Value-Based Insurance Design (VBID) Model

Overview of the CY 2021 Hospice Benefit Component

Center for Medicare & Medicaid Innovation, CMS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Agenda

- Design, Care Transparency and Beneficiary Quality, and Access
- Application Process for eligible Medicare Advantage Organizations
- Question and Answer

Presenters

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How MA Enrollees Access Hospice Today

Coverage for Medicare Advantage-Prescription Drug plan (MA-PD) Enrollees who Elect Hospice

	Fee-For-Service (FFS) Medicare covers	MA-PD covers
Before hospice enrollment	• Part A, Part B, and Part D benefits	• All Part A, Part B, and Part D benefits and additional supplemental benefits
MA-PD enrollee elects hospice	• Hospice • Part A and Part B services unrelated to terminal condition	• Part D drugs unrelated to terminal condition • Any supplemental benefits (e.g., reduced cost sharing)
MA–PD enrollee disenrolls from hospice	• Until the end of the month, all Part A and Part B services	• All Part D drugs • Any supplemental benefits (e.g., reduced cost sharing) • Beginning the next month after disenrollment, Part A and Part B services

While MA enrollees who elect hospice today remain in their MA plan, payment for their care is divided between FFS and MA

Source: MedPAC Report to Congress 2014

Current Medicare Hospice Experience

	2000	2017
Election	22.9% of decedents	50.4% of decedents
Length of stay (days)*	Average: 53.5 Median: 17	Average: 88.6 Median: 18
Total Medicare payments	$2.9 billion	$17.9 billion
Beneficiaries	534,000	1,492,000
Live discharge rate	13.7%	16.7%

**Substantial variation in length of stay related to a range of factors and across organizational types*

While median length of hospice utilization for beneficiaries has largely remained the same, the average length of hospice stay has increased materially.

Source: Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy, March 2019; and Prsic et al. A National Study of Live Hospice Discharges between 2000 and 2012. J Palliat Med. 2016.

Medicare Payment Advisory Commission (MedPAC)

In March 2014, the Commission recommended including hospice in the Medicare Advantage benefits package. This recommendation was reiterated in 2016 and 2017.

"The current hospice carve-out from MA makes a plan's financial responsibility for end-of-life care uneven across beneficiaries. For beneficiaries who elect hospice care, the plan has limited financial responsibility for their care after hospice enrollment. In contrast, for beneficiaries with terminal conditions who do not enroll in hospice, the plan has full financial responsibility for care through the end of life…

The Commission believes a goal of the MA program is to move away from fragmented payment arrangements, and towards providing an integrated and coordinated benefits package. The Commission is concerned that the hospice carve-out is inconsistent with this goal."

- MedPAC 2014 Report to Congress

Timeline at a Glance

Jan 2019

Conducted Stakeholder Engagement

CMS conducted months of technical information gathering and received broad stakeholder input

Calendar Year (CY) 2019

Announced Model Test

CMS announced that it would begin testing the inclusion of the Medicare hospice benefit in Medicare Advantage (MA) under the VBID Model for CY 2021

Dec 2019

Released RFA

VBID Model - Hospice Benefit Component Request for Applications (RFA) released

CY 2020

Application & Technical Support

CMS will provide application & technical support in advance of model test start

Jan 2021

Model Test Begins

CMS will begin voluntary test of incorporation of the Medicare Hospice Benefit into MA

Goals and Desired Outcomes

Through a voluntary test of coordinating both payment and care responsibility for the Medicare hospice benefit for enrollees that choose Medicare Advantage and elect the hospice, CMS aims to:

- Enable a seamless care continuum that delivers care in a way that fully respects beneficiary and caregiver needs, wishes, and desires;
- Improve quality and timely access to palliative and hospice care; and
- Foster innovation by strengthening partnerships between Medicare Advantage Organizations (MAOs) and hospice providers.

Example Patient Profile

Betsy

Age: 76

Diagnosis: Diabetes, Hypertension, Arthritis, Congestive Heart Failure, End Stage Renal Disease

Patient Notes:

- **Sees multiple different specialists** address her symptoms, but care is not coordinated
- **Recurrent emergency department visits** (5 this year) and hospitalizations (3 in the past 6 months)
- **Complicated treatments** that are impacted by disease interactions, diet, and lifestyle
- **She is "tired"** of travel to dialysis and multiple trips to the hospital, but symptoms worsen without dialysis
- **Her needs and goals are not incorporated in a clear, written plan of care**
- **Develops shortness of breath moving from room to room with cane, no longer feels well enough to have grandchildren visit, she finds it difficult to prepare meals**
- **Her 83-year-old husband drives her 30 miles each way to the dialysis unit three times a week**

Coordinated Patient Experience

Betsy

Age: 76

Diagnosis: Diabetes, Hypertension, Arthritis, Congestive Heart Failure, End Stage Renal Disease

As a result of the Hospice Benefit Component:

- **Received care from an interdisciplinary, home-based palliative care team** that coordinated her care plan
- Betsy and her husband understand her illness; she has identified a long-term plan specific to her goals, **created an advance care plan** including her end-of-life care preferences and identified a healthcare proxy
- **Home safety evaluation** was performed, and through supplemental benefits, home modifications were covered
- Other **supplemental benefits** provided: low salt meals, caregiver support, transportation to and from dialysis
- Betsy **ultimately elected hospice** and is followed by the same care team. She continues dialysis twice per week to help manage her symptoms and receive hospice-specific supplemental benefits
- Betsy, her husband and children know what to do and who to call if symptoms worsen, with a **clinician available 24/7;** she hasn't needed another emergency department visit and has received **care at home**

Model Design:
Service Delivery and Care Model, Transparency and Quality, Access and Payment

Overview of Model Component Design

- Four-year voluntary model for MA organizations (January 2021 – December 2024)
- MAOs offering eligible MA plans in all states and territories may apply to CMS to participate

1. Maintains the full scope of the current Medicare hospice benefit

2. Focuses on improved access to palliative care

3. Enables transitional concurrent care for enrollees

4. Introduces additional hospice-specific supplemental benefits

5. Promotes care transparency and quality through actionable, meaningful measures

6. Maintains broad choice and improves access to hospice

7. Utilizes a budget neutral payment approach to facilitate all of the above aims

Maintaining the Medicare Hospice Benefit

MAOs must provide the full Medicare hospice benefit

Requirement that hospices provide all services necessary for the palliation and management of the terminal illness and related conditions. **MAOs may not "unbundle"** the collection of services and items that make up the hospice benefit

Collaboratively working with hospices and other providers, MAOs will work to ensure **better coordination** of all care to **minimize care fragmentation**

Hospice care may only be provided through **Medicare-certified hospice providers**

Improving Access to Palliative Care in MA

Participating MAOs will develop an approach for providing access to timely and appropriate palliative care services, which includes how they:

- ✓ Develop patient-specific plans of care and updates in response to continuing care assessments and enrollees' needs as their illness advances and needs change
- ✓ Make available advance care planning and discussions around choices through shared decision making
- ✓ Outline how seamless transitions of care will occur, including if beneficiaries elect hospice

Providing Transitional Concurrent Care

To ease care transitions and ensure hospice-eligible beneficiaries and families are able to access and receive the full benefits of hospice care, if they choose

Current state:

- Beneficiaries who elect hospice waive their right for payment related to the treatment of their terminal illness
- Often creates a barrier to hospice election

Tested through inclusion in the Model's Medicare hospice benefit component:

- Participating MAOs will work with in-network providers to define and provide a set of transitions concurrent care services, as clinically appropriate and aligned with care plans

Access to Supplemental Benefits for Hospice

Broad set of hospice-specific mandatory supplemental benefits for enrollees who elect hospice

Set of hospice supplemental benefits could cover, for example:

- Coverage of primarily health-related services and items, e.g., home and bathroom safety devices and modifications and support for caregivers of enrollees
- Coverage of non-primarily-health related services and items to address social determinants of health, e.g., utilities, legal aid, pest control, utilities
- Reductions in cost sharing for unrelated covered Part D drugs that a beneficiary continues to need

Beneficiary Care Transparency & Quality

1. Palliative Care and Goals of Care Experience

- Development of Advance Care Plans (ACPs) and Wellness and Health Care Planning (WHP)
- Access to, and use of, Palliative Care
- Proportion of Enrollees Admitted to Hospice for Less than 7 Days

2. Enrollee Experience and Care Coordination at End of Life

- Days at Home in the Last Six Months of Life
- Proportion Admitted to ICU in the Last 30 Days of Life

3. Hospice Care Quality and Utilization

- Proportion of Lengths of Stay beyond 180 Days
- Transitions from Hospice Care, Followed by Death or Acute Care
- Visits in the Last Days of Life
- Experience of Care Measures (Hospice CAHPS)
- Part D Duplicative Drug Utilization
- Unrelated Care Utilization

Ensuring Broad Beneficiary Access

Phase 1

Enrollees access covered hospice care from the broad set of Medicare-certified hospice providers they do today.

Broad Access

All participants must offer access to all Medicare-certified hospice providers: in- and out-of-network

Voluntary consultation process to coordinate care for enrollees in understanding their care choices

Phase 2

Continued broad access to Medicare-certified hospice providers.

Continued Broad Access

All participants must offer access to all Medicare-certified hospice providers: in- and out-of-network

While enrollees maintain full in- and out-of-network access, MAOs and beneficiaries will engage to understand care choices

Phase 3

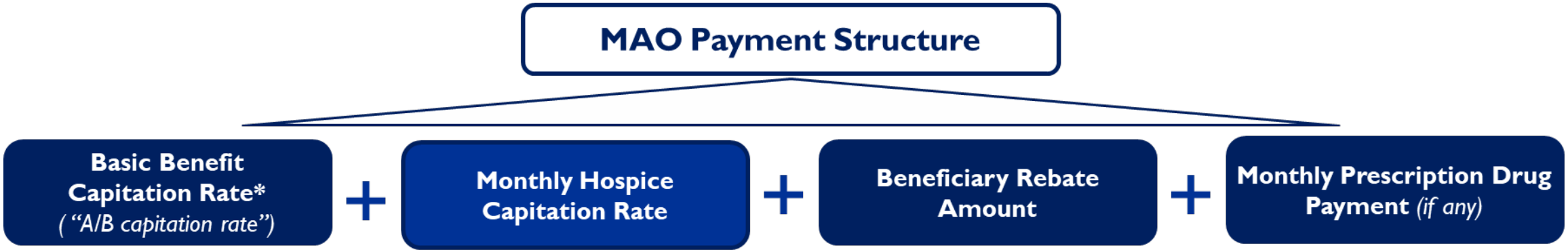
CMS will use existing regulatory guidelines and initial Model findings to develop network adequacy requirements

Access with Focus on High-Quality

CMS will develop network adequacy requirements, in part based on existing network adequacy requirements for similarly situated provider types

In developing these requirements, CMS will be guided by early experiences of both MAOs and in-network hospice providers in defining network adequacy.

Hospice Capitation Payment Structure



*Risk-adjusted and consistent with current law; for only the month in which an enrollee elects hospice

MAOs that participate in the Model will be paid a separate hospice capitation rate for each month a beneficiary elects hospice.

CMS's Office of the Actuary is developing **a national monthly hospice capitation rate**, which:

- Will reflect FFS hospice experience for care both related and unrelated to the terminal condition and related conditions for all Medicare beneficiaries (enrolled in Original Medicare or MA) who elected hospice
- For CY 2021 rate-setting, utilizes multiple years of CMS data (e.g., 2016 through 2018)
- Will be adjusted for each Hospice Wage Index area (CBSA) by a hospice-specific average geographic adjustment similar to the MA Average Geographic Adjustment to result in an adjusted monthly hospice capitation rate
- For Month 1 only, CMS will pay an episode-adjusted hospice capitation rate based on actual beneficiary experience in that month

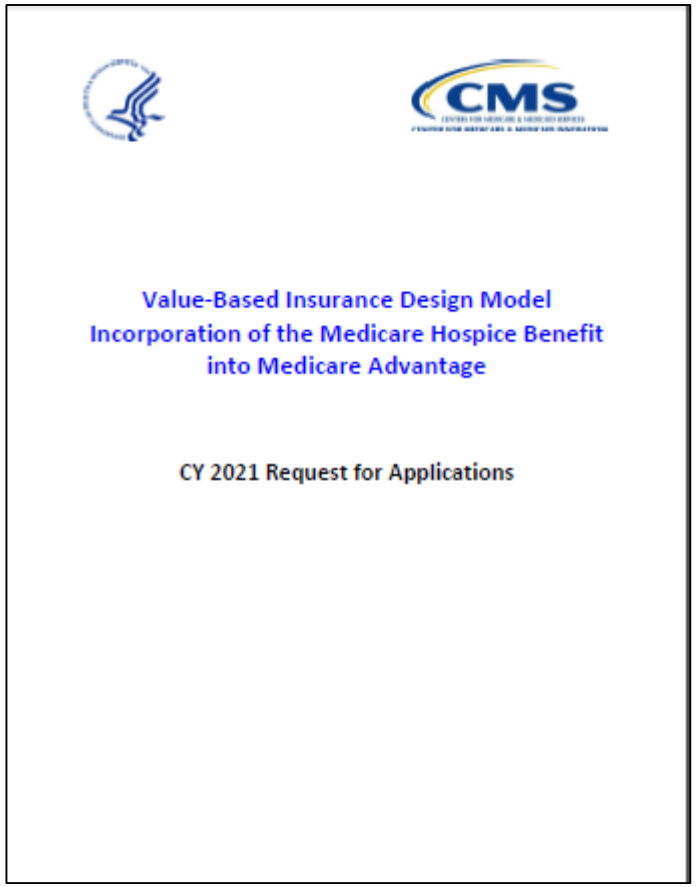
Evaluation

Independently evaluated using qualitative and quantitative methods

The evaluation will assess the impact of the Model on health outcomes and expenditures, and document the perspectives of enrollees, hospices, and MAOs. The evaluation will emphasize:

- Beneficiary experience
- MAO response to Model flexibilities
- Hospice and palliative care provider involvement

Request for Applications



Now Available:

CY 2021 Request for Applications (RFA) for the Hospice Benefit Component

Access the RFA on the Model website at the link below.

https://innovation.cms.gov/Files/x/vbid-hospice-rfa2021.pdf

Next Steps

- Continue to participate in ongoing CMS technical assistance events and webinars
- Review additional information about the hospice capitation rate methodology in **February 2020**, with accompanying webinar
- Initial application and interest to CMS by **March 16, 2020**
- Review release of hospice-specific rate book in **April 2020**
- Finalize Model participation by **May 1, 2020**
- Receive provisional approval in **May 2020**
- Submit MA Bid submissions, due **June 1, 2020**

Thank you!

CMS welcomes feedback and engagement from all stakeholders.
Please engage directly with us by emailing us at VBID@cms.hhs.gov

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