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INSPIRED HEALTH SOLUTIONS

Value-Based Insurance Design (V-BID) Model Incorporation of the Medicare Hospice Benefit into Medicare Advantage

CY2021 Request for Application (RFA) Summary

Background and Overview

The Center for Medicare and Medicaid Innovation (CMMI) released the RFA for the carve-in of the Medicare hospice benefit (MHB) into Medicare Advantage (MA) on Thursday, December 19, 2020. As previously described by CMMI, the purpose of this carve-in is to test "the impact on payment and service delivery of incorporating the Medicare Part A hospice benefit with the goal of creating a seamless care continuum in the MA program for Part A and Part B services." As outlined in the model timeline below, **interested Medicare Advantage Organizations (MAOs) plans must submit their application to participate in this portion of the V-BID model by 11:59PM EST on Monday March 16, 2020.** January 1, 2021 will be the beginning of the first performance period and portion of the demonstration testing the carve-in will last through 2024.

CMMI indicates there are six main components of the carve-in demonstration:

1. Participating MAOs must provide the full scope of hospice benefits as currently defined in the Social Security Act (SSA), including requirements for beneficiaries to meet the definition of "terminally ill," to provide beneficiaries with the four levels of hospice care as currently defined in regulation (subject to future revisions), and for the choice to elect or revoke hospice to remain solely with the beneficiary;
2. Participating MAOs must have a strategy around access and delivery of palliative care services for beneficiaries who are not eligible for or have chosen not to receive hospice services;
3. As part of the care transition process, participating MAOs must work with in-network hospice and non-hospice providers to provide transitional concurrent care to address any patient needs related to a terminal condition;
4. CMMI will monitor the performance of individual participating MAOs and aggregate performance of MAOs across the Model, based on the following quality domains: (i) Palliative Care and Goals of Care Experience; (ii) Enrollee Experience and Care Coordination at End of Life; and (iii) Hospice Care Quality and Utilization.
5. For CY 2021, all participating plans must cover hospice services furnished by both in-network and out-of-network providers, with out-of-network providers to be paid at a rate equal to the fee-for-service (FFS) payment for hospice services;
6. Participating plans will be paid a monthly hospice capitation payment for each month that a beneficiary elects hospice. The rate is based on both related and unrelated costs paid by the FFS payment system for all beneficiaries who elect hospice.

Model Timeline

Date	Milestone
December 19, 2019	VBID Model – Hospice Component-Request for Application and Application released
December 19, 2019 – March 16, 2020	CMS provides feedback and technical assistance to MAOs applying for the hospice component
Mid-February 2020	CMS, in conjunction with the Office of the Actuary releases additional information about the hospice capitation rate methodology
March 16, 2020	Completed Application due to CMS by 11:59pm EST
April 2020	Office of the Actuary releases Hospice Wage Index Area (CBSA) payment rates and CMS completes review of applications and provides feedback to MAOs for inclusion in their CY 2021 plan benefit package
June 1, 2020	CY 2021 MA and Part D Bid submission deadline
September 2020	Contract addenda for model participation executed
October 2020	Initial hospice provider directory available, including in-network providers, as well as communication of benefits under the Evidence of Coverage.
January 1, 2021	CMS begins test of incorporation of the Medicare Hospice Benefit into Medicare Advantage; CY 2021 performance period of the VBID Model begins

Hospice Benefit Incorporation

CMMI divides its approach to incorporating and expanding upon the MHB into MA through seven model design parameters:

1) Maintaining the Medicare Hospice Benefit
2) Palliative Care
3) Transitional Concurrent Care
4) Hospice Supplemental Benefits
5) Care Transparency for Beneficiaries, Families, and Caregivers
6) Ensuring Beneficiary Access to a Network of High-Quality Hospice Providers
7) Model Payments

Maintaining the Medicare Hospice Benefit

CMMI indicates that it will not permit MAOs to "unbundle" the collection of benefits that a hospice provider must provide under Medicare Part A, including the use of an interdisciplinary team (IDT) and the four levels of hospice care (i.e. (i) routine home care (RHC); (ii) continuous home care (CHC); (iii) general inpatient care (GIP); and (iv) inpatient respite care). Additionally, only a hospice provider may furnish these hospice services and participating MAOs cannot design alternative ways of providing these hospice services to enrollees who elect hospice. MAOs must have written agreements with all in-network hospice providers.

Palliative Care

In their applications, MAOs must propose their approach for providing access to timely and appropriate palliative care services for their enrollees. Specifically, participating MAOs must include:

- how palliative care resources will be targeted to any appropriate sub-population(s);
- how care will be coordinated for enrollees, including how providers will develop an individualized plan of care inclusive of all relevant services and providers;
- how continuing care will be provided to enrollees to meet their needs as their illness advances and as enrollees' needs change based on participating MAOs' providers' continuing care assessments;
- how advance care planning will be offered through the WHP requirement of the Model;
- how medical, counseling, and social services will be made available as clinically necessary and appropriate; and
- how a seamless transition from palliative care to hospice services will be provided for beneficiaries who wish to elect hospice.

The availability of these palliative care services must be clearly described in the application. Participating MAOs must project associated medical service utilization related to its program in its Parts A and B bid. CMMI notes that it does not expect participating MAOs to factor in a net increase in the A/B bid, given the nature of the services offered.

Transitional Concurrent Care

CMMI notes that only approximately half of all Medicare beneficiaries elect the MHB because, in part, beneficiaries must waive Medicare coverage for services that are considered curative in favor of receiving services that are more palliative in nature. Subsequently, CMMI requires all participating MAOs to work with their network of hospice providers, as well as non-hospice providers, to define and provide a set of concurrent care services. They must be related to a hospice enrollee's terminal condition and related conditions, appropriate to provide on a transitional basis, aligned with an enrollee's wishes, and provided by a non-hospice provider. [1]

The demonstration also permits MAOs and hospice organizations to work together to arrange for the provision of concurrent services provided on a transitional basis by an in-network hospice provider, if those services are within the hospice's clinical scope. This includes services that would not be provided by the hospice under current regulation because they could be viewed as mainly curative in nature.

MAOs must include provisions for hospice providers to work in conjunction with non-hospice providers to develop a plan of care that clearly identifies the concurrent care services the enrollee will receive as the enrollee transitions into hospice, and the specific services and items or services that are being foregone (if any). The plan of care should clearly specify how the hospice will ensure coordination among all hospice and non-hospice providers.

MAOs must limit the availability of concurrent care services to MA enrollees who elect an in-network hospice provider as their designated hospice "given the importance of care and financial coordination between the participating MAO, hospice providers, and potentially non-hospice providers in the provision of concurrent care."

[1] CMMI provides an example of transitioning or phasing out of treatments such as chemotherapy services, blood transfusions, or dialysis that may permit an enrollee to conclude or phase out over time a course of therapy while concurrently receiving hospice care and services.

Hospice Supplemental Benefits in the V-BID Model

Participating MAOs may offer a specific set of mandatory supplemental benefits for enrollees that elect hospice beyond the mandatory supplemental benefits offered to all enrollees in the MA plan. CMMI will allow participating MAOs to identify additional items and services that extend beyond the MHB, as well as set a specific dollar amount for the aggregate coverage of the set of items and services that may be provided to enrollees receiving hospice care. MAOs must clearly identify the items and services restricted to hospice enrollees, as well as any use of care managers or other approaches based on objective standards that allow for the provision of these supplemental benefits for enrollees that have elected hospice.

Some examples of these supplemental benefits include:

- Coverage of primarily health-related services and items such as adult day care services, home and bathroom safety devices and modifications, support for caregivers of enrollees, over-the-counter (OTC) benefits, care services, meals, transportation, and other items.
- Coverage of non-primarily health related services and items to address social determinants of health that have a reasonable expectation to maintain or slow the progressive decline of the health or overall function of an enrollee, based solely on socioeconomic status. This could include meals (beyond the current allowable limits), utilities, legal aid (e.g., to obtain or maintain shelter), personal care items, linens, clothing, pest control, service animal expenses, and other items.
- Coverage of non-primarily health related benefits of room and board within a hospice residential facility or equivalent residential facility may be included for enrollees that need custodial care (e.g., no caregiver at home or without safe discharge location) and do not have access to those services through their Medicare benefit or any other benefit.

Care Transparency for Beneficiaries, Families, and Caregivers

CMMI will monitor the impact of the Model on the following quality domains: (i) Palliative Care and Goals of Care Experience; (ii) Enrollee Experience and Care Coordination at End of Life; and (iii) Hospice Care Quality and Utilization. CMMI may monitor for additional impacts on quality, beneficiary safety, and potential discrimination beyond the domains described below. The full list of utilization and quality measures can be found on pages 19 through 21 of the RFA.

Beginning in CY 2023, CMMI anticipates making a quality payment adjustment for MAOs that participate in the carve-in for both CY 2021 and CY 2022 based on performance relative to a quality benchmark of selected measures. CMMI anticipates the following measures, at a minimum, would be utilized in a quality benchmark:

- Proportion of Enrollees Admitted to Hospice for Less than 7 Days;
- Rate of Lengths of Stay beyond 180 Days; and
- Transitions from Hospice Care, Followed by Death or Acute Care.

Ensuring Beneficiary Access to a Network of High-Quality Hospice Providers

CMMI will use a three-phase approach to gradually implement a series of network adequacy requirements for participating MAOs "because hospice providers are largely a new provider type for MAO networks."

- **Phase 1**: For CY 2021 and CY 2022, to meet network adequacy requirements for hospice providers, a first year participating MAO must offer access to in-network hospice providers as well as out-of-network hospice providers except those not allowed by the MAO due to posing risk of harm to enrollees as described below.
    - CMMI encourages MAOs to implement a voluntary consultation process aimed at engaging enrollees in understanding their care choices and both in-network and out-of-network hospice provider options prior to their accessing an out-of-network hospice. If chosen, this experience must take the form of a high-touch care manager available 24/7 by phone and other means to all enrollees and serviced in a way that is clear, immediately available, culturally competent, and knowledgeable about the hospice benefit and choices.
- **Phase 2**: For CY 2022, MAOs that participated in CY 2021 may implement a formal version of the consultation program beginning on January 1, 2022. An MAO utilizing a formal consultation program could require an enrollee to have a consult prior to accessing an out-of-network hospice provider. Participating MAOs would still be required to provide access to covered hospice services through either in-network or out-of-network hospice providers, but the MAO can require that the enrollee connect with the MAO prior to utilizing an out-of-network provider; they may not require written confirmation or supporting documentation from the enrollee or his/her representative as a precondition for seeking care from an out-of-network hospice provider.
- **Phase 3**: For CY 2023 and on, CMMI will allow participating MAOs to use a more traditional MA program network approach. While HMOs may choose to offer a hospice-specific point of service benefit for enrollees to still have access to out-of-network providers, CMMI will require participating MAOs to meet model-specific network adequacy requirements, whereby there must be at least one Medicare-certified hospice that will provide access to beneficiaries across the entire county of application and provide the full range of covered services.

Network Provider Limitations to Ensure Beneficiary Safety

Participating MAOs may propose to exclude hospice providers that meet any one or more of the following criteria, based on the past three years in which data are available, if the hospice provider:

- was found through publicly available data or sources to pose a risk for beneficiary harm;
- consistently has not offered all four levels of hospice care, infrequently provided physician services, or rarely provided care on weekends;
- does not respond to the MAOs' credentialing attempts that the hospice provider does or does not meet the above network exclusion criteria.

General Payment Requirements

Participating MAOs cannot require prior authorization or implement other utilization management protocols that create inappropriate barriers to medically necessary and time-sensitive hospice care for the following:

- hospice election,
- authorizations for levels of care, and
- changes between levels of hospice care.

However, subject to CMMI approval, participating MAOs may implement program integrity safeguards such as prepayment review policies (e.g. a prepayment review strategy to ensure that their out-of-network hospice providers are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D).

Model Payments

CMMI divides MAO payments into two portions:

- The basic benefit capitation rate ("A/B capitation rate") paid consistent with current law for the month an enrollee elects hospice; and
    - The basic benefit capitation rate will not be paid for the month following an enrollee's hospice election if, as of the first of that month, the enrollee still has elected hospice;
- For all calendar months that a beneficiary elects hospice, including the initial month, the MAO will receive the following:
    - a monthly hospice capitation rate for all months that a beneficiary elects hospice, including the initial month;
    - the beneficiary rebate amount (supplemental benefit rebate); and
    - the monthly prescription drug payment under Part D (if any).

The A/B capitation rate will only be paid in Month 1, where Month 1 reflects the month that an enrollee elects hospice. The A/B capitation rate will not be paid effective from the first day of the month after the first month that the beneficiary elected to receive hospice care, until the first day of the month after the month when the election is terminated.

Hospice Capitation Rate Payment

CMMI indicates their Office of the Actuary is developing a national monthly hospice capitation rate. CMMI will release additional information about the hospice capitation rate methodology in February, following the release of the Advance Notice of Methodological Changes for CY 2021 for MA Capitation Rates. This rate will reflect FFS paid hospice experience for care both related and unrelated to the terminal condition and related conditions for all Medicare beneficiaries (both enrolled in Original Medicare and MA) who elected hospice, utilizing CMMI data from 2016 through 2018 for CY 2021 rate-setting. The rate will be adjusted for each Hospice Wage Index area (CBSA) by a hospice-specific average geographic. Risk adjustment will not be applied to the monthly hospice capitation rate.

The hospice capitation rate paid for the first month will vary based on the number of days of hospice benefit occurring in the first calendar month of a hospice episode.

- A participating MAO will receive a lower first month rate for any episode of care that has fewer than a specified number of days in the first month (e.g., less than 15 days) and a higher rate for any episode that has that number of days or more in the first calendar month.
- For future months, MAOs will receive a flat hospice capitation rate, the beneficiary rebate amount, and the monthly prescription drug payment, if applicable, for an enrollee that continues hospice. CMMI details specific payment criteria in the case of benefit revocation.[2]

Plan Eligibility Requirements

The following MA only and Medicare Advantage-Prescription Drug (MA-PD) plan offerings are eligible to apply:

- Coordinated Care Plans
    - Health Maintenance Organizations (HMOs), including those with a Point of Service (POS) option
    - Local and Regional Preferred Provider Organizations (PPOs)
- All Special Needs Plans
    - Chronic Condition Special Needs Plans (C-SNPs)
    - Dual Eligible Special Needs Plans (D-SNPs)
    - Institutional Special Needs Plans (I-SNPs)

The following types of Medicare health plan are **not** eligible to participate in the VBID Model:

- Private Fee-for-Service Plans (PFFS)
- Employer Group Waiver Plans (EGWP)
- Medicare-Medicaid Plans or other demonstration plan (MMP)
- Medicare Advantage Medical Savings Account Plans (MSA)
- Cost Plans (CP)
- PACE organizations (PACE)

At least one of the MAO's MA plans/PBPs included in the Model must have been offered in at least three annual coordinated election (open enrollment) periods prior to the open enrollment period for CY 2021 (i.e., open enrollment for 2018, 2019 and 2020).

Additionally, the MA organization must

- Not be under sanction by CMS under any contracting;

[2] If an enrollee revokes his or her hospice benefit, and that revocation is still in effect as of the first of the following month, the MAO will receive the A/B capitation rate and beneficiary rebate (and the monthly prescription drug payment, if applicable) beginning the month following the revocation. For operational purposes, if an enrollee who is in hospice as of the first of the month revokes his or her hospice benefit after the first of a month, but re-elects hospice prior to the first of the following month, the MAO will receive the hospice capitation rate, the beneficiary rebate, and the monthly prescription drug payment, if applicable. If an enrollee elects hospice after the first of a month, revokes, and then re-elects hospice after the first of a new month, CMMI will treat both months at a first month rate and pay based on the number of days as described above, in addition to all current payments (the A/B capitation rate, the beneficiary rebate, and the monthly prescription drug payment, if applicable).

- Have at least a three-star overall quality rating for the plan benefit package (PBP) contract for the most recent year.
    - PBPs that are not rated, due to newness or low enrollment, may participate in the Model if other contracts from the same parent organization meet these requirements or the MAO requests, and CMMI grants, an exception.
- The PBP does not have a "consistently low performing" icon on the Medicare Plan Finder.
- The MA organization that offers the plan is not an outlier in CMS's Past Performance Review

Marketing and Enrollee Communications

Participating MAOs must use the language within the Evidence of Coverage (EOC) for the VBID Model hospice benefit component made available by CMMI that indicates that the benefit is covered by the MAO, not Original Medicare.

MAOs participating in the Model and offering the Medicare hospice benefit must provide beneficiaries with a list of in-network hospice providers through their plan website as well as information and instructions for how to access network providers in the EOC. As part of this communication for CY 2021, MAOs must inform enrollees they may seek hospice services from out-of-network providers with the current cost-sharing structure of FFS Medicare.

MAOs participating in the Model must create communication and marketing strategies that ensure enrollees are engaged and informed. CMMI will provide guidance on Model communications and marketing; all communications and marketing materials must comply with the prevailing requirements for MA and MA-PD plans

Model Monitoring, Data Collection, and Evaluation

At a minimum, participating MAOs should expect to provide a mix of beneficiary-level information and summary data, including:

- summary of total number of enrollees engaged in receiving palliative care services;
- hospice election date(s);
- principal diagnosis(es);
- accounting of the total number of enrollees that received concurrent care services;
- the types and length of concurrent care services received;
- level of care by hospice days;
- types of unrelated care provided (if any);
- unrelated spending for beneficiaries;
- date of death (or date of hospice revocation date(s) and reason(s) as applicable);
- percentage of enrollees that elect hospice; and
- additional data as necessary to fully support the implementation and monitoring of the Model.

CMMI will use a contractor to regularly monitor and review compliance with the terms of the Model test.

In addition to timely submission of required data and reports, all model participants will be required to cooperate with models evaluation efforts. For the full list of specific research questions related to the evaluation, please see pages 35 and 36 of the RFA.