Introduction to the CY 2021 Hospice Component

VBID Model Information Session

Centers for Medicare & Medicaid Services (CMS) Innovation Center

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Presenters

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Agenda

- Introducing the CY 2021 Hospice Component in the VBID Model
  - Perspectives
  - Policy Goals, Vision and Guiding Principles
- Current State
  - Medicare Advantage (MA)
  - The Medicare Hospice Benefit
  - How MA Enrollees Access Hospice Today
- Next Steps & Q&A

Perspectives

"The carve-out of hospice from MA fragments financial responsibility and accountability for care for MA enrollees who elect hospice. Including hospice in the MA benefits package…would promote integrated, coordinated care, consistent with the goals of the MA program."

- MedPAC 2014 Report to Congress (reiterated in 2017)

"…By giving plans greater flexibility in their targeting and delivery of services, eliminating the MA hospice carve-out could reduce the difficult and arbitrary distinctions that Medicare hospice eligibility criteria force clinicians, patients, and families to make about having an expected prognosis of 6 months or less and about forgoing potentially life-prolonging therapies."

- D. Stevenson & H. Huskamp, JAMA 2014

"A policy change to include hospice care in the MA benefits package (colloquially referred to as a carve-in), however, is fraught with complexity, disquieting to many hospice providers and health plans, and susceptible to misunderstanding. Consequently, any policy to carve hospice into Medicare Advantage requires a deliberative approach and must be designed in a way that is unequivocally seen as a "win" for Medicare beneficiaries."

- J. Driessen and T. West, Health Affairs, 2018

How MA Enrollees Access Hospice Today

Coverage for MA-PD enrollees who elect hospice

	FFS Medicare covers	MA-PD covers
Before hospice enrollment		• All Part A, Part B, and Part D services, and any 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

Source: MedPAC Report to Congress 2014

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Policy Goals

- Broadly, the CMS Innovation Center supports the development and testing of innovative health care payment and service delivery models to enhance quality of care.

- Through the VBID model, CMS is testing the incorporation of the Medicare Hospice Benefit into MA beginning in 2021 to:

01 Improve Quality and Access

By increasing appropriate and timely access to care, aiming to promote better care coordination for beneficiaries who choose MA and elect the Medicare Hospice Benefit

02 Enable Innovation

By fostering partnerships between MA organizations and hospice providers that aim to lead to improved beneficiary experience through a more seamless and integrated continuum of care

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Furthering the Care Continuum as a Platform for Better Care and Innovation

Vision: Beneficiary access to a seamless and integrated care continuum whether receiving care through MA or Original Medicare (also referred to as "Fee-For-Service" (FFS))

Core Characteristics of Care Continuum

- Accountable to reduce gaps in care caused by fragmentation of responsibility
- Seamless connection to care and supportive services
- High-quality, integrated, and person-centered care
- Focused on bridging beneficiary needs and marshaling and integrating the resources to meet those needs
- Respects beneficiary choice – seeks to enable and support shared decision-making with beneficiaries and their families

Care Continuum

Care continuum should focus on the person-centered care in a way that is agnostic to whether a beneficiary chooses MA or FFS

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Vision for this Component of the Voluntary Model Test

Respects and supports access to the beneficiary's election of hospice benefits and choice of hospice provider, while drawing on the strengths of MA to integrate and bridge forms of care

Pulls upstream a broader range of palliative and supportive care services

Creates better awareness of and access to hospice geared toward supporting beneficiary choice

Reduces issues seen in both "tails" (i.e. short and long lengths of stay issues)

Realigns incentives to support concurrent care as part of a care transition where appropriate

Reflects a partnership between MA plans and hospices, with the model by the CMS Innovation Center

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Direction

In developing this model test, the CMS Innovation Center engaged with stakeholders for guidance on goals important to them:

Beneficiaries

Have greater awareness, access to, and understanding of all care options

Hospices

Are given a platform to support meeting patient needs through enhanced collaboration with plans and other providers

Have an opportunity to showcase role of hospice and upstream palliative and supportive services

MA Organizations

- Are the point of accountability and hub for ensuring robust access to seamless continuum of care

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Introduction to Medicare Advantage and the Medicare Hospice Benefit

Introduction to Medicare Advantage

- **Medicare Advantage is population health focused:**
  - Medicare pays MA plans a risk-adjusted, per person, pre-determined rate (a per member per month (PMPM) rate) rather than a per service rate
  - The PMPM rate is determined by comparing the MA plan's bid to a county benchmarks that is based on the product of (i) Medicare FFS per capita costs in the area and (ii) a percentage that is set based on the plan's quality star rating and the area's ranking based on FFS costs; the benchmark acts as a cap on the PMPM rate. The PMPM rate is then risk adjusted using enrollee risk scores.
  - As a result, plans have incentives to innovate to deliver more efficient care
- **Supplemental Benefits:** In addition to covering all Medicare Part A and Part B benefits excluding hospice, some MA plans offer Medicare beneficiaries supplemental benefits, such as vision, hearing, dental services, reduced cost-sharing and Part B premiums, and prescription drug coverage (Part D, through a MA-Prescription Drug (PD) plan)
- **Flexibilities:** Through MA and the VBID model, MA plans have the ability to offer additional supplemental benefits, including for primarily and "non-primarily health related" items or services, for a subset of enrollees (e.g. depending on program, based on chronic condition, socioeconomic status, or both)

Types of Medicare Advantage Plans

- **Plan Types:**
  MA plan types that enrollees choose can vary by offering different provider networks or out-of-pocket costs for certain services
- **Special Needs Plans (SNPs):**
  Additional classifications cut across plan types, including SNPs, which offer integrated benefit packages to beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions
- **Highly Specialized Services**

Illustrative MA Plan Type

MA-participating Preferred Provider Organizations (PPOs) have network lists, but provide for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers (42 CFR § 422.214). Furthermore, these plans must pay non-contract providers the Original Medicare payment rate in those portions of its service area where it is providing access to services by non-network means (42 CFR § 422.4)

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Enrollment in Medicare Advantage

- **Beneficiary Choice and MA Enrollment:**
  - Annually, Medicare beneficiaries may elect to receive their Medicare benefits from a MA Plan rather than through Fee-For-Service for the following year
- **More Beneficiaries are Choosing MA:**

  In 2018, ~36% of beneficiaries enrolled in MA; the range in number of MA plans varies by county

  MA prevalence ranges from <10% to >50% of Medicare beneficiaries in each state receiving their Medicare benefits through MA plans

Prevalence of MA Enrollment among Hospice Enrollees:

Similar rates of hospice election across MA and FFS

Almost all hospice patients enrolled in MA maintained their MA enrollment for their entire hospice election

Sources: Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy, March 2019; and RTI International Analysis.

Introduction to the Medicare Hospice Benefit

- **Medicare Hospice Benefit:**
  - Designed to provide comfort, pain relief, and emotional and spiritual support to patients with a terminal diagnosis and their family members and caregivers
  - Covers an array of services provided by an interdisciplinary team, and includes spiritual, family bereavement, and other counseling services and volunteer services
- **Choice and Election:**
  - Beneficiaries receive the Medicare hospice benefit only if they elect to do so and may revoke the hospice election at any time
  - If they do, beneficiaries agree to forgo Medicare coverage for conventional non-palliative treatment of the terminal illness and related conditions
  - A beneficiary electing hospice must be certified by the hospice medical director or physician member of the interdisciplinary group (IDG) and the individual's attending physician, if he/she has one, as having a life expectancy of six months or less (prognosis-based) & may be recertified after six months for two 90-day periods, and an unlimited number of 60-day periods as long as he or she remains eligible

Payment for the Medicare Hospice Benefit

Payment

- Paid on a per diem basis, based on enrollment, with the hospice assuming all financial and clinical responsibility for care related to the terminal condition
- Daily payment rates are made according to a fee schedule that has four different levels of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC)
- As of 2016, there are two RHC base payment rates and Medicare makes additional RHC payments for services provided during the last seven days of life
- Hospice payment rates are updated annually by the hospital market basket and other adjustment factors; hospices that fail to report quality data have the market basket % increase reduced by 2% points

Caps

- Limit the payment that any individual hospice agency receives in a single year, in relation to shared inpatient care and aggregate Medicare payments, but does not limit the amount of care that can be provided

Minimal Cost-sharing

- Under the Medicare Hospice Benefit, the only services potentially subject to cost sharing are drugs and biologicals for the palliation and management of pain and symptoms of a patient's terminal illness and related conditions while the individual is receiving routine home care or continuous home care (coinsurance of 5% per prescription provided outside inpatient setting – not to exceed $5) & inpatient respite care (not to exceed inpatient hospital deductible)

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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

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

Source: Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy, March 2019.

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Next Webinar: Key Policy Considerations for CY 2021 VBID Hospice Benefit

Beneficiary Access

- Ensuring beneficiaries access hospice consistent with their preferences and eligibility, and addressing short and long length of stay issues
  Providing access to and choice of hospice care for MA enrollees in model-participating plans

Payment

- Ensuring both financial stability and sustainability for MA plans and hospice providers, as well as creating opportunities for innovation

Quality

- Measuring and monitoring to ensure that MA hospice beneficiaries are receiving appropriate and high-quality care

Evaluation

- Evaluating the impact of the model on cost and quality, consistent with the CMS Innovation Center's mission and statutory requirements

Collaborative Approaches for Plans and Hospices

- Consideration of different approaches for collaboration and ways in which the CMS Innovation Center can facilitate

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Please visit the VBID Model Website for more information and announcements: https://innovation.cms.gov/initiatives/vbid/

Please email all questions to: **VBID@cms.hhs.gov**

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