Hospice and Medicare Advantage: Priorities to Enhance Care for Individuals with Advanced Illness and Preserve the Integrity of the Medicare Hospice Benefit

BACKGROUND

The Hospice Benefit: While Medicare's hospice benefit was created more than 35 years ago, its coverage and payment structure have a striking similarity to innovative models now being tested in the health care system: the benefit package includes a focus on coordination, patient-centered care, payment limits and provider risk. This bundled, end-of-life care benefit pays hospice programs at prospectively-set per-diem rates (one of four levels of care depending on the severity) to arrange, coordinate and manage care for a hospice patient's terminal illness and related conditions. The payment system also imposes two "caps" that limit overall spending. Hospices provide all items and services determined by the interdisciplinary team to be reasonable and necessary to address the physical, medical, psychosocial, emotional and spiritual needs of a hospice patient, and to support family members. Due in large part to its comprehensive and compassionate approach to care, hospice patient and caregiver satisfaction rates are high.

Hospice and Medicare Private Insurance Plans: Since its inception hospice has been excluded ("carved out") from Medicare private insurance plan coverage (currently Medicare Advantage–MA); however, MA enrollees may opt to receive hospice care. For the duration of hospice care, all standard benefits are covered by fee-for-service (FFS) Medicare. The MA plan continues to cover supplemental benefits and Part D, if applicable. Hospice usage and length of stay is generally similar for hospice decedents enrolled in FFS and those in MA.

In recent years the Medicare Payment Advisory Commission (MedPAC) proposed inclusion of hospice as part of the MA benefit package, using the following rationale:

- MedPAC wants to move away from fragmented payment arrangements. A hospice carve-in will give MA plans full financial and care responsibility for patients at the end of life, creating incentives for plans to provide coordinated, efficient care;
- Coverage rules for MA patients that elect hospice are complex and at times confusing; and
- If hospice is carved in to the benefit package, MA plans may be willing to offer additional services to patients who elect hospice – such as concurrent care – that are not available under standard Medicare coverage.

The Centers for Medicare & Medicaid Services (CMS) plans to test inclusion of hospice under MA as part of the Value-Based Insurance Design (VBID) model program for calendar year 2021. CMS indicated, "This change is designed to increase access to hospice services and facilitate better coordination between patients' hospice providers and their other clinicians." Additional details are anticipated in coming months.

ISSUES/CONCERNS

Carving hospice into the MA benefit package would subject hospice care decisions to an additional layer of financial and utilization controls that could fragment the existing hospice benefit and diminish its value. Areas of particular concern include:

- Patient choice of hospice would be limited to the hospices with which the MA plan has a contract, rather than based on a patient's personal preference.
- Admission to care, levels of care, and services could be subject to prior authorization requirements, resulting in service delays.
- MA plans may override the hospice's care decisions, undermining the professional integrity of the hospice medical director and interdisciplinary team.
- The unit of service under the hospice benefit includes the patient, family members, and others who are impacted by the patient's imminent death. This breadth of responsibility is unique to hospice care and may not be fully recognized by MA plans as part of their coverage and payment structure for hospice.
- Most patients receive hospice care at no charge. MA plans may impose out-of-pocket charges that would result in increased costs to patients and their families.

- Hospice eligibility requires that a patient be terminally ill with a prognosis of six months or less. Tensions could arise between the MA plan and a contracted hospice as to whether a patient does or does not meet hospice eligibility.
- Unlike other Medicare benefits, only a hospice patient (or their legal representative) may decide to elect or revoke hospice services. Incentives and limited understanding could lead MA plans to steer patients toward (or away from) election of hospice care or inhibit a patient's right to revoke hospice at will.
- The hospice benefit covers care related to the patient's terminal illness and related conditions. Financial incentives may lead MA plans to shift responsibility for unrelated services to the hospice provider.
- The terms under which MA plans contract with hospices could run counter to payment reform and quality of care goals designed to incentivize delivery of more intensive care when it is most needed.
- The impact of recent policy changes (including expansion of advance care planning coverage and the addition of palliative services as a supplemental MA benefit) on coordination of advanced illness and end-of-life care is not yet known and could be obscured by inclusion of hospice under MA at this time.

Given the profound nature of hospice, any changes that could impact this care – even on a demonstration basis – must be closely considered to ensure that harmful consequences do not result. At this time, however, there are insufficient means for ensuring MA plan accountability for end-of-life care, particularly with regard to:

- **Quality:** MA plans are not subject to quality measures that assess the effectiveness of care coordination or care satisfaction at the end of life, and such measures are not fully developed for application.
- **Utilization:** Encounter data collected by MA plans are insufficient to fully evaluate plan performance and beneficiary outcomes.

RECOMMENDATIONS

Inclusion of hospice as part of the MA benefit package has great potential to disrupt care for terminally ill patients and their families. Further, the lack of appropriate end-of-life quality measures and methods for monitoring care utilization under MA create serious challenges for even testing a hospice/MA carve in at this time. Any concerns with the "fragmentation" of MA plan responsibility identified by policymakers can be addressed with targeted actions rather than wholesale integration of one managed care Medicare benefit into another.

At this time Congress and the Administration should focus efforts on addressing areas that hold the greatest potential for improvement in end-of-life care, including:

- **Creation of a robust set of cross-setting end-of-life care measures** that can be utilized under FFS and MA to assess quality of care, adequacy of care coordination and transitions, and patient/family satisfaction;
- **Education of stakeholders (plans, hospices, and patients) around the interaction of MA and hospice care coverage** to reduce existing confusion and **exploration of potential MA coverage modifications, such as the transfer of non-related care at the end of life to MA plans**, to reduce coverage complexity and increase plan responsibility;
- **CMS testing of a fee-for-service palliative care model for patients with serious illness based** on proposals by the Center to Transform Advanced Care (CTAC) and the American Academy of Hospice and Palliative Care Physicians (AAHPM) to support advanced illness needs and provide a smoother transition to hospice care where appropriate; and
- **Thorough analysis of the impact of developments in end-of-life care and recent changes to the MA benefit package** (including the allowance of palliative care as a MA supplemental benefit) **on utilization of hospice care**.

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