Medicare Advantage VBID – Update on Medicare Advantage (MA) & Hospice Demonstration

March 31, 2021 | Melinda A. Gaboury, COS-C | Chief Executive Officer

Healthcare Provider Solutions

Agenda

1. Welcome
2. Value Based Insurance Design Model (VBID) Overview
3. Six Main Elements of the Demonstration
4. Medicare Hospice Benefit Component
5. Hospice Benefit Component Payment Design

Value Based Insurance Design Model (VBID) - Background

- The VBID Model began in January 2017 and will be tested January 2021 through December 2024.
- The Model is designed to test whether furnishing certain flexibilities in coverage and payment for MA organizations, to promote MA health plan innovations, would reduce Medicare program expenditures, enhance the quality-of-care Medicare beneficiaries receive, including dual-eligible beneficiaries, and improve the coordination and efficiency of health care service delivery.
- In January 2019, CMS announced that beginning in CY 2021, through the Model, participating MA organizations could apply to test the Medicare hospice benefit as a covered benefit. efficiency of health care service delivery.

Value Based Insurance Design Model (VBID) - Background

- Beginning in Calendar Year (CY) 2021, under the hospice benefit component, CMS will test 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 Medicare Advantage (MA) program for Part A and Part B services.
- Participating Medicare Advantage Organizations (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 and hospice-specific supplemental benefits.
- The hospice benefit component will be tested over four performance years, and participation in the Model is voluntary for eligible MAOs – this is NOT voluntary for hospices, if patient is a part of the plan then the hospice must bill through the demonstration

Hospice Participating Medicare Advantage Organizations

- For plan year 2021, 19 Medicare Advantage Organizations (MAOs) offering MA benefits to plan benefit packages (PBPs) with 4.6 million projected enrollees will provide tailored Model benefits
- Out of the 19, nine Medicare Advantage Organizations (MAOs), through 53 plan benefit packages (PBPs) are participating in the Hospice Benefit Component.

- Commonwealth Care Alliance, Inc.
- Hawaii Medical Service Association
- Humana, Inc.
- Summit Master Company, LLC
- Kaiser Foundation Health Plan, Inc.
- Presbyterian Healthcare Services
- Intermountain Health Care, Inc.
- Triple-S Management Corporation
- Visiting Nurse Service of New York

Hospice Participating MAO by State

Kaiser Foundation Health Plan, Inc
- California

Humana Inc
- Colorado
- Georgia
- Indiana
- Kentucky
- Ohio
- Virginia

Summit Master Company, LL &
Triple S-Management Corporation
- Puerto Rico

Hawaii Medical Service Association
- Hawaii

Intermountain Health Care, Inc
- Idaho
- Utah

Commonwealth Care Alliance, Inc
- Massachusetts

Presbyterian Healthcare Services
- New Mexico

Visiting Nurse Service of New York
- New York

Incorporation of the Medicare Hospice Benefit Component into Medicare Advantage (MA)

- 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.
- MAOs will be paid a hospice capitation
- MAOs will provide services in alignment with quality improvement goals and the network adequacy structure.
- 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.

Six Main Elements of the Demonstration

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,".
- Through contracting hospices, MAOs must work with an interdisciplinary care team (IDT) and provide the four levels of hospice care. Routine/Respite/Continuous/GIP
- The choice to elect or revoke the hospice benefit will remain exclusively with a participating MAO's enrollee (or his or her representative.

Six Main Elements of the Demonstration

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.
- 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 Part A and B expenditures.

Six Main Elements of the Demonstration

Third

- To ease care transitions and 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 nonhospice 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.

Six Main Elements of the Demonstration

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
  - (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.

Six Main Elements of the Demonstration

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.
- Cost sharing for hospice services may be no higher than the cost sharing in Original Medicare for hospice benefits.

Six Main Elements of the Demonstration

Sixth

- 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.

Medicare Hospice Benefit Component for CY 2021

- Participating MAOs that volunteer to be part of the hospice benefit component will include the Medicare hospice benefit as one of the Original Medicare services offered through and managed by the MA plan.
- MAOs will work with their network of high-quality providers to improve service delivery by offering access to:
  - (1) palliative care services for enrollees who are not yet hospice eligible or eligible but choose not to elect hospice
  - (2) transitional concurrent care for those enrollees who elect hospice
  - (3) more consistent, higher quality, and standardized hospice care

Maintaining the MCR Hospice Benefit

- Under the hospice benefit component MAOs must provide the full Medicare hospice benefit as specified in current law and regulation, except as explicitly waived to allow for the Model test.
- Participating MAOs are not permitted to “unbundle” the collection of benefits (services and items) that a hospice provider must furnish under Medicare Part A (section 1861(dd) of the Act), including the use of an IDT and the four levels of hospice care.
- Participating MAOs must use Medicare-participating hospice providers.
- Only a hospice provider may furnish these hospice services; participating MAOs do not have the option of designing alternative ways of furnishing these hospice services to enrollees who elect hospice. In this model test, CMS deems hospice providers to be “first tier entities” with the participating MAO, as defined in 42 CFR § 422.2, for purposes of other MA requirements (such as § 422.503), and MAOs must have written agreements with hospice providers.

Palliative Care

- Enrollees living with serious illness and who have begun a process of progressive and significant decline may benefit from palliative care either prior to their becoming eligible for the Medicare hospice benefit, or, when eligible, their choosing not to elect hospice.
- Unlike hospice, palliative care does not require an enrollee to have a life expectancy of six months or less and may be provided together with curative treatment at any stage in a serious illness.
- The goal of palliative care is to improve quality of life for those living with serious illness and their families and caregivers by providing specialized medical care, support and relief from the symptoms and stress of a serious illness, while allowing the necessary space and time for enrollees to understand their care choices and decide on a plan of care that best reflects their needs and wishes.

Transitional Concurrent Care

- As set out in the Act at § 1812(d)(2) and reflected at 42 CFR § 418.24(d)(2), beneficiaries who elect hospice care waive all rights to have payment made for any services “related to the treatment of the individual’s condition with respect to which a diagnosis of terminal illness has been made" except for services provided by the beneficiary’s designated hospice, or another hospice under arrangements made by their designated hospice or the individual’s attending physician (if the attending physician is not an employee of their designated hospice).
- As a result, by electing hospice, beneficiaries waive Medicare coverage for services that are considered curative in favor of receiving services that are more palliative in nature.
- Due, potentially in part to this choice between curative and palliative care, only approximately half of all Medicare beneficiaries elect the Medicare Hospice benefit at the end of life, and those who do elect hospice often do so too late in their disease trajectory to experience the full benefits of hospice care.

Transitional Concurrent Care

- The overall goal of encouraging MAO collaboration with non-hospice and hospice providers to arrange for the provision of concurrent care and related services on a transitional basis is to support more consistent use of these services, in light of current variation in provider beliefs and practices related to the provision of concurrent care (including those services that may be difficult to distinguish between curative and palliative).
- For example, a transitional continuation or phasing out of treatments such as chemotherapy services, blood transfusions, or dialysis may permit an enrollee to conclude or phase out over time a course of therapy while concurrently receiving hospice care and services.
- The provision of transitional concurrent care under the Model does not change the necessary criteria for hospice benefit eligibility or the requirement that the designated hospice provider provide all services and levels of care available under the hospice benefit.

Transitional Concurrent Care

- To ease care transitions and ensure that hospice-eligible enrollees face a less stark transition and choice between foregoing either curative or hospice care, as part of the Model, participating MAOs must work with their network of high-quality hospice providers, as well as non-hospice providers, to define and provide a set of concurrent care services related to a hospice enrollee's terminal condition and related conditions that are appropriate to provide on a transitional basis, aligned with an enrollee's wishes and provided by a non-hospice provider.
- The demonstration permits MAOs and hospice organizations to work together to arrange for the provision of similar concurrent services provided on a transitional basis by an in-network hospice provider, as long as those services are within the hospice's clinical scope, even where such services would not be provided by the hospice under current regulation because they could be viewed as mainly curative in nature.

Transitional Concurrent Care

- As part of providing transitional concurrent care, MAOs must establish transparent guidelines and processes for enrollees to access concurrent care at their in-network providers.
- These processes must include provisions for hospice providers to work in conjunction with non-hospice providers to develop a plan of care that clearly identifies the concurrent care services the enrollee will receive as the enrollee transitions into hospice, and the specific services and items or services that are being foregone (if any). The plan of care should clearly specify how the hospice will ensure coordination among all hospice and non-hospice providers.
- As part of these processes, MAOs must work with their networks to have policies and procedures for coverage of concurrent care that are standardized, administratively simple, and consistent for all enrollees.
- All MAO network providers and care management teams must work closely with the MAO's network of hospice providers to facilitate the transition of services from those directed towards a cure to those directed towards support and palliation.

Transitional Concurrent Care

- Given the importance of care and financial coordination between the participating MAO, hospice providers, and potentially non-hospice providers in the provision of concurrent care, MAOs must limit the availability of concurrent care services to MA enrollees who elect an in-network hospice provider as their designated hospice.
- Participating MAOs must cover the full hospice benefit out-of-network (that is, all out-of-network services necessary for the palliation and management of the terminal illness and related conditions that hospices provide as set out in regulations at 42 CFR § 418.56(c) at Original Medicare rates).
- Nothing in this demonstration prohibits hospices, whether operating on an in- or out-of network basis with a given MAO, from continuing to provide services to a beneficiary that are intended to be palliative in nature even if they would otherwise potentially be viewed as curative to the extent allowed under current regulation.

Hospice Supplemental Benefits in the VBID Model

- Participating MAOs may offer a broad set of mandatory supplemental benefits for enrollees that elect hospice in addition to mandatory supplemental benefits offered to all enrollees in the MA plan.
- CMS recognizes that the set of items and services that a hospice enrollee may benefit from could be broad, depending on the hospice enrollee's individual circumstances.
- CMS will allow participating MAOs to identify additional items and services that extend beyond Original Medicare hospice care, as well as set a specific dollar amount for the aggregate coverage of the set of items and services that may be provided to enrollees receiving hospice care.
- MAOs would then be in a position to work with their in-network hospice providers and enrollees to identify the items and services that a specific enrollee who has elected hospice has access to.

Hospice Supplemental Benefits in the VBID Model

- Examples of these supplemental benefits may include:
  - Coverage of primarily health-related services and items (that is, services and items that ameliorate the functional/psychological impact of hospice enrollees' health conditions and/or reduce avoidable emergency and healthcare utilization). These could include adult day care services, home and bathroom safety devices and modifications, support for caregivers of enrollees, over-the-counter (OTC) benefits, care services, meals, transportation, and other items.
  - Coverage of non-primarily health related services and items to address social determinants of health that have a reasonable expectation to maintain or slow the progressive decline of the health or overall function of an enrollee, based solely on socioeconomic status. These could include, but are not limited to, meals (beyond the current allowable limits), utilities, legal aid (e.g., to obtain or maintain shelter), personal care items, linens, clothing, pest control, service animal expenses, and other items.
  - Reductions in cost sharing for unrelated covered Part D drugs that an enrollee receives during hospice election.

Care Transparency for Beneficiaries, Families & Caregivers

- In order to ensure MA enrollees' experience at the end-of-life and in hospice is safe, high-quality, and appropriate, as well as to create transparency for enrollees and their families and caregivers, CMS will monitor and benchmark enrollee experience and provider quality at the start of the Model component and over time to track enrollee access to care and care paths, including palliative care and hospice care for those enrollees who elect hospice.
- CMS will monitor the impact of the Model on the following quality domains:
  - (i) Palliative Care and Goals of Care Experience
  - (ii) Enrollee Experience and Care Coordination at End of Life
  - (iii) Hospice Care Quality and Utilization
- These domains were selected to address key improvement opportunities – relevant to beneficiaries who choose hospice and those who do not, and their families and caregivers – and to limit reporting burden for providers and MAOs mainly by using CMS analyses of claims and enrollment data.

Care Transparency - Palliative Care and Goals of Care Experience

- CMS will monitor the impact of the Model on how MAOs, hospices, and others focus on the provision of appropriate and timely palliative care services for enrollees with serious illness who are either not eligible for hospice or are hospice-eligible but have chosen not to elect hospice.
- The Model will monitor the below measures to
  - (1) verify that MA enrollees' goals of care are captured over time to reflect that plans of care change and care needs may increase;
  - (2) verify MA enrollees receive access to and use palliative care services (as appropriate); and
  - (3) evaluate whether an improved continuum of care improves the timeliness of appropriate hospice election.
- Measures:
  - (1) Development of Advance Care Plans (ACPs) and Wellness and Health Care Planning (WHP)
  - (2) Access to, and use of, Palliative Care
  - (3) Proportion of Enrollees Admitted to Hospice for Less than 7 Days

Care Transparency - Enrollee Experience & Care Coordination at End of Life

- CMS is testing different service delivery approaches with the goal of improving MA enrollees' experiences at the end-of-life, including better coordination across the continuum of care and concordance with patient preferences for place and types of care received.
- This includes both enrollees who elect, and enrollees who do not elect, hospice.
- The Model will monitor the below measures:
  - (1) Days Spent at Home in Last Six Months of Life
  - (2) Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life

Care Transparency –Hospice Care Quality and Utilization

- CMS's fundamental aim through testing the Medicare hospice benefit component is to improve access to high quality hospice care for MA enrollees who elect the hospice benefit.
- CMS will assess MAOs and both their network and out-of-network hospice providers on the following measures:
  - (1) Proportion of Lengths of Stay beyond 180 Days
  - (2) Transitions from Hospice Care, Followed by Death or Acute Care
  - (3) Visits in the Last Days of Life
  - (4) Experience of Care Measures
  - (5) Part D Duplicative Drug Utilization
  - (6) Unrelated Care Utilization

Ensuring Beneficiary Access to a Network of High-Quality Hospice Providers

- Access and Availability Rules for Coordinated Care Plans for Hospice Providers
- Because hospice providers are largely a new provider type for MAO networks, CMS has adopted a phase-in approach for MAOs to develop and meet network adequacy standards for hospice providers over the first two years of the model.
- This approach allows MAOs and hospice providers to develop networks while still ensuring enrollees maintain adequate access to safe hospice care choices as networks form.
- CMS regulations at 42 CFR § 422.204(b) require that providers of services, as defined in section 1861 of the Act, that furnish Original Medicare benefits must have a participation agreement with Medicare in order to be in the MAO's network. Hospice programs are providers of services as that term is defined in section 1861 of the Act.

Ensuring Beneficiary Access to a Network of High-Quality Hospice Providers – Phase 1

- For CY 2021 and CY 2022, to meet network adequacy requirements for hospice providers, a first year Model participant must offer access to in-network hospice providers as well as out-of-network hospice providers except those not allowed by the MAO due to posing risk of harm to enrollees.
- While enrollees must be able to access covered hospice care from any allowed Medicare-certified hospice provider, CMS encourages MAOs to implement a voluntary consultation process aimed at engaging enrollees in understanding their care choices and both in-network and out-of- network hospice provider options prior to their accessing an out-of-network hospice.
- In implementing any type of consultation service, MAOs must ensure the experience takes the form of a high-touch care manager accessible by phone and other means available 24/7 to all enrollees and serviced in a way that is clear, immediately available, culturally competent, and knowledgeable about the hospice benefit and choices.

Ensuring Beneficiary Access to a Network of High-Quality Hospice Providers – Phase 2

- For CY 2022, MAOs that participated in CY 2021 may, based on having the benefit of CY 2021 experience, implement a formal version of the consultation program outlined above beginning on January 1, 2022.
- An MAO utilizing a formal consultation program could require an enrollee to have a consult prior to accessing an out-of-network hospice provider.
- To be clear, an enrollee must be able to access covered hospice services through either in-network or out-of-network hospice providers, but the MAO can require that the enrollee connect with the MAO prior to utilizing an out-of-network provider.

Ensuring Beneficiary Access to a Network of High-Quality Hospice Providers – Phase 2

- Participating MAOs will be required to inform any enrollee who requests to access out-of-network hospice providers (except those not allowed by the MAO due to posing risk of harm to enrollees) of their ability to do so and may not require written confirmation or supporting documentation from the enrollee or his/her representative as a precondition for seeking care from an out-of-network hospice provider.
- Participating MAOs must communicate to enrollees that they will not be able to access applicable hospice supplemental benefits or transitional concurrent care services from out of-network hospice providers.
- For enrollees that utilize an out-of-network provider, a participating MAO is required to cover these services and to make payment at the same amount that the hospice provider would receive from Original Medicare for covered hospice services in order to ensure enrollees are not balanced billed.
- A hospice provider must accept the Original Medicare amount as payment in full when it furnishes Medicare-covered services to MA enrollees but does not have a contract or other agreement in place to set the payment amount.

Ensuring Beneficiary Access to a Network of High-Quality Hospice Providers – Phase 3

- For CY 2023 and on, CMS will permit MAOs participating in the Model to use a more traditional MA program network approach.
- HMOs may choose to offer a hospice-specific point of service benefit for enrollees to still have access to out-of-network providers, CMS will require participating MAOs to meet model-specific network adequacy requirements based on aligning with the network adequacy requirements for current specialty types that are not subject to time and distance parameters, whereby there must be at least one Medicare-certified hospice that will provide access to beneficiaries across the entire county of application and provide the full range of covered services.
- This phase-in approach for network adequacy seeks to strike the balance of ensuring enrollees maintain access to hospice care as MAOs develop networks with the incentives for high-quality hospice providers and MAOs to develop relationships and agreements for the provision of hospice care within a service area.
- Over both the short- and long-term, CMS believes developing high-quality hospice provider networks is critical for care coordination and management across the care continuum of palliative care, transitional or concurrent care, and then, for those who choose, hospice care.

In-Network and Out-of-Network Cost Sharing

- Participating MAOs may not charge higher cost sharing for hospice services provided in-network or out-of-network than those levels permitted under Original Medicare.
- As under Original Medicare, an enrollee who has elected hospice has no deductible and is responsible for the following applicable coinsurance amounts, which are relatively small, pursuant to Section 1813 of the Act, 42 U.S.C. § 1395e:
  - 1. Coinsurance on outpatient drugs and biologicals: a coinsurance amount equal to 5 percent of the reasonable cost of the drug or biological to the hospice, but not more than $5, for each prescription furnished on an outpatient basis. The individual is not liable for any coinsurance for hospice-related drugs or biologicals provided while he or she is receiving general inpatient care or respite care. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The drug copayment schedule will be reviewed for reasonableness and approved by CMS; and
  - 2. Coinsurance on inpatient respite care: a coinsurance amount equal to 5 percent of the national Medicare respite care rate, after adjusting the national rate for local wage differences (which is not counted toward the hospital deductible but is limited to the same amount).

In-Network and Out-of-Network Cost Sharing

- No other coinsurance or deductibles may be imposed for hospice services furnished to enrollees during the period of an election, regardless of the setting of the services.
- MAOs must count toward the maximum out-of-pocket (MOOP) limit those amounts the individual enrollee is responsible for.
- Effectively, this means that, for enrollees who elect hospice who have minimal beneficiary cost sharing, the MOOP limit will rarely be reached.
    - MAOs must still track out-of-pocket spending for these enrollees.
- Currently and under the Model component, when MA enrollees get services unrelated to their terminal condition and related conditions from Medicare FFS providers, they are subject to the Original Medicare 20 percent coinsurance.
- Alternatively, an MA enrollee who needs treatment unrelated to the terminal condition and related conditions may choose services through their MA plan at the plan cost-sharing level.

Network Provider Limitations to Ensure Beneficiary Safety

- Beyond the application of the usual limitations on MAOs at 42 CFR §§ 422.222 and 422.224 that prohibit payment to providers on CMS' preclusion list and OIG's exclusion list, subject to CMS approval, participating MAOs may propose to exclude hospice providers that meet any one or more of the following criteria, based on the past three years in which data are available, if the hospice provider:
  - 1. was found through publicly available data or sources to pose a risk for beneficiary harm; and/or
  - 2. consistently has not offered all four levels of hospice care, infrequently provided physician services, or rarely provided care on weekends.

General Payment Requirements

- A participating MAO cannot require prior authorization or implement other utilization management protocols that create inappropriate barriers to medically necessary and time-sensitive hospice care as it relates to hospice election and authorizations for levels of care and changes between levels of hospice care.
- Participating MAOs may implement appropriate program integrity safeguards in line with the MAO's policies and procedures.
- For example, MAOs could implement the following prepayment review policies:
  - A prepayment review strategy to ensure that their out-of-network hospice providers are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D.
  - A prepayment review to address long lengths of stay (for example, greater than 180 days) to assess whether recertification was appropriate.

General Payment Requirements

- CMS will track complaints or other feedback from hospices and MAOs on their experiences working with each other as well as from enrollees or their representatives and caregivers
- Participating MAOs must make timely and reasonable payment to or on behalf of the plan enrollee for services obtained from a provider or supplier that does not contract with the participating MAO to provide services covered by the participating MA plan.

General Payment Requirements

- CMS expects MAOs to include similar timely data submission requirements as outlined in the Medicare Claims Processing Manual within network participation agreement used with hospice providers.
- For example, MAOs may require timely-filed Notices of Election (NOEs) to be filed within five calendar days after the hospice admission date.
- In instances where an NOE is not timely-filed, the MAO may follow processes outlined in the Medicare Claims Processing Manual and not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the MAO.
- Consistent with current policy, any care provided for these days would be a provider liability and the provider could not bill the enrollee for them.

Hospice Capitation Rate Payment

- CMS developed a national monthly hospice capitation rate.
- This rate reflects FFS paid hospice experience for care related to the terminal condition and related conditions during a hospice stay (“Hospice FFS Payment”) and FFS-paid non-hospice experience (“Non-Hospice FFS Payments”), which consists of two parts:
  - (1) FFS-paid non-hospice care provided by non-hospice providers during a hospice stay, and
  - (2) other FFS-paid non-hospice care provided after a hospice stay ends (in the event of a live discharge, including non-hospice care provided on the last day of the stay and through the end of the calendar month that the stay ends) for all Medicare beneficiaries (both enrolled in Original Medicare and MA) who elected hospice.

Hospice Capitation Rate Payment

- CMS followed a standard rate development process, which consisted of three parts:
  - (1) Base data appropriate to the population and benefits being priced (e.g., use of three years of complete data for Hospice and Non-Hospice FFS-paid Part A and Part B claims from CY 2016 to CY 2018);
  - (2) Retrospective adjustments to the base data to adjust the base data for known changes that have occurred since the base data was incurred (e.g., taking into account repricing to reflect FY 2020 per diem payment rates and FY 2020 Hospice Wage Index);
  - (3) Prospective adjustments for changes that are anticipated to occur between the base data incurred period and the period being priced (e.g., trending Hospice and Non-Hospice FFS paid claims from CY 2020 to CY 2021).

CY 2021 Month 1 Base Capitation Payment

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

- For the first month of hospice coverage, MAOs will also receive a capitation payment tied to the number of Month 1 days of hospice enrollment a beneficiary has
- Three different experience adjustments will apply:

Days in Month 1	Base Rate
1 – 6	$1,764
7 – 15	$3,320
16+	$5,291

CY 2021 Months 2+ Base Capitation Payment

- For hospice stays that occur in a second calendar month and on (Months 2+), MAOs will receive a monthly hospice capitation payment, the MA rebate amount, and monthly prescription drug payment, if offering prescription drug coverage

Month 2 and Later	Base Rate
Monthly Capitation	$5,187

Billing MAO Plan

- The same billing practices apply as with Original/Traditional Medicare.
- In addition, the agency will have to bill BOTH the MAO plan AND Traditional Medicare.
- As mentioned earlier, the MAO CANNOT require prior authorization & the MAO plans will have to pay an out of network hospice in 2021 and there will be some capacity for out of network in following years.
- They MUST pay the Traditional Medicare Rates for hospice services.

Hospice FY2021 Final Payment Rates

Code	Description	FY2020 Payment Rates	Wage Index Standardization Factor	FY2021 Payment Update	FY 2021 Payment Rates
656	General Inpatient Care	$1,021.25	0.9999	1.024	$1,046.66
655	Inpatient Respite Care	$450.10	1.0004	1.024	$461.09
652	Continuous Home Care Full rate = 24 hour of care	$1,395.63	1.0004	1.024	$1,432.41 ($ 59.68/hour)

Hospice FY2021 FINAL Payment Rates

Code	Description	FY2020 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY2021 Payment Update	FY 2021 Payment Rates
651	Routine Home Care (days 1-60)	$194.50	1.0002	1.0002	X 1.024	**$199.25**
651	Routine Home Care (days 61+)	$153.72	1.001	1.0004	X 1.024	**$157.49**

Thank you

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Melinda A. Gaboury, COS-C | Chief Executive Officer | healthcareprovidersolutions.com