National Alliance for Care at Home

Hospice and Palliative Care in a Value-Based World

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About the National Alliance for Care at Home

The Alliance is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers.

Formed through the joint affiliation of the National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO), the Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, persons with chronic and serious illnesses, as well as dying Americans who depend on those supports.

https://allianceforcareathome.org

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Value-Based Care

What Is Value-Based Care?

- Fee-for-service (FFS) pays providers for each visit, procedure, or service
- Value-based care (VBC) ties payment to quality, outcomes, and total cost of care
- Common VBC tools: shared savings, capitation, bundled payments, quality incentives, and benefit enhancements
- VBC shifts accountability:
    - Did you perform the service? *vs.*
    - Did the patient have a good outcome, in the right setting, at the right cost?

The FFS → VBC Spectrum

- **Traditional Fee-for-Service (FFS):** payment per service, no accountability for cost or outcomes
- **Pay-for-reporting / pay-for-performance:** small bonuses tied to quality reporting/performance
- **Shared savings:** providers share in savings if they spend less than a benchmark
- **Two-sided risk:** Providers share savings and repay losses if they exceed the benchmark
- **Capitation:** Fixed monthly fee to manage the total health needs of a patient population

CMS Innovation Center

- Created by Section 1115A of the Social Security Act under the Affordable Care Act
- Test innovative payment and delivery models that may reduce Medicare/Medicaid spending while preserving or improving quality
- Models that are successful can be expanded in both duration and scope
- CMMI announced three strategic pillars:
    - promote evidence-based prevention
    - Empower people to achieve their health goals
    - Drive choice and competition for people
- Committed to models that include downside financial risk

How an ACO Works

- **Accountable Care Organization (ACO):** group of providers jointly accountable for the cost and quality of care for an attributed population
- **Medicare Shared Savings Program (MSSP):** CMS's permanent, national ACO program
- Approximately 12.6 million traditional Medicare beneficiaries were assigned to 511 ACOs
- Beneficiary attribution is generally claims-based or voluntary alignment, i.e., where they receive most of their primary care
- CMS sets a benchmark, i.e., the expected total cost of care for that population
- If actual spending comes in below the benchmark, the ACO shares in the savings
    - under two-sided risk, repay if spending exceeds the benchmark
- Quality performance affects how much of the savings the ACO keeps
- Most ACOs operate at the TIN level

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Why is this Important?

Where Hospice Has Historically Fit

- The Medicare hospice benefit has operated outside Medicare Advantage (MA) and total-cost-of-care VBC models since its creation in 1982
- The Medicare hospice benefit already includes VBC features
- The MA VBID hospice carve-in was an attempt to integrate hospice into MA
- Roughly three-quarters of MSSP ACOs did not formally contract with any hospice or palliative care physician as of 2014[1]
- That dynamic is changing in value-based care

(1) Driessen J, West T. Recent Evidence on the Inclusion of Hospice and Palliative Care Physicians in Medicare Shared Savings Program Accountable Care Organization Networks. J Palliat Med. 2018 Mar;21(3):373-375

Relevance to Hospice and Palliative Care

- CMS has pushed to move more Medicare beneficiaries in accountable care relationships
- The model onramp is quickly accelerating: more models, longer duration, and broader participation
- Many referral partners are already in these models: e.g., health systems, ACOs, physician groups
- Providers that understand these models early can help shape potential partnerships

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The CMMI Model Landscape

New Model Developments

- CMMI is in the middle of an active model launch cycle
- Mandatory models:
    - **TEAM** (Transforming Episode Accountability Model): began Jan 2026
    - **CJR-X** (Comprehensive Care for Joint Replacement Expanded) Model: proposed start Oct 2027
- CMMI recently announced several new voluntary models
    - **ACCESS** (Advancing Chronic Care with Effective, Scalable Solutions): Beginning July 5, 2026
    - **MAHA ELEVATE** (Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence): Beginning 2026
    - **ASPIRE** (Accelerating State Pediatric Innovation Readiness and Effectiveness) Model: Notice of Funding Opportunity to be released in 2026
    - **LEAD** (Long-term Enhanced ACO Design): Beginning Jan 2027

ACCESS Model Overview

- ACCESS is a 10-year voluntary national demonstration
- Tests an outcome-aligned payment approach for technology-enabled chronic care,
- Four initial clinical tracks: Early Cardio-Kidney-Metabolic, Cardio-Kidney-Metabolic, Musculoskeletal, and Behavioral Health
- First performance period begins July 1, 2026
- Applications were due April 1, 2026 for the initial cohort
- Uses Outcome-Aligned Payments (OAPs), i.e., recurring payments tied to measurable health outcomes
- Medicare FFS Beneficiary enrollment is voluntary and prospective, through alignment or enrollment with an ACCESS participant

ACCESS Model Payment Design

- ACCESS participants bill Medicare using ACCESS-specific G-codes
- No FFS claims for other services during an active care period
- OAPs are paid monthly, with a 50% withhold pending reconciliation after the 12-month care period
- Separate co-management payment to PCPs and referring clinicians
- $15 additional payment for beneficiaries in rural areas aligned to eCKM/CKM tracks (Initial Period)

Annual Payment Allowed Amounts by Track

Clinical Track	Initial Period	Follow-On Period
Early Cardio-Kidney-Matabolic (eCKM)	$360	$180
Cardio-Kidney-Metabolic (CKM)	$420	$210
Musculoskeletal (MSK)	$180	N/A – No Follow-on Period
Behavioral Health (BH)	$180	$90

See Table 1, ACCESS Payment Amounts and Performance Targets

ACCESS Model Implications

- ACCESS participants will likely manage beneficiaries before hospice eligibility
- Opportunity for referral handoff – how will an ACCESS participant identify and refer patients nearing end of life?
- ACCESS organizations may seek palliative care partnerships for serious-illness members not ready for hospice
- Managed care plans have pledged to adopt similar outcome-aligned arrangements
- Beginning 2028, ACCESS OAP expenditures will flow into ACO calculations

MAHA ELEVATE

- Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence
- ~$100 million in 3-year cooperative agreements with up to 30 awards across two cohorts
- Cohort 1 launches fall 2026
    - Applications due May 15, 2026 with a mandatory Letter of Intent by April 10, 2026
- Cohort 2 expected to begin in 2027
- Tests whole-person functional or lifestyle medicine interventions
- All proposals must include a nutrition or physical activity component
- Three awards reserved for dementia interventions
- Broad participant eligibility include any organization that meets the Notice of Funding Opportunity requirements
    - must show a track record of successfully implementing their proposed interventions and generating measurable cost savings
    - capacity to enroll a large participant population using a randomized study design and robust data infrastructure

MAHA ELEVATE Implications

- Provides window into CMMI's prevention-oriented direction under MAHA
- Signals a broader policy shift – prevention and lifestyle management
- May be opportunities to partner with eligible applicants
- Important to pay attention to contract awards – who are the players?
- Lessons learned from MAHA ELEVATE may inform future policy and regulatory refinements

ASPIRE Model

- Accelerating State Pediatric Innovation Readiness and Effectiveness (ASPIRE) model announced March 2026
- Voluntary state-based model up to 10 years
- Targets children/youth up to age 21 on Medicaid/CHIP with, or at risk of, complex medical and/or behavioral health needs
- Up to 5 state Medicaid agencies will receive Cooperative Agreements
- NOFO coming later in 2026
- Builds on lessons from the earlier Integrated Care for Kids (InCK) model
- States partner with MCOs and ACOs that hold accountability for pediatric cost and quality
- Emphasizes care coordination, behavioral health integration, and keeping children in the least restrictive setting

LEAD Model Overview

- Long-term Enhanced ACO Design — the direct successor to ACO REACH
- 10-year voluntary national ACO model running Jan 1 2027 - Dec 31, 2036
- Application portal for 1st cohort opened March 31, 2026 and closes May 17, 2026
- Intended to addresses barriers that have kept providers out of ACOs
- Focused on high-needs patients, including dually eligible, homebound, and home-limited beneficiaries
- Expected to qualify as an Advanced Alternative Payment Model (AAPM)

LEAD Focus on High-Needs Beneficiaries

- ACOs with 40%+ high-needs beneficiaries qualify for lower alignment minimums
- Required care delivery capabilities include:
    - 24-hour, 7-day-a-week access to a healthcare provider with access to a patient's electronic medical record
    - Providers with training in advanced care planning conversations
    - The ability to deliver care in patients' homes
- High Needs beneficiaries must meet standard eligibility plus at least one marker of serious health burden, such as mobility-impairing conditions, signs of frailty, significant chronic or serious illness reflected in a high clinical risk score, multiple unplanned hospitalizations in the past year, or an extended skilled nursing facility stay (45+ days) in the past year[1]
- Once a beneficiary meets one high-needs criterion, they remain high needs for the model duration

(1) For a full list of eligibility criterion, see Section VII.A, LEAD RFA

LEAD Benefit Enhancements

Benefit Enhancements Carried Over from ACO REACH	Brief Description (See additional details in Appendix F of the RFA)
3-Day Skilled Nursing Facility (SNF) Rule Waiver Benefit Enhancement	Waives the 3-day inpatient stay requirement prior to SNF or swing-bed hospital admission
Care Management Home Visits Benefit Enhancement	Allows Care Management Home Visits by auxiliary personnel under general supervision
Post Discharge Home Visits Benefit Enhancement	Allows Post Discharge Home Visits by auxiliary personnel under general supervision
Home Health Homebound Waiver Benefit Enhancement	Allows home health services for beneficiaries with certain clinical risk factors that are not homebound
3-Day Skilled Nursing Facility (SNF) Rule Waiver Benefit Enhancement	Waives the 3-day inpatient stay requirement prior to SNF or swing-bed hospital admission
Nurse Practitioner (NP) and Physician Assistant (PA) Services Benefit Enhancements	Allows NPs and PAs to certify and order six types of care for beneficiaries
Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit Enhancement	Allows beneficiaries who have elected Medicare Hospice Benefit to concurrently receive hospice and curative care
Telehealth Benefit Enhancement	Allows beneficiaries to receive telehealth services from home; covers some asynchronous Telehealth services

See Table 4, LEAD RFA

LEAD Risk, Payment, and Quality Considerations

- Two risk options:
    - Professional (50% shared savings/losses)
    - Global (100% up to corridor limits, with benchmark discount)
- Population-based capitation:
    - Total Care Capitation (Global only)
    - Primary Care Capitation (both tracks)
- First-dollar savings and losses: no minimum savings/loss thresholds to trigger settlement
- Benchmarks set using 3-year historical baseline, NOT rebased over the 10-year performance period
- Seven quality measures, including Days at Home for Patients with Complex, Chronic Conditions

LEAD Capitation Payment

Total Care Capitation Payment

Provider Type	Requirements	Fee Reductions
Participant Providers in Participant TINs	Required to participate in TCC payment mechanism	100%
Preferred Providers	Optional to participate in TCC payment mechanism	1-100%, selected by ACO

Primary Care Capitation

Type	Payment Mechanism Participation Requirements	Claims Reduction Requirements
Primary Care Specialist Participant Providers (Previous ACO REACH Participants)*	Mandatory participation in PCC payment mechanism	100%
Primary Care Specialist Participant Providers	Mandatory participation in PCC payment mechanism	PY2027: 1-100% PY2028: 5-100%
Preferred Providers	Optional participation	

See Tables 14 & 15, LEAD RFA

LEAD Implications

- Multiple ACO REACH participants already operate in Tennessee
- Many hospices participated as preferred providers in REACH
- Opportunities to explore potential partnerships in LEAD

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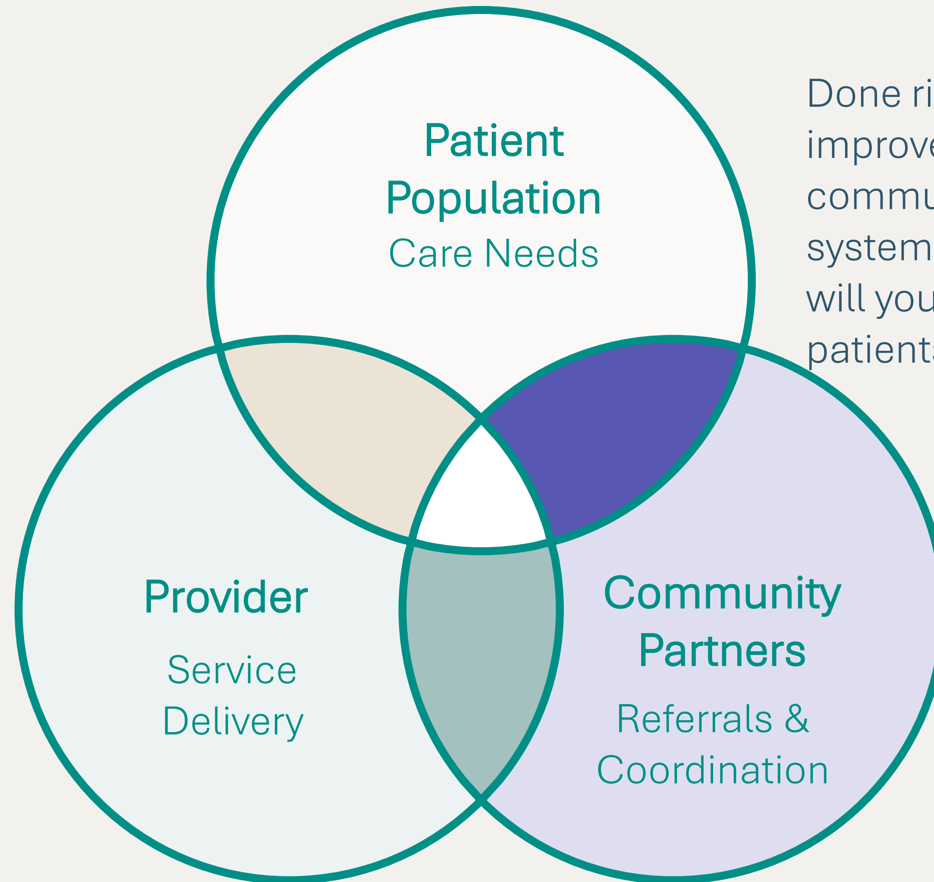
Implications & Opportunities

The Tennessee Landscape

- 50.8% Percent of Medicare Decedents that Use Hospice Services
- 27.4% Percent of Medicare Decedents that use Hospice Services in Rural Areas
- 26.9% Percent of Dual Eligible Decedents that use Hospice Services
- 19 Days Median Hospice Length of Stay across Hospice Stays Completed in a Given Year
- 75 Days Average Hospice Length of Stay across Hospice Stays Completed in a Given Year
- $444M Total Medicare Spending on Hospice Care Across Hospice Stays Completed in a Given Year
- $164.75 Per Day Hospice Spending by Year

Source: KNG Health Consulting, LLC and the Research Institute for Home Care
(Citing and analyzing from 2018-2023 Medicare Claims Data)

Understanding Impact



Done right, value-based care arrangements can improve outcomes for patient populations in our communities and reduce costs in our healthcare system. Who is in your patient population, and who will you be? As VBC models expand, more of your patients may be attributed to an ACO.

What is our VBC story as a provider? Referral partners and payers may increasingly ask about quality metrics. Can we tell our quality story with numbers? What would it take to be a provider that an ACO actively seeks out?

These are the healthcare providers and practitioners who facilitate patient referrals and can help coordinate care, working to ensure patients receive the right care in the right place at the right time.

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Potential Benefits of Value-Based Care Engagement

Market differentiation

ACO engagement can signal quality to referral partners, stakeholders, and the community.

Data access

Enables proactive outreach to your highest-risk patients & informs market strategy and impact.

Early referrals

Structured partnerships can help promote earlier patient referrals.

Diversify revenue

Opportunities for shared savings and distributions.

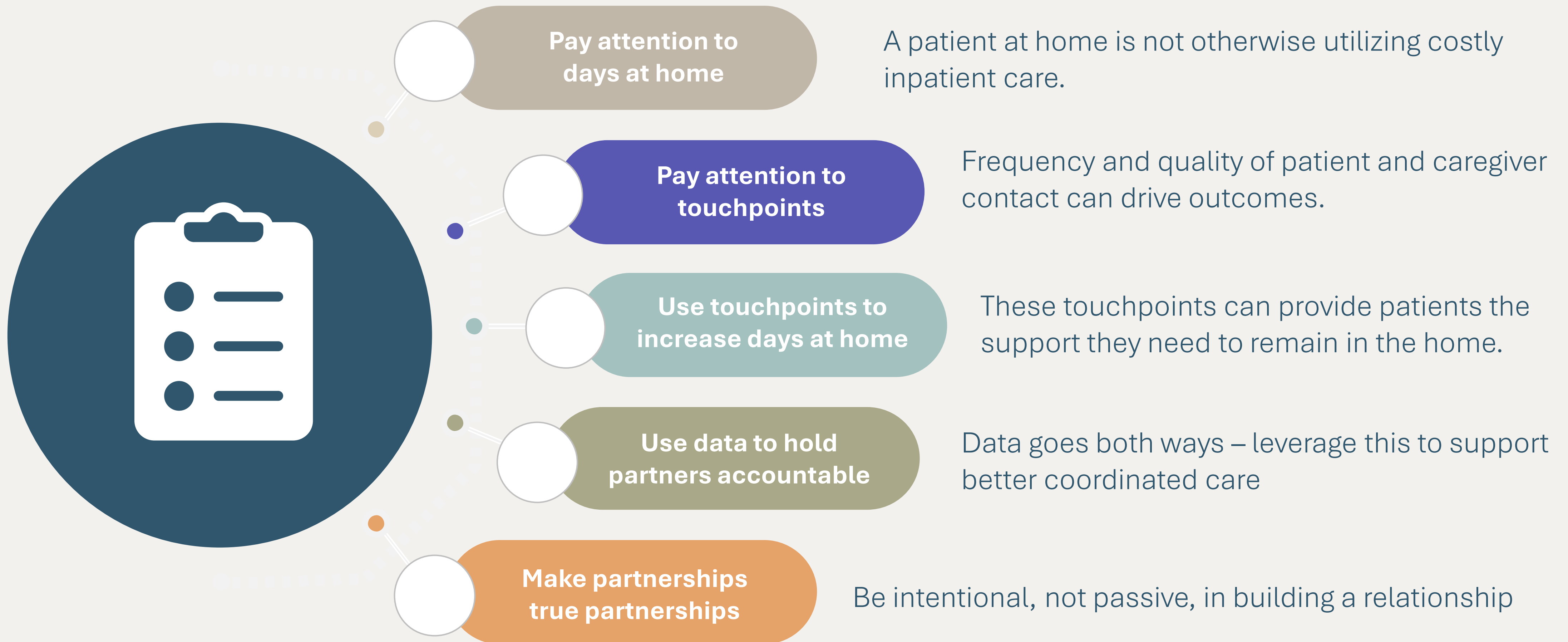
Improved outcomes

Can lead to better care coordination and outcomes for patients, providers, and our health system.

Risks and Pitfalls

- Risk of financial losses in risk sharing arrangements
- Lack of data means rolling the dice
- Referral volume is not guaranteed in preferred provider agreements
- Data sharing complexity
- Administrative burdens and costs

Lessons Learned from a Successful ACO



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Practical Readiness Checklist

- Know your quality profile
- Map the ACOs in your service area
- Know your mission and leverage this in alignment with ACO priorities
- Identify existing data capabilities and where there are gaps
- Assess potential entry points in value-based care

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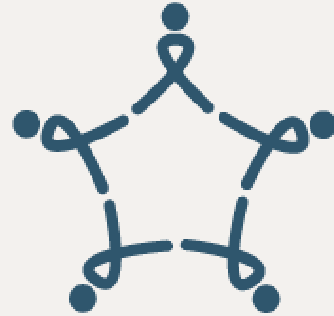
Questions?



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