

Transcript: CMS Leader Explains Hospice Fraud, Medicare Risks, and the Future of Healthcare | Part One

Cause And Purpose In Leadership

Melody King 0:00

Everything rises and falls on leadership. The ability to lead well is fueled by living your cause and purpose. This podcast will equip you with the tools to do just that. Live and lead with cause and purpose. And now, author of the book, *The Anatomy of Leadership*, and our host, Chris Comeaux.

Chris Comeaux 0:22

Hello and welcome. I'm so excited today. We have Kim Brandt with us, who's the Chief Operating Officer and Deputy Administrator at CMS. Welcome, Kim. Thanks. I'm excited to be here. Oh, we're so excited to have you. And first off, Kim, before I jump in, I want I'm going to read your bio and introduce you to our listeners. But I just want to say our condolences for our team. I think you your family just lost someone recently who actually got some good hospice care. And um, you've been such a champion for us recently. But then to experience hospice yourself, just please know that our thoughts and hearts are with you.

Kim Brandt 0:54

Thank you so much.

Hospice's Role And The Fraud Crisis

Chris Comeaux 0:56

Well, well, let me introduce you, Kim. So Kim uh previously was a partner at the Washington, D.C. based policy firm, Tarplin Downs and Young, where she provided strategic advice on a broad array of healthcare regulatory enforcement and policy matters. She also served as an advisor to the private equity firm Enhanced Healthcare Partners, private equity firm focused on healthcare, and she held key board positions at two of its portfolio companies. Kim has held multiple senior executive positions in the government, including serving as principal deputy administrator for policy and operations during the first Trump administration. In that role, she oversaw all activities necessary for

the operation and management of CMS's \$1.4 trillion budget. You think you got budget challenges? She had a pretty big one in addition to leading those efforts. Um, in addition to leading those efforts to reform the physician self-referral regulations, and she helped develop the first CMS interoperability rule. Kim previously served as a chief oversight counsel and general counsel on the staff of the U.S. Senate Finance Committee, where she led multiple healthcare investigations, investigation into the IRS political targeting and oversaw the political nominations process as well. Before joining the Finance Committee staff, Kim was a senior counsel at Austin and Byrd in Washington, D.C. And her previous government service includes serving as a CMS director of the Medicare Program Integrity Group and working at the HHS Office of Inspector General as a senior counsel and director of external affairs. Kim has a JD with a concentration in health law and an MA in legislative affairs. So again, we are so honored to have Kim here. He has an amazing amount of influence. And so, Kim, we're just really pleased to talk to you about really where healthcare is going to go from here. In fact, as I was preparing for the show, kudos, because I just saw that you were named ex officio on the healthcare advisory committee that RFK is putting together to discuss the future of healthcare. In fact, if it's okay with you, I'm going to send you a couple of podcasts. Last year, we brought TR Reed, who wrote a book called The Healing of America, and Rita Numeroff, who's actually written several books and writes for Forbes about how to fix healthcare going forward. So we did that. So we're going to send you those podcasts. And so we're super interested in healthcare as a whole because obviously we're passionate about hospice because it plays a key role in the whole continuum of healthcare, because we're at the very end of people's lives, but we reside in this broader ecosystem that is healthcare. So, you know, and you know this because you're going to have a front row seat. You have a front row seat. We're in the middle of an enormous transformation. You got aging demographics, the growth of Medicare advantage, push towards value-based care, and just growing recognition that we need better models to care for people throughout all stages of life, but also during the serious illness stage. And unfortunately, we have a ticking time clock that Medicare potentially may go bankrupt by 2033 if we don't do something. So I imagine at some level you might be pinching yourself, going, Oh my gosh, I'm in an incredible position to actually make a difference in these major challenges. Yeah, I could understand. Heart goes out to you there. So so how is CMS thinking about hospice within the larger healthcare ecosystem? What policy changes might be on the horizon? And maybe third portion of that question, what should leaders across the hospice field be paying attention to?

Kim Brandt 4:34

Well, first, I really do want to stress that we view hospice as a vital tool within the Medicare ecosystem. We want to make sure the hospice services are available to our beneficiaries. And Dr. Oz and the entire senior leadership team is very committed to

ensuring that we're doing what we can to make sure we're providing good, legitimate hospice services and paying for them at the right price. So I just want to set that. That being said, we have had a real challenge, as many of you have seen over the past uh year, certainly that I've been back at CMS and Dr. Oz and I have been focused on this for the better part of let's say nine months out of that, because he started a little after me on this, at looking at the fraudulent hospices that are actually um taking advantage of the system and giving good hospices a bad name. Uh the fact is we really have seen firsthand, thanks to several of your members, we've gone out and visited some hospices. We've been able to see examples of excellent hospice care. Um, as you noted, I unfortunately recently lost my uncle. Um, he was in a relatively good hospice, but even there we had some challenges with, you know, some of the care and ensuring that they were following all the appropriate guidelines and everything. But then there are those that are just completely false. Um they're not providing care at all. In fact, they have live discharge rates um of a hundred percent at six months or more and things like that, which is just a little questionable. Um you just don't see those, you don't see those numbers on a regular basis. And so I think um we're approaching it from a multi-prong approach. The first is we want to ensure that we are ensuring that we're getting the payments right and the services right for those legitimate hospices who are providing service to beneficiaries so they can die with dignity. That's the goal. We want people to be able to have resources, to be able to help their loved ones. My own mother um had hospice at the end of her life a couple of years ago. That was my first experience with it. And we were super grateful to the hospice um that helped us because um we were overwhelmed. She was at the end of her life. It was something none of us are medical professionals, and I was super grateful to have them to help us manage her pain and help answer our questions and serve as a resource. And that's exactly what you want. Um, what you don't want are the hospices that we're seeing, particularly in Los Angeles, California, and um certain other parts of the country where they are allegedly providing services to beneficiaries who are not receiving any types of services. They're taking their name and number and billing for those services, or in some of the more egregious cases that Dr. Oz and I have seen recently on the Medicaid side of the house, they're getting paid \$6,000 a month for people allegedly on hospice and putting them in group homes where they aren't even providing them with good food or good surroundings. They have moldy food, unclean surroundings, and they basically they call them six packs. They put six people to a home in these California suburbs, and they get \$36,000 a month for not providing any services at all, all under the guise of it being hospice services. That's what we want to stop, and that's unacceptable. We don't want that.

Chris Comeaux 7:37

Yeah, I'm Kim. We just had an incredible opportunity actually yesterday before you and I are taping this. Um, University of Virginia, Arlington, the Darden School of Business has

written a case about Telios and talking about how we're trying to help nonprofit hospices. So had these amazing international students from all over the world, super bright. They're kind of bathing themselves in the hospice challenge. Unfortunately, they've also been exposed to some of the horrible fraudulent stuff that's happened on the West Coast. Uh, the John Oliver HBO special, which is a horrible skit, kind of a commentary on some of the worst parts of the for-profit hospice. And one of the kids gave me an analogy I thought was pretty awesome. Apparently, there was a basketball player who was prosecuted for cheating, and they were basically throwing the game, and they were contrasting that against, you know, a basketball player trying to be the best player ever and working out, taking care of themselves, and said, You guys are like that trying to be that greatest basketball player. And then that other stuff is like not even playing the same game. And I thought that's a really good analogy.

Kim Brandt 8:39

It's a great analogy, yeah.

Value-Based Care And The 2033 Clock

Chris Comeaux 8:41

Yeah, so and kudos to you guys because unfortunately, you know the word hospice, and when people hear the word hospice, most people will say afterwards, we wish we'd have chosen you sooner. But when in their throes of a family situation, that human nature of I don't want to give up on that loved one is usually what they're thinking about because hospices become synonymous with death. And then you get this horrible fraud stuff, and it just taints the word. Now, this is where brilliant programs like the ones we've worked with have rebranded themselves as Carolina Caring, Four Seasons, these names that give you a picture of the care, and then people will they choose it hopefully sooner and get the care that they actually need. Well, before we go a little bit further, because I do want to towards the end, I want you to really talk about some of the great stuff you guys are doing to eliminate the fraud. Let's go back a little bit to the broader healthcare stuff. Um, because I just think it's super cool. You're going to be sitting at this table with some brilliant people talking about the future of healthcare. So when you look at over the next decade of this healthcare policy, because we do have this looming challenge in 2033, what do you think are the biggest forces that are shaping the future of healthcare? I alluded to some in the beginning, but I'd love to hear from your perspective.

Kim Brandt 9:54

Sure. So I think, you know, in terms of some of the bigger forces, obviously the mood to a value-based care. I mean, looking at how we're going to shift to value-based care and

how we think about value-based care is huge. I think another thing is how we think about end-of-life care. Um, you know, what you all um do and some of the things we talk about with respect to hospice, home health, et cetera. Um, the majority of the costs for a beneficiary that goes on to Medicare are experienced within their last six months of life. And so how do we think about that? How do we think about those costs? How do we think about shifting those costs to hopefully also helping them live longer, more fulfilling lives so that we can help them manage their conditions? It's one of the reasons one of the things I'm most excited about that we're doing at CMS these days is investing in healthcare, infrastructure, and healthcare tech. Um, how it is that we can build the tools and resources to help people manage their health conditions and really be a partner with us. Not only are we supposed to do the things we're a payer, we need to pay for the care, we need to make sure there's people to provide the care. But at the end of the day, the people that we're providing that for need to be able to know that they're partners with us and trying to manage their care and help us with those costs. Um, as you well know, the healthcare trust fund is on this careening uh road towards insolvency, and we want to try and extend that as long as possible. Part of that is the fraud, waste, and abuse, which I spend a lot of my time on. And as you said, we'll talk more about it. But then the other part is on the payment side. How do we get the dollars right? And how do we ensure that we're getting the best value and the best quality for the beneficiaries? So for me, it's value-based care, it's using technology to be more efficient, and it's us rethinking how we do healthcare to really think about where the incentives and alignments are as a person goes through this whole journey called life.

Chris Comeaux 11:40

Yeah, that's well said, Kim. One of the, again, I'm just because it's so top of mind because having been in this class yesterday, you probably know this, being probably a student of history. Eisenhower said, beware of the military industrial complex of people who will make war because it's profitable. But then people forget the line after that. Easy said, beware of the healthcare industrial complex, the people who are incentivize to do more stuff to you as opposed to make you healthier. And so it does, you know, at least some of the good rhetoric about make America healthy again, the challenge of 2033, it feels like there's a lot of stars aligning here for you guys to think about how do we fix this going forward? And though, by the way, right, we have the largest demographic generation of partakers of healthcare. Some people call it the silver tsunami coming up. And so it probably is the opportunity of a lifetime to fix healthcare. And if we probably don't, I'm not sure it ends so well for our country as far as what the future of healthcare looks like. No pressure.

Kim Brandt 12:41

No pressure at all. But you're right. I mean, you talk about the silver tsunami. I think about this every day. Um, right now, CMS covers 170 million Americans between Medicare, Medicaid, and the marketplace. Every day for Medicare, because of the baby boomer generation, until 2030, we will enroll 10,000 new beneficiaries every day onto the program, which and then at a certain point, 2030, that starts to tail off. But then unfortunately, we don't have enough people paying for all those that have then gone in. So then it's that inverse proposition that we're gonna have to deal with.

Chris Comeaux 13:14

Yeah, that's huge. Well, then the next question, Kim, is like, how do you see hospice fitting into this future? Um, and let me preface it this way there's good MedPack report came out recently. The margins on the for-profit side are 13%, and the nonprofit side is a negative 1.3%. That's a tale of two cities when you look throughout the country. I'm a capitalist by nature, but have grown up in nonprofit hospice. And I do think that as you've got you actually have gone and see for yourself, you know, it is different what a lot of these nonprofit programs are doing. They're doing powdered care, they're doing pediatric programs, their community raises funds. We've done it the right way, even when things don't make financial sense, and the community is invested in the model so we could keep it solvent over the years. And I do think nonprofits have probably saved the government billions of dollars because of, you know, no more futile care, they're going for one more treatment, etc. Because when you get good hospice, you actually get the cost to go down. And the crazy thing is the family is satisfied because it's such a beautiful model of care. So I say all that to ask you like as you think about the future, my concern would be the lines get erased in some kind of way, hospice gets impacted in a in a negative way as we redesign the future.

Kim Brandt 14:32

Yeah, I think it's an interesting question. And to me, uh there's a couple of buckets I would put it in. I mean, I do think that your your point about that line getting blurred a little bit, that line between treatment and comfort care definitely uh will blur. But I'm really hoping that um we'll have a hospice blend more with palliative care earlier, so that you know, we'll start doing hospice, you know, um, months, maybe even a year or so before death, so that you've got people being able to have um people with serious illnesses will get that supportive care much earlier. To your point, people won't associate it with a death sentence. It's more like this is one of the treatments and this is something that can actually be helpful. Um, people have had hospice care and have gone on to actually live beyond that six months or or even 12 months and maybe five, six, seven years. And that's a good thing. Um, you know, and the the fact of the matter is that hospice can be very helpful for that. I also am very optimistic about the growth of home-based care when it comes to hospice. Um, I mentioned, you know, as you indicated at the beginning, I've had

two relatives, uh, my mom and my uncle both who have received hospice, my uncle in a facility, my mom at home. Um, and you know, so very different experiences. But I think, you know, having more, um, now that Congress has extended the hospital at home model for an additional five years, I think looking at hospice, um, you know, a lot of it has already been delivered at home. And I think that trend maybe accelerates even more. I think we're gonna see more home-based care because people overwhelmingly prefer to die at home. Um, when my mom got her terminal diagnosis, the very first thing she said to me was, you will not let me die in a hospital or a nursing home. That was her number one thing. And there was no equivocation about it. She was just very clear that's what she wanted. And I think a lot of people feel that way. So I think you're gonna see more of that. And then I think the other thing um that's kind of a multi-pronged bucket, if you will, is sort of um there's gonna be a lot more technology to help us, you know, more telehealth for faster support, like especially if there's home-based hospice, a lot more remote monitoring for pain and breathing and symptoms to kind of help the family monitor that kind of stuff. And then um, you know, AI helping us with better um care plans and better adjustment of that. And as a result, then hopefully hospice and palliative care, as I mentioned at the beginning, will will merge more over time and they can be, you know, a very helpful thing. But I think using technology, being more home-based and really focusing on that integration of palliative care with hospice care, to me, those are all things that are gonna help shape this going forward.

Chris Comeaux 17:09

Well said. Um, so you've alluded to this earlier, but and I think I've lost sight. Originally, the prior administration was very adamant by 2030, 100% of health care is gonna be in value-based care. I thought I read something, current administration maybe kind of backed off on the 2030. You may fix me on that. But here's really the gist of my question. What role will hospice play in value-based care? Because some people interpret that, well, if we're going in value-based care, then hospice's reimbursement model has got to completely change. In my experience, because I grew up in other parts of healthcare, when you give people upside and downside risk in what they do. So if you've got quantitative results and you're in the top 90 percentile, you could get an add-on to your rate. If you're lower, you get a deduct. That's value-based care. And now we're starting to get quantitative measures through hope. And we've got CAP surveys, but I'm sure you know we've got a problem there. Something like 60% of the hospital, maybe it's not that much, 50% don't participate in CAP surveys. That's crazy because their number of patients served is so low. So hopefully you guys will do something about that. But back to the main question about value-based care.

Kim Brandt 18:19

So um there's a lot to unpack there, but I'll do my best. Um, so anyway, I think value-based care, we have moved away from the 2030. Um, you know, the goal of the last administration was 100% of people and some sort of value-based by 2030. I think our goal is to still try and get as many people into value-based care as possible. But I think particularly when it comes to things like hospice, we're gonna look at value-based models that reward quality, not just enrollment. I think the the focus that this administration has, the last administration had it from an enrollment. Everything was about enrollment with the last administration. Get them on Medicaid, get them on the exchanges, get them enrolled in something. Um, I think we're less focused on enrolling. Um, obviously, you know, we want people to wear appropriate, but we want to make sure that we have value-based models that reward quality. And that includes things like hospice. And I think other things that you'll see in terms of payment and policy changes, at least on the hospice front, are there's gonna be a movement away from this strict six-month prognosis thing. Um, you know, I think, you know, there's just too much focus on that. Well, they didn't die within six months. Well, the fact is treatments are changing and uh, you know, different approaches are changing. So I think there will be um a lot more flexibility in what services hospice can provide. Um, and I think a lot more flexibility in allowing patients to receive hospice support without giving up curative treatment necessarily. Um, again, the the focus had always been, you know, just palliative, just pain management, nothing else. But I think that there's a shift occurring in terms of the growing number of people in the program that the needs have shifted as a result. And so we need to think about that. So I think in general, from a value-based perspective, yes, we're still focused on value, but even one of our um objective key results or OKRs for this past year under Dr. Oz was uh aligning incentives and quality. That was one of our five OKRs was to align incentives and quality. And I think if you look at any one of the numerous models that have been issued by uh the Center for Medicare and Medicaid Innovation over the last few months, that's what they're all focused on. It's not about like having 100% of the people enrolled in them, but it's about trying to make sure that they are aligned in such a way that there can be a good upside and that people know how to get there and that they can make it worthwhile. And I think hospice fits right in with that.

Chris Comeaux 20:35

That's so cool, Kim. Kim, I don't know. And if you need this, you let me know. I have a Tom Hoyer article who before it was ever CMS, it was HICFA.

Kim Brandt 20:44

And he wrote Oh my god, I remember Tom Hoyer from way back in the day. I was a baby baby uh attorney.

Chris Comeaux 20:50

So you're gonna love this article. In the article, Tom they asked him, like, how did the six-month benefit for hospice come to be? And he literally said it was the 12th hour to get the legislative legislation done. And someone said, wait a minute, we can't leave this open. And so they literally pulled six months out of the air. It wasn't evidence-based medicine. That's the act, that's where six months came from.

Kim Brandt 21:12

I would love to see that. I didn't know that history at all, but it is something, you know. I mean, it really is kind of um, I remember there was an OIG report a few years ago when I was working on uh Capitol Hill for Senator Hatch, and it was basically people aren't dying fast enough, you know, because of the six months. And and that's just not even uh at this point, that's not even an issue anymore. I mean, hospice needs to be a part of, but not a niche part of healthcare. And you really need to think about, you know, sort of effect is as you pointed out, the silver tsunami. I mean, there's rising demand for these types of things as the number of people that need them are aging in, and we need to rethink what that looks like. And it also means we don't like to focus on um the the deaf part anymore here at CMS. We're trying to think about how you age with dignity and Then die with dignity. But you want to age with dignity as long as possible before you get to that last part, obviously.

Quality Data HOPE And CAHPS Gaps

Chris Comeaux 22:06

Yeah, you would love this. The very first hospice that I grew up in, I was 25 when I came to work for it. One of their key adages is we add life to days when days can't be added to life. And that always kind of um stuck with me of this work that we do. And as you've you've gone around the country, when great hospice is provided, it changes the decline of the patient and they may stabilize because it's such a beautiful model of healthcare because we're looking at them body, mind, spirit, socioemotional. We do the med, we do get their med straight, and they do stabilize. And then unfortunately, then you have audits saying, Well, bad you, they didn't die on time, but we're providing great care. And and you will see them live longer with good hospice provided, but you know, assuming that the patient was appropriate when they were actually what admitted originally. I have a follow-up question for you, Kim about the hope. Do you um and about value-based care? Do you feel like the hope is a maybe chassis that will help take hospice into value-based care because of some of the maybe quality data that eventually will be coming out of it?

Kim Brandt 23:08

I hope so. But I mean, our hope is always, again, that integration of value and quality and sort of how they come together. The whole reason of being able to do um the measures in general and quality measures in general is to help us be able to learn from them and improve the quality of care overall. Um, one of the things I think CMS has struggled with is we have so much data and so much information. We have not done as strong of a job as we might have or could have in terms of really using that to help people make good care-based, data-driven care-based decisions. And that's something that I'm hoping that this could help us with. And you look and you go and you know, visit like the really I mean, there's so many good hospices, but Dr. Oz and I were at the Nathan Adelson hospice out in Nevada. And it was uh again, uh there's plenty of that I could chat at. That's just one that I visited recently. But we were both just incredibly impressed by the very thoughtful approaches that they were using to care. And um, their medical director, whose name I'm blanking on, talked a lot about how um many of what they do or much of what drives their decision making is data and quality information and things like that. And I we were just very struck by how thoughtful of an approach that was.

Chris Comeaux 24:24

Yeah, that's great. I alluded to this because you did say I threw a lot at you in that last question. I don't want you to miss this part of it. So because um, you know, you probably had a statistics class somewhere in your career. If you don't have a large enough in a number of basically surveys in a survey, people will say it's not statistically relevant. Well, some of these large programs, what they do is they have multiple provider numbers. So the aggregated number might be a thousand patients a day, but the individual provider number levels might be little 30 patient day hospices. So they don't have a large enough in, so they don't have to do a CAP survey, and then they fly under the radar screen. So therefore, about half, I don't know if this is exactly right. I've heard 60% half, um, but it's a large number, don't do patient satisfaction surveys. Oh, wow. Okay. And and and it's like, well, it's a statistics problem, but it seems like that's just wrong because some of these flyby night for profits literally could strategically go, it's great, we don't have to do a survey because that that N is so small. I mean, we're living in the Amazon generation, right? Every one of us purchase Amazon every day and we look at those ratings, and you know, they had a bunch of one and twos. I'm not gonna order that product, but yet well over half of hospitals in America don't have to report that part of the data. That feels like a problem to be fixed. And if a if we could help you with that, um, but that's kind of the gist of as I understand what the problem is.

Kim Brandt 25:50

Right. So I'll definitely that's a good question. Um, I'm not as familiar with that approach. That's getting into a little bit level detail behind the weekend familiar, and I'm just gonna admit that, but I do know that that is something that we have talked about with the

multiple CCNs and trying to go ahead and make sure that we can account for you don't um you know aggregate across the CCNs to your point from a statistical perspective, and that we are trying to make sure that um the cap calculation is real and that it really does get to the individual entities in a meaningful way. But um that's about as deep as I can get on that one. That's good though.

Chris Comeaux 26:25

You're on the breadcrumb trail because there are other ways they use it that I'm sure as you guys unpeel the onion and some of the fraud stuff, you get to see how that And that's how I know just enough to be dangerous is from the fraud piece of it.

What To Watch Next

Kim Brandt 26:35

But it's a great question and something that I'll definitely follow up with my team here as to what the policy folks are feeling in that regard.

Jeff Haffner 26:42

Don't miss part two of this episode coming this Friday.