PROMOTING VALUE IN THE MEDICARE HOSPICE BENEFIT

In Medicare's fee-for-service model, reimbursements incentivize medical interventions, even if treatments offer nominal benefits. This "pathway of least resistance" is detailed by Joan M. Teno and Irene Higginson in the *Health Affairs* article, "Paying For Value: Lessons From The Medicare Hospice Benefit." This way of providing services, they say, overlooks the in-depth conversations needed to formulate and execute personalized plans of care.

However, recent efforts like the Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) aim to use alternative payment systems (APMs) to shift these incentives to focus on value rather than volume. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) has approved two new APMs to help patients pursue both curative and palliative care treatments not allowed under the current Medicare Hospice Benefit. This benefit system, *Health Affairs* points out, was developed in the mid-1970s and warrants review and new strategies to care for the seriously ill.

The first lesson the article draws from considering the Medicare Hospice Benefit is to "Design An Actionable Accountability System With Testing Of A New Payment Model." Today, we see a growing number of people living longer with prolonged periods of functional disability. The payment system we have now was "developed around cancer disease trajectories of the 1980s," the article explains, and so it doesn't fit modern disease trajectories.

Changes to the benefit structure of hospice transform its business model and practices of enrolling patients. Additionally, *Health Affairs* says, a "lack of regulatory oversight and accountability of the Medicare Hospice Benefit played an important role in research findings of striking variation in live discharges, lack of professional hospice visits in the last two days of life, and spending outside of the Medicare Hospice Benefit." Accountability efforts involving public reporting are now underway, but the writers point out this can lead to a "check box" mentality that "stifle critical thinking." This is further complicated by scores that are seemingly quickly "topped out." Considering this, "Further work is needed to provide actionable outcome measures to guide consumer choice of hospice programs and future pay-for-performance models."

Lesson two revolves around "Operationalizing Value And Avoiding Unintended Consequences." Today, U.S. government programs use various models to combine costs and quality. In unconditional models, hospitals may receive additional payment despite poor quality of care. "Considerations must be given to the proposed cut points that are used and how best to apply weights to combine quality measures," the authors argue. "For example, what weight do you assign to an organization's quality measure of hemoglobin A1C levels compared to measures of inadequate communication about the goals of care of seriously ill people? Weighting these quality measures differently may result in unintended consequences, such as a greater focus on hemoglobin A1C levels that could potentially lead to the unintended consequence of neglecting communication with seriously ill people about their goals of care."

The third and final lesson has to do with "Formulating A Denominator That Balances Access, Cost Neutrality, And Allows Easy Case Finding." *Health Affairs* points to a key policy decision in the implementation of the proposed APM that will define who is "seriously ill." This definition will affect who has access to hospice care and the financial impact of the proposed new payment model.

The authors offer this word of caution: "Creating complex eligibility criteria will not solve the [cost savings] problem." Any proposed APM, they say, should have easily applied criteria. It should also, as possible, rely on big data and technology to streamline the process of determining eligibility. Instead of a "one size fits all" solution, they offer a two-tiered payment system—one for active patients and the other for remote monitoring.

The hope is that an effort is put into motion to test a new APM that can demonstrate models that lead to better quality measures. The new model can be "transformative by extending the needed access to palliative services," Teno and Higginson write. But "implementation must achieve the right regulatory balance that ensures a person's care is guided by his or her preferences and goals instead of potential cost savings." From its conception, this new model must "develop an accountability system that is not overly burdensome, while paying heed to the important lessons learned from the Medicare Hospice Benefit." (Health Affairs)