yet observed innovative payment arrangements but speculated that this may be attributed to palliative care being delivered separately by several MAOs. Without the opportunity to participate in the delivery of both palliative care and hospice, it can be challenging for hospice providers to engage in the opportunities for innovative payment arrangements. Outside the Hospice Benefit Component of VBID, some plans are focused on offering palliative care to members as a bridge to hospice services. The member then has hospice services delivered through fee-for-service Medicare and outside of MA. Some of the innovative learnings can come outside of this particular model and be applied to VBID.