

The National Hospice and Palliative Care Organization (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 Hospice Benefit Component of the VBID 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.

Significant Learnings and Key Considerations for CMMI

Mutual respect and collaboration are key across CMMI, MAOs, and hospice providers 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:

- 1. 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.
- 2. There is no data on rates of palliative care use or conversion to hospice.** CMS has offered no visibility into the 1) rates of palliative care use or 2) 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.
- 3. The model has the ability to 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.
- 4. Access to hospice 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.
- 5. 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.

