WHITE PAPER

HOSPICE VBID – PART 1
NEW OPTION FOR MEDICARE ADVANTAGE PLANS IN CY2021

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Introduction

This paper is the first in a series intended to provide an overview of the impact to Medicare Advantage Organizations (MAOs) of upcoming changes to the way hospice benefits are provided. For calendar year 2021 (CY2021), MAOs may offer the hospice benefit to their beneficiaries by electing to participate in the Value Based Insurance Design (VBID) model option. The change from a fee-for-service (FFS) benefit supported by CMS to a Medicare Advantage covered benefit has implications that will be discussed throughout this series.

Hospice is a program of care and support for terminally ill patients and their families. A terminally ill patient is defined as having a life expectancy of six months or less, if the illness runs its normal course, as determined and certified by the patient's regular doctor (if any) and a hospice physician. The focus of hospice care is on palliative care (comfort), not on curing the illness. Specially trained professionals and caregivers form a team and prepare a plan to provide complete care for the patient, including addressing physical, emotional, social, and spiritual needs. The hospice benefit typically provides physical care, counseling, drugs, medical equipment, and supplies for the terminal illness and related conditions. Hospice care is usually given in the patient's home, but may also be covered in a hospice inpatient facility, nursing home, or hospital.

Current Medicare Hospice Benefit

Medicare began offering the hospice benefit in 1983 [1]. Beneficiaries may elect the Medicare hospice benefit after being certified as terminally ill by their physician and a hospice physician. The terminally ill patient must sign a statement indicating that they choose hospice care in lieu of Medicare-covered treatments for their terminal illness and related conditions. Once the hospice benefit starts, original Medicare will cover all services related to the terminal illness as long as the care is delivered by a Medicare-approved hospice provider, even if the patient chooses to remain in a Medicare Advantage Plan or other Medicare health plan. The Medicare hospice benefit does not cover:

- treatments intended to cure the terminal illness and/or related conditions;
- prescription drugs, except those for symptom control or pain relief;
- care from any provider that wasn't initiated by the hospice medical team;
- inpatient room and board charges not associated with stays mandated by the hospice team; and

- outpatient care that was not arranged by the hospice team.

Medicare Advantage and the Current Hospice Benefit

When a beneficiary who is enrolled in a Medicare Advantage plan elects to receive hospice care, payment for that hospice care is made directly to the hospice program/provider by CMS, while the services not related to the beneficiary's terminal illness and related conditions remain the responsibility of the MAO. During the period when the hospice election is in effect, CMS's monthly capitation payment to the MAO is limited to beneficiary rebate amounts and the monthly Part D payment (for plans with Part D coverage).

Hospice Service Providers

A hospice program is a public agency or private organization providing hospice care to terminally ill individuals. Services are provided in the patient's home, on an outpatient basis, or on a short-term inpatient basis. Services may be provided, as needed, up to 24 hours per day during periods of crisis. Core services include physician, nursing, medical social services, counseling, bereavement, and spiritual services. Hospices providing services to Medicare beneficiaries must have a valid Medicare provider agreement.

The use of hospice services has grown substantially since its inclusion as a Medicare benefit in 1983, with a 400% growth in dollars spent on hospice services by Medicare between 2000 and 2012 [2]. Hospice services represented approximately $17.9 billion in services for nearly 1.5 million Medicare beneficiaries in 2017 [2]. As the number of beneficiaries choosing hospice has increased, the number of for-profit hospice providers has increased as well. As of November 2019, approximately two-thirds of the 4,879 CMS Medicare-certified hospice facilities are for-profit [3].

Hospice Provider Reimbursement

Medicare reimburses a per diem payment to Medicare-approved hospice providers for one of four prospectively-determined rate categories of hospice care:

- Routine Home Care (RHC) – Scheduled, routine visits to the patient's home, assisted living facility, or nursing facility by a multidisciplinary care team. The majority of hospice care is provided within this category.
- Continuous Home Care (CHC) – During brief periods of crisis, a nurse and/or home health aide will remain in the patient's home from 8 to 24 hours per day.
- Inpatient Respite Care (IRC) – An inpatient stay of up to five days due to the absence or need for relief of the family or other caregivers at home.
- General Inpatient Care (GIP) – When the patient's symptoms cannot be effectively managed at home, a more medically intense level of care is provided in a Medicare-certified hospice facility, skilled nursing facility, or hospital, until the patient is able to return home.

The Fiscal Year 2020 (FY2020; October 1, 2019 - September 30, 2020) Medicare hospice reimbursement rates are shown in the table below.

Rate Category	FY 2020 Payment Rate
RHC (days 1-60)	$194.50 per day
RHC (days 61+)	$153.72 per day
CHC	$58.15 per hour
IRC	$450.10 per day
GIP	$1,021.25 per day

[4]

There is also a cap on the total Medicare payments a hospice facility can receive per Medicare hospice patient in one fiscal year. For FY2020, the cap amount is $29,964.78. The total receipts and number of beneficiaries in the hospice determine if the hospice has remained below the aggregate cap amount or if reimbursements to CMS are required [5].

Hospice VBID Overview

For CY2021, CMS and CMMI have initiated a Hospice Value Based Insurance Design (VBID) Model. Similar to other VBID model programs, the intention of the Hospice VBID is to improve quality, improve access to care, and enable innovation. Per CMMI, the overarching goal of the program is to improve care coordination through encouraging relationships between MAOs and established hospice organizations. The hope is that these improved relationships will provide a seamless continuum of care for the beneficiary transitioning to the hospice benefit. As with the existing VBID model components, participants in the hospice benefit component must also meet the requirements of the Wellness and Health Care Planning component.

There are six main elements of the Hospice VBID model:

1) Participating MAOs must incorporate the full, current Medicare hospice benefit into their covered benefits.
2) MAOs must have a strategy around access to and delivery of palliative care services for beneficiaries with serious illness who are not eligible or have not chosen to receive hospice services.
3) MAOs must work with in-network hospice providers and non-hospice providers to make available the transitional concurrent care services necessary to address continuing care needs, as clinically appropriate, for the treatment of hospice beneficiaries' terminal conditions.
4) CMS will monitor and aggregate the performance of participating 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) Participating MAOs must cover hospice services furnished by both in-network and out-of-network providers, and must pay the Medicare FFS payment to the non-contracted hospice providers. Cost sharing for hospice services may be no higher than the cost sharing in Original Medicare for hospice benefits. For 2020, beneficiary cost sharing includes prescription drug coinsurance of 5%, with a maximum of $5 for each script received when receiving continuous or home care (not inpatient care), and 5% coinsurance for of the payment made by Medicare for daily respite care [6].
6) Participating MAOs will be paid a monthly hospice capitation payment for each month that a beneficiary elects hospice.

Participating MAOs must use Medicare-participating hospice providers, whether in-network or out-of-network, and only those providers may furnish the hospice services.

MAOs may offer beneficiaries that qualify for and elect the hospice benefit mandatory supplemental benefits in addition to those mandatory supplemental benefits available to all beneficiaries in the MA plan. Examples of potential supplemental benefits provided by CMS include:

- Coverage of primarily health-related services and items, namely adult day care services, over-the-counter (OTC) benefits, meals, transportation, and others.
- Coverage of non-primarily health-related services and items to address social determinants of health: meals, utilities, personal care items, linens, pest control, service animal expenses, and others. Coverage of these additional benefits would be based solely on socio-economic status.
- Coverage of non-primarily health-related benefits: room and board within a hospice residential facility or equivalent residential facility for beneficiaries that need custodial care and do not have access to those services through their Medicare benefit or any other benefit.
- Reductions in cost sharing for necessary care received unrelated to the treatment of a beneficiary's terminal illness and related conditions received during hospice election.
- Reductions in cost sharing for covered Part D drugs unrelated to the terminal illness that a beneficiary receives during hospice election.

For MAOs that participate in the hospice model for both CY2021 and CY2022, CMS anticipates making a quality payment adjustment in CY2023 based on their performance relative to a quality benchmark of selected measures. Proposed measures include, but are not limited to: (i) Proportion of beneficiaries admitted to hospice for less than seven days, (ii) Rate of lengths of stay beyond 180 days, and (iii) Transitions from hospice care followed by death or acute care.

Hospice VBID Model Payments

For all calendar months that a beneficiary elects hospice, including the initial month, the MAO will receive a monthly hospice capitation rate, the beneficiary rebate amount, and the monthly prescription drug payment (for plans with Part D coverage). Additionally, for the initial month that a beneficiary elects hospice only, the MAO will continue to receive the A/B bid capitation rate.

CMS will develop a national monthly hospice capitation rate for CY 2021 which will reflect FFS paid hospice experience for care both related and unrelated to the terminal condition and related conditions for all Medicare beneficiaries (FFS and MA) who elected hospice, using CMS data from 2016 through 2018. The national rate will be adjusted by a hospice-specific average geographic adjustment, similar to the Medicare Advantage Average Geographic Adjustment. Risk adjustment will not be applied to the monthly hospice capitation rate.

For the initial month only, the monthly hospice capitation rate will have an additional adjustment applied. The rate will vary based on the number of days of hospice benefit in that initial month, and will be stratified to at least two payment rates (e.g. the rate paid for a beneficiary entering the hospice with fewer than 15-days in the month will result in a lower capitation payment than a beneficiary with more than 15-days in the hospice). The number of days has not been finalized and the final rule may include more than two stratifications [7]. First month hospice

capitation rates will be made in a lump-sum retrospectively to the MAOs on a quarterly basis.

The national monthly hospice capitation rates for CY2021 and full payment methodology are expected to be released in February 2020. The geographic adjusted rates for CY2021 are expected to be released in April 2020.

Hospice VBID Application

The CY2021 VBID application is open to eligible MA Organizations in all 50 states and all United States territories [7]. The hospice benefit will be a Part A benefit. MAOs may propose one or multiple MA and MA-PD plans for participation in the VBID Model and the hospice component. At least one of the MAO's plans/PBPs included in the model must have been offered in at least three open enrollment periods before the open enrollment period for CY 2021 (2018, 2019, and 2020 for CY2021). In addition, the PBP's contract must have at least a three-star overall quality rating for the most recently available year.

MAOs participating in the hospice VBID will be required to outline how they will provide palliative care to eligible beneficiaries, irrespective of the election of hospice. Participating MAOs may make transitional, concurrent care services as well as hospice-specific supplemental benefits available to beneficiaries who elect hospice through network hospice providers. MAOs must include in their application projections of any changes in medical costs and non-benefit expenditures due to their participation in the hospice benefit component. The costs of services provided while a beneficiary is under a hospice election must not be included in the pricing of the A/B bid. Additional mandatory supplemental benefits offered to the hospice beneficiaries must be included in the application for CMS review and approval.

The application deadline is March 16, 2020, at 11:59 pm EST. Applications must be submitted through the VBID Model website [7]. MAOs will have through May 1, 2020 to work with CMS and finalize which contracts and PBPs will be selected to participate in the model. Provisional approvals are expected to be given by April 2020 for model participation. MAOs that choose not to participate even after being provisionally approved may do that by informing CMS and not including the cost in its bid.

Considerations for MAOs

Many questions are outstanding regarding the impact of covering the hospice benefit. As CMS provides additional information, Wakely will be providing additional papers refining MAO considerations. In the meantime, if the MAO is considering participating in the CY2021 Hospice VBID, there are immediate actions for MAOs to consider:

1. Identify licensed Medicare hospice providers in the MAO's service areas. Providing a hospice benefit to a Medicare beneficiary requires appropriate licensing based on state regulations for the hospice benefit and approval as a Medicare provider. Regardless of participation in the Hospice VBID, establishing relationships with local licensed hospices will encourage the continuity of care that CMS is seeking.
2. Research state licensing guidelines. If the MAO determines that developing a hospice will provide the most continuity of care for beneficiaries, state guidelines should be researched to begin the licensing and provider approval processes.

3. Watch for further information on the capitation rate methodology from Wakely. CMS will publish the hospice capitation rate methodology in February 2020.
4. Watch for additional information on the Ratebook release from Wakely. CMS will release the Ratebook in April 2020.
5. Apply online no later than March 16, 2020 if the MAO is interested in the Hospice VBID for CY2021.

Please contact Jackson Hall at jacksonh@wakely.com or Alison Pool at alisonp@wakely.com with any questions or to follow up on any of the concepts presented here.

[1] TEFRA, "https://www.govinfo.gov/content/pkg/STATUTE-96/pdf/STATUTE-96-Pg324.pdf," [Online].

[2] MedPac, "Chapter 12 Hospice Services," *Report to the Congress: Medicare Payment Policy,* p. 313.

[3] CMS, "https://data.medicare.gov/data/hospice-compare," [Online].

[4] Rates, "https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11411.pdf," [Online].

[5] Payment, "https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7838.pdf," [Online].

[6] Sharing, "https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.pdf," [Online].

[7] Application, "https://innovation.cms.gov/Files/x/vbid-hospice-rfa2021.pdf," [Online].