Transcript: Carve-In or Carve-Out? The Future of Hospice Under Medicare Advantage | Part One

Leadership Framing And Show Promise

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 excited. Our guest today is Robin Heffernan. She is the PhD, co-founder and CEO of Impassion. Robin, it's so good to have you.

Robin Heffernan 0:32
So great to be here, Chris. Thanks to being back.

Chris Comeaux 0:34
Yeah, I was gonna say good to be back, actually. We bumped into the idea of this podcast earlier in February on measures that matter, which I'll talk about in a couple moments. But let me read from your bio just in case there are some hospice and palic care folks who don't know who you are. So Robin is the co-founder and CEO of Impassion. It's a new company focused on giving more good days to patients and families with advanced illness. Robin's a serial entrepreneur and experienced executive and former venture capitalist focused on healthcare and technology. She's worked with some pretty incredible companies. And really interesting, she has a chemical engineering kind of training degree by background. She earned her PhD and her BA at Harvard University. Robin, one thing I love asking our guests, what's your superpower?

Robin Heffernan 1:17
Yeah, well, I you did raise in the background. I'm a chemical engineer. I am, I am true and true an engineer. So I'm a systems person. Love it or hate it in many systems. But I think my superpower is I'm really good at putting pieces together and building systems. I also like puzzling, having to be really good at puzzling, uh, but I think it's along the same vein.

Chris Comeaux 1:41
And then you thought, well, what the hell? The most complicated puzzle on the face of the earth, American healthcare system. Let me go and kind of try try that. Well, well, again,

you were a great guest. We had you, Mindy Stewart Coffee, and Bob Tavares for our top news story of the month for um January, which we aired at the beginning of February. Well, we used to do it at the end of the month. And it was all focused on measures that matter. And in that podcast, we bumped into the car bin. And I said, ooh, that's a whole nother conversation. And right away I followed up afterwards, and you were gracious enough to say, yeah, I'd love to actually do that. So I really want this to be a real conversation. Um, because I have to admit, I'm gonna own it from the get-go. I I come into this skeptical about the carve-in, not because I resist change. In fact, I've had some great debates with Peter Benjamin quite a bit on this podcast. And quite often, Peter will kind of pint a lot of our people on our hospice and powder care field as kind of just resistant to change. I I grew up in corporate America, I'm a CPA. That's kind of not where I'm coming from. So, but I really do worry about the unintended consequences for patients and families. And then based upon my interpretation of some of the findings and researches, uh, research was done around the VBAC carbon demonstration. So just fully owning it from the get-go, but I really am uh just based on some of our conversations, I'm very open-minded and really want to learn from you. So, ready to dig in?

Why Hospice Was Carved Out

Robin Heffernan 3:02
I'm ready to dig in. Yeah. Maybe, maybe we'll sway you a little bit.

Chris Comeaux 3:06
So, what specific problem is the hospice carbon solving that cannot be solved under the current structure where hospice is carved out of Medicare Advantage?

Robin Heffernan 3:16
Yeah. Um, so I think the first thing that was really interesting for me to see not growing up in hospice and coming into the hospital space is we have Medicare Advantage plans responsible for Medicare members from the second they become Medicare eligible all the way until their last most expensive, most vulnerable six months of life. And so again, like I guess from a system standpoint, it didn't really make sense to me, hey, why would I trust a Medicare Advantage plan to be responsible for this patient and their associated family members, caregivers, except for at the time when it probably matters most that we align accountability and responsibility. There weren't a lot of people who used it, there weren't a lot of hospice providers, there were some sort of basic certification licensing requirements that got put in place for hospice. And then it grew and grew and grew and grew. And now, you know, if Medicare Advantage Manage plans, they're enrolling more than half of our Medicare Advantage members. I think it's up to like, you know, 52, 53%.

Some people think this will get as high as 70%. Uh, if that's true, I don't think we can leave one of the most important benefits for a Medicare member outside the scope of those who are actually responsible for them. So I I think the intent uh of a good carbon is to say, look, like you've been treating this patient, you've been managing them for many years at some point. You've been helping them through chronic illness. When this patient gets into serious illness or they get towards end of life, there's no reason they should come off of your books. You should still be responsible for them. You have an established relationship with them. So why can't we create a program where you you truly have responsibility and alignment of a great outcome for that patient all the way through to the end?

Chris Comeaux 5:32
Well, I'll tip my hand early then. So thank you for that answer. That's a really great answer. Um, but before I tip my hand, let me ask a question. I didn't tell you I was gonna ask you this. Do you know the logic behind why a hospice was carved out originally? Do you know the history on that?

Robin Heffernan 5:46
I'd love to hear more from you.

Chris Comeaux 5:48
Oh, actually, I I don't know the history. Do do you know the history? Um, I I didn't tell you I was gonna ask you that. So we both probably could have done some research. But do you know any of the reason why they originally carved it out?

Robin Heffernan 5:58
I I think it was sort of similar vein of why they originally had carved out patients with end stage renal disease.

Chris Comeaux 6:05
Okay. I thought I had heard something similar as well.

Robin Heffernan 6:08
Patient, you know, very complicated. Again, it was small numbers, right? And so small numbers can drastically sway a cost profile for a payer. And so they didn't really know how to price it and the bids, and they didn't feel like it was fair to be responsible for patients, you know, who could they could have a million dollars, two million dollars in claims over a year. And so it got carved out. But but then again, I would say, like, okay, well, over time, end stage renal disease has gotten carved back in.

Chris Comeaux 6:41
So hospice is the only one that's currently still carved out.

Robin Heffernan 6:44
That's that's my understanding, really, is hospice is is the only thing at this point that's carved out. Um, you've got all the primary care services, you've got specialist services, you've got home health services, pharmacy spend, all of that is the responsibility of an MA plan.

The Skeptic Case And Patient Trust

Chris Comeaux 7:01
So totally understand your logic. So here I'm gonna tip my hand early on. Um, you know, hospice is so difficult for people to choose at the right time. Because as human beings, the way I say it is kind of be funny, but it's not. Everybody wants to go to heaven, nobody wants to die. It's that old song. And so it is that huge barrier. And based upon the BBID demonstration, the some of the research kind of proved that out that people felt like I'm overstating this, but like the health insurance company was becoming the death panel, like they didn't trust them to make that referral. And so to me, this and you know, these health insurance companies are spending a lot of money to build a brand for healthy aging because with the baby boomers now, don't blame them. That's exactly the brand I would want to be building. And if you carve hospice in, do they really want us even carved in? Because of based upon some of that early research, I'm not sure that, you know, I trust my insurance company being the one to refer me to a hospice. And so there could be an argument that this is so different as far as the psyche of a human being, um, which we're gonna get to some of the other questions, and also their roadmap in history is typically cost uh avoidance, cost reduction, and will they really have my best interest in mind? And so that's really kind of where my perception comes from that hospice is so different because of the type of care it is. Um, but there's a side to me that, like just this uh weekend, reason why I sound a little tired, my father-in-law had his third stroke, my wife is still there caring for him. So front row seat of how fragmented our healthcare system is and how beautiful hospice people practice and their holistic approach and care coordination approach that you don't quite see kind of further upstream in other places. So you could see where, especially on the powdered care side, and so my opinion is that love having powdered care bridged in with the um different payers, but then keep hospice carved out. So I'm just giving you kind of my two cents early on because you could refute it as we keep going further here. Um, so if we strip it down to first principles,

what is really broken in a hospice today that absolutely requires a carbon and Medicare advantage rather than maybe targeted reform of the existing system?

Accountability For Hospice Quality

Robin Heffernan 9:19
Yeah. So I think you brought up a couple of really good points, right? Which is someone has to care both about the upstream palliative piece, right? And about the high quality hospice experience. It's very hard, frankly, and I think you would agree, it's very hard to do the high quality hospice if you don't have good palliative care because you haven't set someone up for success. And and so we can talk a lot about good upstream palliative care. But I I think what has happened by carving out hospice is because the MA plan doesn't quote unquote care about the high quality hospice experience, people are going to any hospice.

Chris Comeaux 10:03
Right.

Robin Heffernan 10:03
And and and you're sort of perpetuating a bunch of the hospice fraud, and that's what folks are starting to crack down on now. Um and I I think until you actually make them accountable for having a high quality hospice experience, there will just be more fraud because there isn't a lot of oversight on the hospice, networks that get created. I think there's a lot of there's a large gap, sort of, when someone does a referral to hospice of knowing like, is this a good hospice or not? Um, it's not a bad intention. They just don't have enough information. And the MA plans have zero alignment to try to make that better. Um, to your point around like it's a very difficult decision. It's not something you would want to push someone into a hundred percent. This is a question of medical necessity, right? Like, it's not that a payer can just refer someone into hospice, right? Hospice has to be approved by two physicians, it has to be medically necessary, it has to be something that a patient and a family wants to do. And so I I think you can protect this idea of like, I'm just gonna shove someone into this death panel thing. I think you can protect that through a lot of these mechanisms you have around medical necessity and and true need for it. But what is missing if it keeps getting carved out is you don't have enough accountability over a high quality experience. So I guess it's sort of I guess said another way, like if you just reform the hospice benefit, how are you weeding out the bad actors? How are you making sure that more people refer to good actors? How are you gonna like, you know, manage revocations and burdensome transitions when a lot of the

people who probably should care about that and should put energy against it are gonna say, it's not my problem.

Chris Comeaux 12:10
Yeah, that's interesting. So um, you know, there's so many times in our Measures That Matter podcast, because I was obviously interviewing you guys, and I wanted to say, gosh, I got to tell you about TCN. I mean, why we created TCN is to be a high performance network of community-based hospice programs, chassis to high performance, community-based care programs. And we are the first clinically integrated network in the country, true CIN, some people that use that word. We have actually journeyed that and spent a lot of dollars to be a true clinically integrated network. So we are 100% like on the opposite end of that extreme. Um, you know, we've used Dr. Ira Byock's framework. Robin, I don't know if you read his interesting paper, Strategic Framework for a path forward for the field, and he pokes on some of these things. I think it's kind of sad that the Medicare advantage would have to be the one to come in and help us get our stuff cleaned up, which is why I love what Ira is kind of poking on. And he's not playing the for-profit, nonprofit thing. He's just like saying, here's a framework, and we all agree to it. And we're like 100%, we're all over it. So much so we talk about it in our board meetings or even using it to highlight our top news stories of the month podcast. I could understand your perspective from because what you do on a day-to-day basis. Um, I've grown up in this field now 30 years. I did grow up in corporate America, but I came in at 25. And with the other interesting thing, I want to make sure I communicated about the perception of the people that are being referred in the demonstration. We've seen this even with our work with the payers as we're educating them. Hey, we are that network. Like, like Robin, you don't need to look any further. We're we're we're your network, at least for where we cover and where we have network adequacy. But you start to see that that end-of-life mentality is different than aggressive curative care, than the rest of healthcare. So you've even seen how the MA plans and how they refer, and they even like they even talk to us like, how do we talk about this? Like, how do we actually make this referral? It's um, you know, I've spent 30 years of my life. Many of our listeners, this is what we've spent our life is how do you bring this care and you bridge it to the other parts of healthcare to make that good transition? And that's where Palliative Care has just been such a wonderful bridge in many cases. Plus, you're doing great pharmacotherapy, good clinical care, and then that transition of hospice is much better. You just see the just carving it in doesn't solve the problem of how you still talk about it. It's like the whole ethos of a plan of you know, helping someone age well and get the care that they need. Let's fix this problem. It's hard to put into words, but the holistic approach to adding life to days when days can't be added to life, it's a different paradigm. And it's hard to shmush those together, as many healthcare systems have learned. There's not a lot of great world-class hospices or a chassis to our healthcare system. There's a reason for that. Whereas I think they're great,

especially the world that I walk in, nonprofits like the MPHI world, where most of the nonprofits are part of that kind of association, they're just a different kind of um class of hospice. Not disparaging all the others, but then your challenge is, yeah, but I've got to cover the map. I've got to make sure that, you know, we've got good providers in all markets, which again is why we're doing the work that we're doing. I don't know if you want to respond to any of that.

What Broke The VBID Hospice Test

Robin Heffernan 15:30
Yeah, look, I the work you're doing in developing these high-value networks is critical, right? I guess. So so let's take an example. Today, when hospice is not carved in, a Medicare Advantage are what we've seen from Medicare Advantage plans is they like sort of care about palliative, but not as much as they should. If they were financially responsible for a patient through the hospice period, well then I care a lot that when the patient goes to hospice, they actually knew what they were signing up for. It's a high quality hospice, so there isn't a burdensome transition, and they go have an expensive hospital event and they go, Oh, if I do palliative care for six months before handing someone off to hospice, that's a much better experience. The patient goes to the hospital less. Right? And so, and so then, sort of by default, they start caring about I only want to refer someone to a high quality hospice, and I want to do more palliative upstream. All of this is better for the patient. It's better for the family. But but we have seen like they don't switch into this really caring about it mode because they don't have to burden the cost of it right now.

Chris Comeaux 16:56
So you think that we're getting less referrals and a shorter length of stay because that is that part of the outcomes that are are and and then interesting, right? In the demo, the referrals didn't go up and the length of stay actually went down. Um, is and maybe I misread the data, but that was part of what I think I saw in some of the data, which then that's why the well, there's a lot of reasons why the demo um did move forward. Maybe we'll actually have you speak on some of that as we get to the end.

Robin Heffernan 17:22
I I was just gonna say, like, I think very specifically to that, they were not allowed to create a high performing hospice network.

Chris Comeaux 17:30

There was just that.

Robin Heffernan 17:31
There was no teeth in the network, right? And so a patient could go to any hospice and that's it. Right. And I I think that was the single flaw. And and and we have heard from folks, you know, United was a big player in that. That was the single flaw for them. Because if you can't weed out the bad actors in hospice, then none of the journey we just walk through works.

Cost Containment Fears And Math

Chris Comeaux 17:58
Or it makes any sense.

Robin Heffernan 17:59
Yeah.

Chris Comeaux 17:59
Well, so let's get to maybe some of the fears of um myself, some of my peers, leaders. How do you prevent hospice then from just becoming a cost containment lever inside of MA plants?

Robin Heffernan 18:12
Yeah, I think the big piece here is there is an understanding. What you are trading off is, you know, $30,000, $40,000 in hospitalization spent for daily hospice rate. Those two are like not even the same order of magnitude. Right. Um, and so if I end up spaying paying more on a daily rate for a good quality hospice, I will still earn that in spades if I avoided hospitalization and other unnecessary spend. Um, and so I don't see any of the MA plans doing the calculus of, oh my God, the hospice daily rate is too high. Because when you weigh that against, well, if the patient goes to the hospital again, that's another $20,000. And then they've got the downstream sniff stay, and then they've got, you know, the additional home health, and like, again, these are orders of magnitude different couple hundred dollars, tens of thousands of dollars. Um and so I I think if they again they get responsible, if they have financial responsibility for the whole hospice period, I will just inherently care a lot more about reducing hospitalizations than like, am I paying some small incremental amount for the daily hospice fee? We could debate and and you would probably agree with me, like I would probably restructure the way hospices are paid. Right? You could do it more on a capitated basis than on like daily fee for service. But

even in that scenario, like the math is small money to save large money. Got it. And I think they would do that every day.

Chris Comeaux 20:00
So this is where, again, I I hear you. Um, and you would appreciate this quote as an engineer, because I did grow up in manufacturing too. Every system is perfectly designed to produce the results it produces. It's kind of a tongue-in-cheek way, right? Because you live that as an engineer to go, well, why is that outcome so screwed up? Well, it's the way the actual process is designed, maybe intentionally or not so intentionally. So when we get into conversations with Medicare Advantage today, because those negotiations with hospitals, who are typically 200% to 400% of Medicare rates, automatically the conversation is, well, we need to, we're gonna start with negative 25% compared to Medicare. What? We we save you money and we're going to accept a 25%. So I'd love to have you respond to that. And it's it's not, and we make that same case, but you feel like you're talking to a wall because they just have that ethos is so embedded in their systems that, you know, because they're having to hammer so many other healthcare providers because they're so much higher than that Medicare baseline.

Robin Heffernan 21:01
Yeah. I mean, look, I I look at primary care, right? Like there was a world before there were Chen Meds and Oak Street and other risk-bearing primary care entities, and payers paid for primary care fee for service. And then along came these risk-bearing primary care entities, and they said, you pay 3% right now for primary care. We want a lot more than 3% because we're gonna save a bunch of unnecessary spend, hospitalization, snipstays, whatever. Right? And and that worked. And if you look now at the spend of patients who go through any of these risk bearing primary care entities, again, like Oak Street, Main Street, Agilon, all the ACO reach programs, they spend seven to eight percent on primary care. Primary care makes more in these models. Because they are on the hook for the total cost of care and they meaningfully bring down hospitalizations.

Home Health Bundles And Tango Example

Chris Comeaux 22:07
Gotcha. So let me reinterpret for my um peers out there. So what you're saying is, hey, if we keep just hammering that per diem today, you just change the conversation. You go for let's say, like more of like a PM, PM per member per moth, maybe type rate with some upside-downside risk, you could end up better than you are today just trying to fight for,

well, no, don't take away 25% of my per diem. Is that a fair interpretation of what you just said?

Robin Heffernan 22:33
100%, right? And and I would say like this is happening to a small extent in home health, right? If you look at Tango as an example. So home health providers.

Chris Comeaux 22:44
Can you speak on that? Because I don't know a lot of people that do know about Tango.

Robin Heffernan 22:48
Yeah. So Tango is sort of an aggregator middle layer MSO for home health. So they go to a payer and they say, I don't, I don't want you to keep paying home health just on your normal, you know, visit research, fee for service type deal. I want to take a 90, 60 day bundle for a patient after they have an acute event. I'm gonna manage the home health network. You're gonna pay me on this capitated basis. They pay home health more than home health would make, fee for service. And they're able to generate profit margin and bonus for themselves as this MSO layer. It's another example where, you know, there are a lot of home health players who are just operating fee for service and their their margins and their rates get cut every year.

Chris Comeaux 23:44
Yeah. Right? Like it's even worse, right? It's on a per visit basis, which is even a fraction of how they get paid.

Robin Heffernan 23:51
Yes. Um, and and you know, the payers think about that as a commodity service.

Chris Comeaux 23:55
Yeah.

Robin Heffernan 23:56
Right. Um, and so what have some of them done? They've migrated, and there's other players besides Tango, but they've migrated to these other places where they can be in more of a value bundle and then they make more. And and what does it squeeze? It squeezes out the bad home health providers. Right. And I and I think we would see the same in hospice. It would squeeze out the bad actors, but it would allow the really good performers, I think, to make more and deliver great outcomes.

Chris Comeaux 24:28

So another question. So the interdisciplinary team model. So that holistic approach is built around time-intensive keyword on time, psychosocial, spiritual care. So, in a risk-based environment, what prevents the plans from pressuring providers to, yeah, you don't need that woo-woo stuff. That's actually what I've heard. You don't need that woo-woo stuff. You know, you've seen it in hospitals, right? You don't see many social workers and chaplains like you used to, maybe a part of the discharge planning department. I wouldn't even say they had really a holistic model like us, but it does seem like in some areas, as those cost pressures have come and and then that reimbursement shrinks, that's I think that's a concern of a lot of my peers.

Robin Heffernan 25:09

Yeah, yeah. I mean, I I think again, uh, you don't want the payer trying to micromanage what services are being delivered. Right. And so what happened in these other specialties is the contract was great, you know, you have such and such medical expense. I'm gonna guarantee you to be a little bit better than that. You're gonna give me this lump sum payment and I'm gonna manage it. Um, and and by doing that, then you're allowed to flow down to the providers, I can pay for a social worker, I can pay for a chaplain, you know, I can pay for community health aid. Whereas fee for service, you know, these folks are not even able to drop a claim. And from the payer standpoint, they go, I negotiated my margin up front, and then it's your job. You figure it out.

Chris Comeaux 26:06

You manage the care. Um, do you also see maybe there might be some uh incentives or risks that might narrow eligibility and then shorten length of stay, which I think, you know, national median 14, 15 days average of 75. And then you really got to kind of look between for-profit, nonprofit providers, because in that average, you've got for-profit providers with long length of stay patients. So I think that's a concern amongst our peers, is that again, from that reimbursement mechanism, cost containment, we're gonna get it more, even more brink of death care, and then you're just gonna throw them over the fence in the 12 hour.

Robin Heffernan 26:44

Yeah, again, for me, like the switch is fee for service to total cost of care. If I want to manage total cost of care spend, I'm inherently incentivized to not have the short days and not have the really long days, right? And and I think for fee for service, like that's where you see the hospice caps come in. And there already is some rate compression in fee for service, right? To to try to not have those things. Um but if you're trying to manage someone's total spend, everyone knows if I get you too late, I'm not impacting your total

spend. If I get you too early, I'm not impacting your total spend, right? Um, and and so the problem is that the parties involved are not financially aligned.

AI Tools For Earlier Palliative Care

Chris Comeaux 27:35
Gotcha. Do you think we're headed to a future? I didn't tell you I was gonna ask you this, but um, how our podcast with Bob came to be is Bob and I had this long lunch at we were both presenting at a New York conference, and I was telling Baba some of these um I'll just call it for today, predictive analytics companies that are saying with high level of certainty that they can flag that patient as being certainly hospice eligible, and then the holy grail they were going for was actually powered care eligible. Do you think we're headed to a future via AI tools that that's gonna be not only feasible, but definitely part of the game that that flags the patient? So that maybe way we could kind of uh mitigate that risk of getting them too late, that there might be some tools that really kind of help guide people that are in the process, if you will.

Robin Heffernan 28:24
I think two things will happen that are along those lines. Uh I think there'll be better predictive tools to pick out a patient at the right period of time. I also think the cost of serving patients who are relatively stable, right? But like they're seriously ill, but they're not 12 months to death. They're they're 24 months to death, right? And so what do you want with those patients? You want to start having the conversations, you want to start engaging them, but you can't be sending the palliative care provider into their house four times a month, right? Because that will sort of never work on the program economics. And so I think there may be some interesting advancements in these AI chatbots, you know, whether it's text or or phone, right, that sort of bring the cost of managing that relatively stable patient very low. And you say, great, I want to open the funnel of patients I would target for palliative care. Because now the cost to serve them is much lower. And by the way, if I'm constantly interacting with you, I know when you deteriorate and you and now like you need more intensive in-home palliative care. I'm not looking at a claims file trying to figure that out. Like I know you, I know your family, I can get involved quickly. Um, and so I do think the analytics will get better, but I I think the funnel will get larger. I think you will target more than like right now, most people target about 4% of a population because the death rate is about 4%. Um, and the models are okay, but they're not great, right? I best we've seen is 65% of the patients you think are gonna die actually die.

Chris Comeaux 30:10

Yeah.

Robin Heffernan 30:11

Someone could debate if if that's really good or not that good, right? But but I I think that because the cost of care will come down, you'll say, oh, like maybe I should go look at 8% of the patients, and I should start having these difficult conversations earlier, not later. Um, and then I can do a better job escalating when the time is right.

Jeff Haffner 30:32

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