Medicare Advantage Value Based Insurance Design Update

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Stacey Plizga: Okay. Our next session features speakers who will provide participants with information on the VBID model component, including for 2021, a test of carving in the Medicare hospice benefit into the Medicare Advantage program, and a 2021 roadmap for participating in the VBID model. From the Center for Medicare and Medicaid Innovation, please help me welcome Gary Bacher and Laura McWright.

[applause]

Laura McWright: Good morning. So testing, it works.

So, thank you for coming today. I'd like to welcome everyone here on behalf of the Innovation Center. I'm pleased to be here to talk about the Value-Based Insurance Design model update for 2020. We are experiencing a lot of exciting times at the CMMI or CMS Innovation Center where just even last week we announced a new set of model options in the primary care space. And, of course, as many of you know, at the beginning of the year in January, we announced the – the VBID model update in addition to the Part D – the Medicare Part D Payment Modernization model. And so a lot of interesting work these days at the Innovation Center.

So before we dive in to the – to the VBID model updates, I think it's always a good idea to ground ourselves in the statutory authority for the

Innovation Center. And really it's about testing innovative payment and service delivery models to reduce program expenditures and preserve or enhance the quality of care for beneficiaries. And three different scenarios are really contemplated by – by the statute. One is where quality is improved but costs remain neutral. Two is where quality remains neutral but costs are reduced. And third, the best-case scenario, would be where quality improves and the costs are reduced. And in any of these scenarios that – that are outcomes, we would be able to expand the – the model through rule making.

Okay. So let's talk a little bit about our agenda today. And what we'd like to do is review the history and the goals of the VBID model. And then dive in and talk about the 2020 model VBID update. And then my colleague Gary Bacher will be talking with you about coming attractions for the 2021 plan year and doing – and doing a deep dive on hospice.

Okay. So the – the goal – the general goals of the VBID model are really to test concepts that are relevant to modernizing the Medicare Advantage plan. And really, there are three – three ways. By increasing choice, lowering costs, and also finding ways of coordinating quality of care for beneficiaries. In addition, identifying strategies for more efficient coordinated care is definitely a goal.

So, in addition, I think really as I think about the underlying goal of the VBID model, it's really important that we're coordinating with the – with our colleagues in the Center for Medicare and making sure we're identifying areas for testing that are relevant to the program now but also are able to think a little bit outside the box and that would inform sort of future decision making around the program and updates.

Okay, so let's step back for a minute in history and talk about the – the VBID history. The VBID model began in 2017, really with the idea of testing the impact of providing Medicare Advantage organizations the flexibility to offer reduced cost sharing and supplemental benefits to

enrollees with certain chronic conditions. Those conditions were identified initially by CMS based on health outcomes and expenditures data. And we looked at the conditions that had the highest incidence in the Medicare population.

Initially we began on a limited basis with seven states, Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee, and we targeted plans – oh, sorry, targeted beneficiaries with these different disease states that had the high incidence, and that included COPD, CHF, what other ones? The hypertension, coronary artery disease, mood disorders, and a variety – a variety of combinations of those conditions.

Then in the following year, in 2018, we updated the model to include additional states, Alabama, Michigan, and Texas, and also we added a couple more relevant diseases, dementia and rheumatoid arthritis.

So, for 2019, the evolution has continued, and we added 15 more states – won't ready those but available there. We also allowed the – the Medicare Advantage organizations to utilize their own defined chronic conditions and also to be able to do their own targeting methodology.

In addition, we – we also looked at the statute and looking at what the Center for Medicare was doing in preparing for 2020. So the expansion has continued. And first, based on – whoops, sorry – based on the Bipartisan Budget Act, the – the scope of the – of the model has expanded to all 50 states. And that means that not only are all states included, but that – that Medicare Advantage organizations are also able to apply with their HMOs and their PPOs and also regional PPOs because there's no limitation on geography.

We also added additional special needs plan types, and that includes the institutions SNPs in addition to the – to the Dual SNPs.

Okay. So now, let's focus on the model components for 2020. And I think important to step back and talk a little bit about the process that we use to identify the components. And really it was about all of you and providers and consumers, beneficiaries that we solicited comments from in a – in a – an RFI process now a couple of – a couple of years ago. And, really, it was – it was from you all's feedback, conversations based on the RFI comments, that really put us in a situation where we identified sort of themes that we wanted to make sure that were covered. And those were beneficiary choice and engagement, and care delivery strategies, in addition to network management.

So the first – first of the new components was basically built on the initial model foundation, which was the offering of flexibilities in – in plans being able to allow targeted – targeting enrollees based on their chronic conditions. And also targeting by socioeconomic status with a variety of benefits including non-primarily health-related ones.

In addition, we also – we also are testing the – the rewards incentives programs in a different way where we have increased the value of the rewards and incentives allowed per year to $600.00. We also are – are allowing – are allowing the value of the reward incentive to be associated with the benefit of – of the intervention as – instead of just the value of the – of the intervention itself. And the rewards and incentives for 2020 will also include the Part D program rewards and incentives. And, really, the goal for rewards and incentives overall is to engage beneficiaries in their health care in terms of mindful of cost and – and alternatives overall that are – are more healthy for them.

In addition, we also – the third component was the – the development of a telehealth network intervention that could be used as an extension to the current in-person model in rural and underserved areas in a way that enables beneficiaries greater choice in their Medicare Advantage plans and also just the way that they get their healthcare. Recognizing that the

advancements in technology should obviously be taken advantage of and encouraged to – to be available in a variety of ways.

Finally, the – the fourth requirement was – is the – the wellness and healthcare planning – planning component, which that's the only – only one of the components that's required. And it's really allowing plans to – to test the wellness and healthcare planning strategies that they're using now with a focus on the advanced care planning and to begin to look at the structure of their wellness and healthcare offerings and – and look at, in terms of the timeliness and the – the content. And so we're looking forward to – to the results of all the tests, but certainly that's a – that's a really important one for the Innovation Center.

So, before – before ending today, I think important to – to give you all just a little bit about our process with the – the VBID application applications. We received our initial applications in the middle of March. And just yesterday we received the updates for the – the applications. We want to thank all of the – the plans that sent us applications. We are in the process today, beginning today, of finalizing our – our approvals for plans, and we're targeting the middle of May to be back to – to you – to the VBID participants to – to finalize approvals for the – for the beginning of June knowing that you all have your bid submissions due in the – in the beginning of June .

Okay, with that I think I will turn it over to Gary.

Gary Bacher: So, as Laura said, thank you all very much for your attendance today. I really appreciate the opportunity –

Do you know what? Use this one.

Oh, thanks. Sorry about that. Is that better? Great. Okay.

So, again, wanted to thank you for your participation and interest today. It's a pleasure to get a chance to talk to you about the one proposal that we've already put forward for 2021, so for the 2021 contract year. Basically it's – it's to test the idea of incorporating the Medicare hospice benefit into Medicare Advantage, and that would, again, begin for 2021. I'm going to talk about why in some ways that's a change. How that changes from how beneficiaries access hospice today.
And one thing, just as a preliminary note, that I wanted to mention is that this idea has been around for a long time. CMS and the Innovation Center has not really tested it before, but it's appeared in multiple MedPAC recommendations for a long period of time as well as various legislative proposals. We're very excited about this. We think there's a – a good bit of opportunity to improve the care experience for beneficiaries. And we've already been working quite a bit with a wide range of plans, and hospice organizations, and various trade associations and other groups to kind of get their input and perspectives as we kind of work through some of the final details. So, if you're interested in this, make sure you're in touch with us. Obviously love to be talking to you about it.

So basically, what do we mean before we, you know, even get into the goals? So what do we mean by incorporating the Medicare hospice benefit into MA? So I think as most of you probably know, today, and in this – it's really the only exclusion for Medicare Advantage, today if someone becomes eligible for hospice, and so in general that means that they would have – typically it's a six-month prognosis from at least two physicians. And so the thought – the idea is that the physicians determine that if the disease or condition was to run its ordinary course, we would expect the beneficiary to die essentially within six months. And that's the – the central criteria for hospice eligibility.

And if somebody happens to be enrolled in Medicare Advantage at the time and they elect the hospice benefit, it's fully voluntary on the beneficiary to elect the hospice benefit, but what happens, and one slide will kind of get into this in a little bit more detail, but what happens is that

technically the beneficiary remains enrolled in their Medicare Advantage plan, but they effectively access the hospice provider and the hospice benefit through the fee-for-service system. They don't really, unlike other benefits, they don't really access it through the Medicare Advantage plan. And as MedPAC and others have noted, that creates a good bit of fragmentation. And in an environment where more and more people envision the creation of a continuum of care for people who develop serious or advanced illness, the notion that it's really not a juncture point that somebody goes into hospice, but there's sort of a continuum from the time that somebody becomes seriously ill through that, you know, period of end of life, since it's more of a continuum from kind of a medical perspective, we want to make sure that we have a care model, both on the fee-for-service side and on the Medicare Advantage side that kind of matches with that idea of how somebody progresses clinically.

And so, related to that we really have two goals for this pilot and this Demonstration.

So the first is to improve quality and access by increasing appropriate and timely access to care, promoting better care coordination for beneficiaries who choose Medicare Advantage and elect a Medicare hospice benefit.

And a couple of things as you sort of think about that particular goal. What do we really mean by increasing appropriate and timely access to care? So, one of the things that we intend to focus on in the pilot is the idea that hospice, and we'll talk about this in a little bit more detail, has an issue with respect to both tales. And so on the one hand there are many people who only gain access to hospice kind of arguably when it's too late. So they – they die, for instance, within three days or a week of gaining access to hospice. And a lot of people believe that if you're – if you're choosing hospice at that point, and you only have that little amount of time in hospice, you've probably come in too late. So we have a kind of a problem where for certain beneficiaries we have too short a length of stay in hospice.

And then, as we'll show in a couple of slides, the other end of the spectrum, the other tale, is we have increasingly long lengths of stay. And as MedPAC and others have done work, there's a lot of potential reasons for that long length of stay. One of the reasons is that we increasingly see more and more people with Alzheimer's or forms of dementia where it's very difficult, for instance, to – to actually have that six-month prognosis. And so if you look at the data, a lot of the beneficiaries who tend to kind of have those longer lengths of stay are people that would have, for instance, dementia of Alzheimer's.

So, very importantly with respect to that first goal, there's really a focus on can we improve appropriate access to care, can we improve the care coordination. And, again, a lot of that desire to improve the care coordination and the seamlessness has to do with sort of the disjointed nature today, when someone who's in Medicare Advantage that they elect to have hospice, kind of what – what happens.

So then the second goal, related to the first, is we want to enable innovation, and we want to do that by fostering partnerships between Medicare Advantage organizations and hospice providers that create this more seamless and integrated continuum of care. And we think that plans can play a very positive role in that, but there really has to be this partnership between the hospice organizations and the plans.

And one of the other things that we're very focused here on is, and both plans and hospice organizations that we've spoken to have – have focused on this as well, which is thinking about not just the time period when somebody becomes eligible for hospice, and enters hospice, we're really thinking about that time period before. So, as I mentioned, when somebody really begins to develop serious or advanced illness, increasingly seeing plans offering serious illness and advanced illness care management programs, how do you begin bringing those palliative and supportive care services forward to beneficiaries at an earlier period

of time? And, again, the idea if we can create this more seamless continuum, we think it will generate a lot more innovation in terms of thinking about how these pieces kind of fit together.

So one thing, just to kind of level set, and this is a slide or a chart that we had borrowed from MedPAC, I think this is really important, and a lot of people don't kind of realize kind of what happens. And so this is a little more detailed version of what I was describing before.
So basically, this is coverage for people enrolled in a Medicare Advantage prescription drug plan who elect hospice. And basically, before hospice enrollment, as we all know, what happens is the Medicare Advantage plan essentially covers everything. So they cover all the Part A and B services. They provide the Part D benefit. And then any supplemental benefits. And increasingly, supplemental benefits might include the kinds of things that provide for more palliative care opportunities. And, again, plans are offering more and more serious illness or advanced care – advanced illness care management programs.

At the time that the enrollee elects hospice, now technically it's the fee-for-service system that's covering hospice. And – and fee-for-service also covers the A and B services unrelated to the terminal condition. So what's happening is that when somebody enters hospice, basically services that are intended to prolong life, essentially the idea is that the beneficiary is no longer focused on those services, and that's all related to the terminal condition. But there could be things that occur that are unrelated to the terminal condition that the hospice organization under the hospice benefit itself is not responsible for. It's actually not the Medicare Advantage plan that's responsible for those unrelated A and B services, it's actually the fee-for-service system. So what does the MA plan remain responsible for? It remains responsible, for instance, for Part D drugs that are unrelated to the terminal condition. The hospice is responsible for the Part D drugs related to the terminal condition. And then the MA plan is responsible still for providing the beneficiary with access to any supplemental benefits, and that might include reduced cost sharing if

somebody accesses care for – and this is why it gets so confusing – for those services that are being paid for by Medicare fee-for-service.

And then what happens if somebody disenrolls from hospice, and remember, there's a lot of reasons why somebody might disenroll from hospice, at any point they can revoke the – the hospice selection. It could be the fact that they no longer are certified eligible for hospice. It could just be they decide that they don't want to be in hospice, they want to go back to the regular care that they had been receiving in their MA plan. Technically what happens is that until the end of the month, all the A and B services continue to be covered by the fee-for-service program, and then basically beginning the next month after the disenrollment from hospice, Part A and B are then covered by the MA PD.

So if you look at this chart, right, just the fact that there's all these starts and stops and movements, and that's one of the big goals of the Demonstration is to say can we improve the care experience for everybody by creating – trying to help get rid of some of the fragmentation? Can we, instead of all the inevitable arguments about related and unrelated, can we find a way of making this kind of much smoother by allowing a Medicare beneficiary to access the hospice benefit through their Medicare Advantage plan? And, again, that's really fundamentally what we're trying to accomplish here.

But we're trying to go a little bit slow, hence the reason why we didn't propose this for 2020 and proposed it for 2021, because it's never been done before. And because today the hospice benefit is provided through fee for service, there really, in our work and our reconnaissance, there really are few plans that technically have deep relationships or contractual relationships with hospice organizations today. Obviously, there are beneficiaries in Medicaid and the commercial world that access hospice. And very often that might occur through a plan, but Medicare is really responsible for 90% of hospital – excuse me – hospice utilization. And so

we have sort of a much smaller share of hospice experience on the plan side of things outside of Medicare, and specifically Medicare Advantage.

Okay. So just a couple of things specifically about – about hospice. So this is really just trying to give a sense of how – how many people, excuse me, how many people elect hospice today. And so you can see there's been quite a bit of growth. So, by 2017, you can see that it's really a little bit over half, just about half of all decedents in Medicare choose a hospice. And that's pretty evenly split. So the proportion of decedents that choose hospice that are in Medicare Advantage, again even though they access it through fee-for-service, or that are in fee-for-service and access hospice, it's more or less the same, if I recall, with respect to Medicare Advantage and fee-for-service.

You can see the length of stay, this is something I mentioned before. And because, as you see, the median is remaining sort of about the same but the average is increasing, you know, rather significantly, that tells you that what's happening is that there's a fairly large increase in length of stay between 2000 and 2017. And that, obviously, consistent with the growth in the program, you can see the increase in – in the spending with respect to overall Medicare payments. Again, that will be all fee-for-service spending today because it's all through fee-for-service. And then – and then this is the number of beneficiaries that currently receive hospice services.

Now these numbers obviously vary quite a bit, particularly in relation to length of stay, related to a range of different factors and across different – different organizational types. And so, MedPAC, for instance, sees different lengths of stay. If you're looking at a hospice organization that's freestanding versus a hospice organization that might be affiliated with a provider facility, there's some differences between for-profit and not-for-profit organizations in terms of what the data say. So, just to be clear, there's a lot of variation.

The other thing to sort of understand about the hospice benefit is that, you know, how it's paid today and what the benefit really provides for. So just a couple of things on that.

So, if you look, for instance, at the conditions of participation for hospice providers today, they basically have to provide access to four levels of service. And so those four levels are what's often referred to as routine home care hospice care. That's kind of the most basic level. There's actually an inpatient respite benefit. So that means that for caregivers that really need rest, there's a limited benefit where there's a respite benefit provided so, on an inpatient basis, someone who is in the hospice benefit can be taken on an inpatient basis to provide the caregiver a respite. There's what's known as a continuous level of care. That's for someone who needs an intense level of services. And then there's also a inpatient benefit, so for someone whose condition is related to the terminal – whose symptoms related to the terminal condition can't be managed on an outpatient basis, many hospice organizations have an inpatient facility or, for instance, they will lease space from a – a – from a inpatient facility.

And, basically, hospice is paid on a per diem basis, so it's basically a daily rate. And the amount doesn't vary based on somebody's condition, but it does vary based on those four levels of care.

And then just a little bit more detail. Back, I think it was beginning in 2016 or '17, Medicare changed a little bit of how it pays those rates, so the hospices get paid a little bit of a higher rate with respect to the first 60 days of somebody being in hospice, and then there's a little bit of a step down after the – after the – after the first 60 days. And then there's a little bit of a bump, I think, in the last week of somebody's life. And then there's some other adjustments that are made to the payments. But the basic idea is that to understand there's this bundled hospice benefit. If you talk to the hospice organizations, what they'll explain is that they really view this as it's a capitated benefit much in the way that an MA plan is paid. The hospice organizations are already paid on essentially a capitated

basis, a per-day basis. And they're responsible for providing a set of services based on the care – the plan of care that's developed at the time that somebody enters the hospice benefit.

And sort of beginning to understand all those details of the plan is really important for those organizations that are going to be interested in potentially participating in this Demonstration. So one of the big roles, and we'll talk about this in a little bit, that we're sort of focused on, is how can we help hospice sort of better understand how Medicare Advantage works, and at the same time, how can we make sure that Medicare Advantage plans sort of have an understanding of how hospice works. So that way, as we put this pilot into place, we can have sort of a smoother transition. And we'll have some time for questions in a little bit.
Okay. So with all that background, just to provide a little bit more detail of what we're trying to do, so we want to make sure that beneficiaries have access to a seamless, integrated care continuum, whether they're receiving care through Medicare Advantage or original Medicare, which we all know is also referred to as the fee-for-service system.

And just to kind of build on that, why am I focusing on both the Medicare Advantage side and original Medicare? There really is no, today, in fee-for-service Medicare, there is no serious illness benefit. There is no advanced illness care benefit. And so there are a number of organizations that perceive there's really this gap that occurs from the time that somebody develops serious illness to the time that they, for instance, become eligible for hospice, that's there's a wide range of needs, kind of gaps in care, that are not being met for people that have palliative needs, that have supportive care needs.

And, from an overall Innovation Center perspective, we've been looking at this issue, both on the Medicare Advantage side of things, and the main program has been doing that as well in terms of providing more opportunities from a supplemental benefit perspective to be able to provide more upstream services, upstream from hospice. And on the fee-

for-service side, we at the Innovation Center, just as we're working on Medicare Advantage, have also been thinking about this on the fee-for-service side. So as Laura mentioned, last week, I think it was last week, we announced – it was a long week, so –

(Inaudible.)

We announced – yes – we announced a couple of diff – two main model paths with several payment model options. One of those paths was the Primary Care First model, and one of the payment model options within Primary Care First happens to be something that we call the Serious Illness program. So it's basically beginning to provide, on the fee-for-service side, more opportunity for providers to fill that gap in care, so that time that somebody would become seriously ill and have a need but they're not, for instance, ready for hospice yet. So, similar idea on both the Medicare Advantage side and the fee-for-service side, we're trying to make sure that we have the continuum of care that's available for – for beneficiaries.

So, what do we really mean – what are the core characteristics of the care continuum that we're trying to build? So, for one thing, accountable. So that slide I showed you before, what MedPAC has pointed to, is we have so many different points of shifting accountability, there's no one organization, at the end of the day, who, when somebody elects hospice, is accountable for everything. And we think that that creates some of the gaps in care and the fragmentation. And that's one of the areas where we think we can help innovate and improve care by reducing those gaps. And we think one way to do it is to assign accountability. And if we have the Medicare Advantage organization providing access to the hospice benefit, essentially the Medicare Advantage organization, as it is for everything else, would become that point of accountability.

Making sure that we have a seamless connection to care and supportive services. Making sure that the care is, obviously, high quality, that it's

integrated, that it remains person centered. The idea of build of bridging beneficiary needs and marshaling and integrating the resources to meet those needs. And then, of course, that it continues to respect beneficiary choice. And we want to make sure that the Demonstration enables and supports continued shared decision making with beneficiaries and their families in terms of figuring out what's the right level of care for – for them.

This is just a little bit more detail on that. Most of these things we've sort of touched on. But one of the things that, in terms of our kind of different goals for this vis – for our vision, is, again, respecting the beneficiary's choice. I mentioned several times the idea of, as we're focused on the hospice piece, we're also focused on enabling a broader range of upstream services, so tied palliative and supportive in nature. We think for this we can help create better awareness and access to hospice. So, again, trying to help address the other issue, which is the problem that I referenced before that we see in the short tale, so both short and long lengths of stay.

I want to focus a little on concurrent care. I'll come back to that in a second.

Really importantly, for this to succeed, since it hasn't been done before, is it really has to reflect the partnership between the plans and the hospices as facilitated and within sort of the guidelines of the – of the Demonstration that we're developing at the Innovation Center.

So this last point that I wanted to come back to, those of you that are interested in this area might hear this term a lot. That is we want to realign incentives to support concurrent care as a part of a care transition where appropriate. And so, what this means is that the notion of concurrent care is that when somebody officially elects the Medicare hospice benefit, are there services that today somebody might conclude, no, those services aren't available, they're really related to the terminal

condition, that could still be provided. That they're services that help transition someone who wants to enter hospice that they help make that transition easier. And the examples that have tended to come up, I know there's some disagreement just even today whether certain things are related or unrelated to the terminal condition, so also providing for more consistency would be another important goal.

But some of the things that typically come up would be certain kinds of chemotherapy, or blood transfusions. Things that it would be very hard, kind of, if something is just cut off, as somebody kind of elects hospice, the idea of can we do things that provide for a little bit more of a gradual transition into hospice knowing the beneficiary can always revoke that hospice election.

And so, what's our direction kind of going forward? The core thing we're looking for is for beneficiaries, kind of first and foremost in our minds, is we want to make sure that they maintain access to the full scope of hospice services under the current benefit, and they retain the ability to make that choice.

But we also want to ensure that there's greater awareness and access to and understanding of all of their care options.

For hospices, we are looking at this as giving them a platform to better support patient needs through enhanced collaboration with plans and other providers. So, using plans, that nucleus, to help bring together all the different providers that might be necessary to help support somebody who has serious illness. And we think for hospice organizations it's also an opportunity to showcase the role that they can play, not just in hospice, but also with respect to upstream palliative and supportive services. And I mentioned before, with respect to MA organizations, looking at – at you all as that point of accountability and the hub for ensuring robust access to a seamless continuum of care.

So we're really excited about this. As I mentioned at the beginning, there's been a lot of expressions of interest and support. We wanted to kind of do this very, very carefully and thoughtfully, which is why we haven't proposed it for 2020, but 2021. And just (inaudible) of our discussion, you can kind imagine as we kind of work out some of the final policy details, there's a number of things that come up. So, how do we actually ensure that beneficiary access? Obviously, given the nature of hospice, one of the concerns that beneficiaries have, that hospice organizations have, that plans have is how do we make sure that if a beneficiary wants to go to a particular hospice, they still have that ability? And particularly something like hospice where there could be religious reasons or other reasons why someone wants to go to a particular hospice, thinking through that is really important.

Payment. Obviously, plans will all be interested, well, how does this work? How do we – we're now going to be responsible for providing these hospice services, how will our payment change? And so, the hospices, likewise, are very interested in, well, how will the plans pay us for these services? So payment is obviously an important piece of it.

Quality goes right along with it, in terms of measuring and monitoring to make sure that hospice beneficiaries in MA are receiving appropriate and high-quality care.

And then one of the things, as Laura was mentioning at the beginning, that we have a statutory requirement to do, is to evaluate. And to look at the impact of the model on cost and quality consistent with the requirements that we have with respect to the Center's statutory mission.

And then, again, I just want to underscore, the collaborative approach that we're looking to encourage between plans and hospices, and the role that we're hoping we can play to kind of help facilitate that collaboration.

So, again, thank you very much. Really appreciate everybody's attention and opportunity to speak to you about these important issues.

[applause]

Kaye Rabel: We do have time for questions, so if you do have any questions, please feel free to go ahead and step to the microphone in the center of the room. And please state your name and where you're from and your question.

Keavney Klein: Hi. Keavney Klein from Kaiser Permanente. Thank you for the presentation. Wondering, Gary, if you can give any insight into when we will see any further information coming out about the hospice component.

Gary Bacher: Sure. Thanks. Thanks for that. So we have done one webinar, a public webinar. We're going to be – we're in the process of scheduling a second one. The first one was to Level Set. It was really kind of a – a little bit of a variation of this with a little bit more detail in a couple of areas. The next one that we'll be announcing shortly will get into some more of the policy details that I was just flagging. So, so stay tuned. Very soon you'll hear about the scheduling of that follow-on webinar.

And in addition, we're very happy to kind of talk to plans that have interests and some ideas that they would want to share for us for how to design the pilot and some either questions that you might have or just ideas that you might have in terms of things that we might want to keep in mind as we put it together. But stay tuned, you'll be hearing more from us very shortly.

Michelle Ford: Hi. Michelle Ford at Medicare Compliance Solutions. And our question is, would the hospice benefit require contracting with the Medicare Advantage organizations, and if so, will there be a CMS contract template?

Gary Bacher: I'm sorry. Say that last piece.

Michelle Ford: A CMS contract template developed.

Gary Bacher: Ah, CMS contract template. Yeah, that's a great question. So one of the things is – and just to put that into context, that raises a couple of different points, just to kind of phrase the question in a way that everybody might track. So the question is, given that, as I mentioned before, there aren't a lot of agreements in place today between Medicare Advantage organizations and hospices, how would those come into place? Would there need to be an agreement between the Medicare Advantage organization and hospice? And, we're sort of looking at both the idea of ensuring that Medicare Advantage organizations that seek to participate in the pilot have a robust set of hospices essentially in their network. But also looking to make sure that there are ways that if a beneficiary needs to access a hospice that's not in the network, that there's also that opportunity.

For those hospices that would be in the plan's network, we do envision that there would be some form of agreement that would need to be in place consistent with the way that you work with all other providers. And we're thinking internally, from a – and it's very helpful to get the question from a technical assistance standpoint, the most helpful thing that we can do in terms of helping organizations think through what are the key things that need to be in that contract.

So some of the things that we're thinking about, for instance, might be from a – I don't know if we would necessarily put out a template agreement, but, you know, very similar to the way that you contract with other provider organizations, we would make clear, and we would look for it in the applications from the Medicare Advantage plans, what are the things that we expect to be in agreements between Medicare Advantage plans and hospice organizations. So we would be helping provide some assistance that way by outlining what are those things that we think would

be important to have in those agreements. It would be helpful feedback to learn if people feel that we should go even a step further. We've been thinking about that quite a bit internally. What's the right level of technical assistance that we can provide? And so, we appreciate people's further thoughts and comments on that.

Paul Cotton: Thank you for your presentation. This is Paul Cotton with NCQA. Very cool stuff you guys are doing. Laura, in particular, I was interested, you said you got the submissions in mid-March from the plans for the PPID next year. Can you give us a flavor for what kinds of things plans are thinking of? Are there any themes that emerged?

Laura McWright: Thanks, Paul, for that question. You know, right at the moment, because we just literally received – we began the process with the announcement in January, and then in mid-March we received initial applications. And then we've been engaging in a process with the – the plan applicants, and talking to them about their – their applications and proposals. And then asked for some clarifications and updates, which we just received as of yesterday. And so I think we're not really in a position yet to talk about what's – what we've received, you know, prior to the June third bid submissions. And so we look forward to, though, later in the summer, announcing, you know, the participants and their – and what – what we received, what we hope to learn from the different proposals. It's very exciting, and again want to thank the plans that leaned in and are working with us. And look forward to the 2020 plan year, but also, you know, talking with Gary, you know, we look forward as much to the 2021 plan year and including the hospice carve in and looking at, you know, whether there are other tweaks we would consider in – in the 2021 season. Thank you.

Kaye Rabel: Okay. All right. Any more questions?

Well, thank you so much, Gary and Laura, for the information on the VBID model.

[applause]

Okay. If you would like to evaluate this session, please go ahead and take out your phone and text your response. Or go to the Poll EV link on your iPad, tablets or computer, and enter A in response to the question, I would like to evaluate this session, and send your response. When you receive the link, click on it and follow the instructions.

It is now time for our lunch break. We will begin the – this session promptly at 1:00 p.m. EDT. And for our in-person guests, please visit the cafeteria located downstairs. If you pre-ordered your lunch, you can pick it up at the deli inside the cafeteria.

So please enjoy your lunch, everyone. Thank you.