CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10170	**Date: June 9, 2020**
	Change Request 11754

Transmittal 10127, dated May 8, 2020, is being rescinded and replaced by Transmittal 10170, dated, June 9, 2020, to add a note to the effective date and to revise the background section and business requirement 11754.3. All other information remains the same.

SUBJECT: Value-Based Insurance Design (VBID) Model – Implementation

I. SUMMARY OF CHANGES: This CR is an implementation CR for the Centers for Medicare & Medicaid Services (CMS) Innovation Center test incorporating the Medicare hospice benefit into Medicare Advantage (MA) through the Value-Based Insurance Design (VBID) Model ("hospice benefit component") for Calendar Year (CY) 2021. The hospice benefit component of the Model will be tested through 2024.

EFFECTIVE DATE: January 1, 2021 - NOTE: When the Hospice Election Start Date is on or after January 1, 2021 and prior to January 1, 2025.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020 - Analysis, Design and Coding; January 4, 2021 - Testing and Implementation for all contractors. MCS and VMS: all work to be completed in January.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Demonstrations

Attachment - Demonstrations

Pub. 100-19	Transmittal: 10170	Date: June 9, 2020	Change Request: 11754

Transmittal 10127, dated May 8, 2020, is being rescinded and replaced by Transmittal 10170, dated, June 9, 2020, to add a note to the effective date and to revise the background section and business requirement 11754.3. All other information remains the same.

SUBJECT: Value-Based Insurance Design (VBID) Model – Implementation

EFFECTIVE DATE: January 1, 2021 - NOTE: When the Hospice Election Start Date is on or after January 1, 2021 and prior to January 1, 2025.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020 - Analysis, Design and Coding; January 4, 2021 - Testing and Implementation for all contractors. MCS and VMS: all work to be completed in January.

I. GENERAL INFORMATION

A. Background: This CR is an implementation CR for the Centers for Medicare & Medicaid Services (CMS) Innovation Center test incorporating the Medicare hospice benefit into Medicare Advantage (MA) through the Value-Based Insurance Design (VBID) Model ("hospice benefit component") for Calendar Year (CY) 2021. The hospice benefit component of the Model will be tested through 2024.

Note: CWF will continue to set the new reject if all reject criteria are met as outlined in business requirements below **for hospice elections that occur on or after January 1, 2021**, even if dates of service are past December 31, 2024 **as long as the hospice election start date occurs on or after January 1, 2021 through December 31, 2024.**

Through the hospice benefit component, CMS is testing 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. For Medicare Advantage Organizations (MAOs) that volunteer to be part of the Model, CMS will evaluate the impact on cost and quality of care for MA enrollees, including how the Model improves quality and timely access to the hospice benefit, and the enabling of innovation through fostering partnerships between MAOs and hospice providers.

In participating in this component of the Model, MAOs will incorporate the current Medicare hospice benefit into MAO covered benefits in combination with offering palliative care services outside the hospice benefit for enrollees with serious illness and providing individualized transitional concurrent care services.

B. Policy: <u>The six main elements of this demonstration are as follows:</u>

First, participating plans must provide the full scope of hospice benefits, as defined in the Social Security Act (Act) at § 1861(dd). Participating MAOs' enrollees receiving hospice benefits must meet the statutory definition of "terminally ill," as set out in the Act at § 1861(dd)(3)(A). Through contracting hospices, MAOs must work with an Interdisciplinary Care Team (IDT) at § 1861(dd)(2)(B), and provide the four levels of hospice care set out in CMS regulations at 42 CFR § 418.302(c). Additionally, the choice to elect or revoke the hospice benefit will remain exclusively with a participating MAO's enrollee (or his or her representative), as set out in the Act at § 1812(d) and in CMS regulations at 42 CFR §§ 418.24 and 418.28.

Second, in addition to hospice services, CMS will require participating MAOs to have a strategy around access and delivery of palliative care services for enrollees with serious illness who are either not eligible for or who have chosen not to receive hospice services. While MAOs may define the criteria enrollees must meet to receive these palliative care services, participating MAOs must provide coverage of, by furnishing,

arranging for, or making payment for, these palliative care services that are covered by Medicare Part A or Part B as set out in the Act at § 1852 in a way that is neutral to total Parts A and B expenditures.

Third, to ease care transitions, ensure hospice-eligible beneficiaries are able to access and receive the full benefits of hospice care. Participating 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 enrollees' terminal conditions. Any transitional concurrent care must be appropriate and reflective of patients' needs and wishes as identified in their plans of care and coordinated among hospice providers, MAOs, and other treating providers.

Fourth, to provide transparency and improved beneficiary, family, and caregiver experience with end-of life care, CMS will monitor the performance of participating MAOs and aggregate performance of MAOs across this component of 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. CMS has intentionally selected measures that present improvement opportunities relevant to enrollees' care and quality of life, are clinically meaningful, and are aligned with CMS's broader quality measurement strategy.

Fifth, in order to ensure access to hospice providers, for CY 2021, all participating MAOs must cover hospice services furnished by both in-network and out-of-network providers. Consistent with 42 CFR§ 422.214, participating MAOs must pay non-contracted hospice providers at a rate equal to the Original Medicare Fee-For-Service (FFS) payment for hospice services. Additionally, cost sharing for hospice services may be no higher than the cost sharing in Original Medicare for hospice benefits.

Finally, participating MAOs will be paid a monthly hospice capitation payment for each month that an enrollee elects hospice. The monthly hospice capitation payment rate is based on both related and unrelated costs paid by the FFS payment system for all beneficiaries who elect hospice care. For the first month only, an adjustment will be applied to the hospice capitation payment rate to ensure the capitation payment rate more closely reflects beneficiary experience in hospice.

In sum, CMS believes the policies being tested through this Model represent an opportunity for Medicare beneficiaries who choose MA and elect hospice, as well as their families and caregivers, to experience a more seamless transition to hospice care, if aligned with their wishes, with improved coordination of care.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	**Requirement**	**Responsibility**								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11754.1	The Enrollment Database (EDB) shall **add** a new 3-digit Package ID # and a new flag (Y or N indicator) to identify the MAOs participating in the hospice benefit component of the VBID Model on the Health Maintenance Organization (HHMO) transaction.								X	EDB

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11754.1.1	EDB shall send the initial file at the time of implementation for all beneficiaries where the MA Plan is in the Model. **Note:** CWF shall share the EDB file format with STC, after receiving it from EDB. EDB will provide a test file to CWF and STC in mid-to-late October 2020.								X	EDB
11754.2	Upon receipt of the 3 digit packaged ID# from EDB and the flag identifying the plan participating in the hospice benefit component of the VBID model (VBID-Hospice), CWF shall: • Update the existing GHOD auxiliary file to carry the 3-digit packaged ID# and the model flag in Health Insurance Master Record (HIMR). Note: MCS shall then update the MCSDT application and online screen that display the GHOD HIMR information.						X	X	X	
11754.3	CWF shall read the HMO file for the VBID Hospice Flag and create a new reject. CWF shall set the new reject: 1. if the incoming Hospice claim's (81x and 82x, excluding type of bill 8xA, 8xB, 8xC, 8xD, and 8xE) when the **hospice election start date is on or after January 1, 2021 through December 31, 2024** and during MA Plan Period and the Flag is present 2. set for any covered Institutional Claim (PPS Hospital) when the Admit Date is during hospice election start date **on or after January 1, 2021 through December 31, 2024** and for non- PPS Hospital (Skilled Nursing Facility/Outpatient/Home Health, excluding type of bill 322 RAP) when dates of service are during hospice election period and MA plan period and the flag is present 3. set for any covered Part B or Durable Medical Equipment (DME) claim (except read only From Date for Glucose Test Strips) when dates of service are during hospice election start date								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	on or after January 1, 2021 through December 31, 2024 and MA plan period and the flag is present **Note: The new edit will only apply for hospice election start date on or after January 1, 2021 through December 31, 2024.** **Note: CWF shall set new reject and no longer set 5235 or 525Z when above conditions are met.** Additional Note: If the MA Plan does not carry the flag, the Hospice claim should not reject. Responsibility: BDS									
11754.3.1	CWF shall bypass the new reject for IME/GME (Indirect Medical Education/Graduate Medical Education) claim for Institutional claim and continue to allow HMO paid claims to be accepted. **Responsibility**: Beneficiary Data Streamlining (BDS)								X	
11754.3.2	CWF shall ensure that the new reject error code is overridable. Conditions to be determined by CMS.		X		X	X			X	
11754.3.3	FISS shall accept the new CWF reject and process the claims upon receipt of the new error code as indicated in BR # 6.1.					X				
11754.4	CWF shall set the new reject for dates of service after the live discharge/revocation date through the end of the month. Responsibility: Beneficiary Data Streamlining (BDS)								X	
11754.5	CWF shall approve a claim identified in the VBID model as non-covered, deny, and post to history with the new error code if there's payment on the claim and the flag is present.								X	
11754.6	Upon receipt of the new error code, the contractors shall deny the claim at zero payment.		X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Note: The contractors shall send back to CWF for further processing.									
11754.6.1	FISS shall process the claim at zero payment as an HMO covered claim, moving the charge to non-covered and applying no-paid code N, and return the claim to CWF.					X				
11754.6.2	The MACs shall send the following messages explaining the reason for the no-pay claim/ denial of payment: Claim Adjustment Reason Code (CARC) 96 Non-covered charge(s) Remittance Advice Remark Codes (RARC) MA73 Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care. Group Code CO Medicare Summary Notice # 21.9 Payment cannot be made for unauthorized services outside the managed care plan OR Medicare no paga por servicios no autorizados fuera del plan de cuidado de la salud (Spanish Version).	X	X	X	X					
11754.7	With any retroactive MA enrollments (i.e. if or when a plan submits their enrollment information after a Notice of Election (NOE) is submitted and processed) or if the Hospice Notice of Election is received and the MAO is participating in the model, CWF shall ensure they are reading the HMO file for updates to identify if the MAO is participating in the model to ensure no								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	payment is made under Fee-For-Service (FFS).									
11754.7.1	When a retroactive MA enrollment is posted or if the Hospice Notice of Election is received and the MAO is participating in the model, CWF shall do a look back in history for six months based on the condition in Business Requirement (BR)#3 and BR#3.1 and create a new Informational Unsolicited Response (IUR) to identify a claim that should not have paid as FFS.								X	
11754.8	The contractors shall create an IUR adjustment to reverse the payment for the service under FFS if payments were made to a MA enrolled bene. Note: Section 935 rights do not apply.		X		X	X	X			
11754.9	CWF shall modify UR 5196 to ensure subsequent benefit periods apply the same rules for the existing editing criteria. Note: The modification to the edit apply to all dates of services applicable to edit.								X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11754.10	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get	X	X	X	X	

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	article release notifications, or review them in the MLN Connects weekly newsletter.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jason Petroski, 410-786-4681 or Jason.Petroski@cms.hhs.gov , Sharon Andres, 410-786-5890 or sharon.andres@cms.hhs.gov , Sibel Ozcelik, 443-721-7720 or sibel.ozcelik@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0