CY2021 VBID Hospice Benefit Component – November Office Hours

November 10, 2020

MARTINA: Thank you for joining the calendar year 2021 VBID Hospice Benefit November Office Hours webinar. All attendees will be on mute during this presentation, and we're ready to get started. Next slide, please.

Before we move into the content, we wanted to do a quick review of how to submit questions. Questions can be submitted through the Q&A panel on your WebEx screen. You want to select "Q&A," followed by "All Panelists," and then you can type your question and press "Send." The VBID Model Team will read submitted general questions and provide answers.

[00:00:00:49] Please keep in mind that some inquiries may require additional research, and the Model Team will investigate these and reply a little bit later.

So at this time, I'm going to turn this over to Laurie McWright to continue with the presentation content. Thank you.

LAURIE MCWRIGHT: [00:01:11] Thank you, Martina. Hello, and thank you for joining us today. My name is Laurie McWright, and I am the Deputy Director of the Seamless Care Models Group (SCMG), which is responsible for a broad set of integrated care delivery models that focus on increasing value through accountable care and direct contracting organizations, transforming primary care, and improving access to care for beneficiaries with kidney disease while innovating and transforming care in the health plan space. Together, along with other CMS Innovation Center models, we focus on how we can improve the quality of care for the beneficiaries we serve while reducing program cost.

[00:02:10] Our goals for today's session, and with our other office hours and technical support, are to first provide information to the model participant MAOs and hospice providers participating in the model in preparation for the beginning of the model in January 2021. Second, we'd like to give those who are not participating in the model in its first year additional information for their consideration for future years. And third, we'd like to answer questions and make sure that you know about the variety of resources that we have put out or planned to make available, whether you are participating in the model now or considering it in the future.

[00:03:03] Our main goal is the understanding the implications for beneficiaries and making sure that you have the information you need to make the best decisions you can.

[00:03:19] Today, we have designed a short session of some follow-up content based on your questions from the webinar last week. We hope that this material you will find

useful in your preparation for model implementation this January. Generally, we have tried to build on what we shared last week and go into more detail based on the questions that you all gave us. We will then review some questions submitted to us in advance of this session via email or during last week's webinar. And finally, we will turn to questions asked in the live Q&A box that Martina referenced.

[00:04:14] We recognize that we will not get to every question, but we'll do our best to get to as many as we can today. We'll be prioritizing our answers to the most commonly asked questions that we believe will help you all and others the most. If we don't get to your question, we encourage you to submit them to the VBID mailbox as well.

[00:04:44] With me here today, I have colleagues who will be running point on the overview and answer portion of the Q&A, including Sibel Ozcelik, one of the co-model leads for the overall VBID model -- she's also worked in the hospice and palliative care field before joining CMMI; Julia Driessen, who is our VBID model evaluation lead and also has a research background in hospice; and Trudel Pare, who has a health plan background and came to us recently and very happy to have her on our team as well. So as you can see, you're in great hands today.

[00:05:36] If we can go ahead and -- oh, and you know what, I also forgot -- one other person who joined us is Dr. Doug Clarke, who is our medical officer for the Seamless Care Models Group (SCMG), and he has been helping out on all the clinical aspects of the hospice carve-in model and been extremely helpful to have his expertise as well.

[00:06:06] So before we begin, if we could have the next slide. And I just need to put out our general disclaimer that again, our goal here today is for educational purposes and general information, as noted on the slide.

[00:06:32] Okay. Next slide. And so with that, I want to turn it over to Trudel to get us started with an overview about plan participation and the resources available. Thank you.

TRUDEL PARE: [00:06:53] Thanks so much, Laurie. So as many of you know, last week we held a webinar to walk through the most important elements of the calendar year 2021 hospice technical and operational guidance. And during that webinar, we received a lot of questions. Based on the questions we received, we thought it might be helpful to provide you all with a walk-through of the resources on the VBID Model website. So I'm showing that link here, as well as some other key links, and we'll show this again at the end.

[00:07:30] We think that these resources will help to answer some of the questions that you might have, such as around plans, participation, or billing. Okay. So now I'm going to shift, and just want to let everyone know that there might be a little bit of a lag as I pull up the VBID Model website. All right.

[00:08:05] So to get started here, this is the VBID Model website, which is also the home page for the model. As you scroll through the website, you'll see that there are 19 MAOs

participating in the model -- you can see that here. Not all 19 of these MAOs are participating in the hospice benefit component. The VBID Model has a number of different components, including the hospice benefit component, and, more broadly, allows for innovations in Medicare Advantage, providing MAOs with the necessary regulatory flexibilities to deliver on high-value care to beneficiaries that need it the most.

[00:08:51] On this list, only the MAOs that have the asterisk next to them are participating in the hospice benefit component. Now, if you scroll down to the hospice benefit component section, you can find a hyperlink to the hospice provider webpages here. And this is the link right here. Okay. So now you can see the hospice provider benefit overview. These user-friendly webpages provide additional details on the model component for hospice providers. Using this site, you can find a wealth of information.

[00:09:37] On this overview page, we list out the top three things that hospice providers need to know. We list the fact that the model does not permit prior authorization requirements around hospice elections or transitions between levels of hospice care.

[00:10:03] Okay. On the coverage page, you can read about what MAOs must cover under the model. On the billing and payment page, you can review steps to conduct an eligibility check and how to properly bill under the model. The outreach and education page, which you can see here, has a number of different resources, including the hospice technical and operational guidance document that I mentioned and a checklist for hospice providers. We also have an FAQ page, which you can see here, and it has answers to the most frequently asked questions. We'll periodically update this list with additional questions based on webinars and office hours like this one.

[00:11:02] Now, on our last webinar, we received a number of questions specifically related to which plans are participating and how to find the list of participating plans. This is included on the main VBID webpage, as I showed. But on this webpage, you can click on "Participating Plans," which in this takes you to a list of participating organizations and contact information for those plans, which you can see here. Please note that just because an organization is listed as participating does not mean that all of that organization's plans are participating in the model. You should use the list located here -- so this is the link here, and you can see it's downloaded there, and I'll show it in a minute.

[00:11:52] So you can use this page to download that spreadsheet to help identify which plans specifically are participating in the hospice benefit component for calendar year 2021. And now I'm going to switch to show that spreadsheet, so you can see it.

[00:12:13] So this is what the spreadsheet looks like. This list includes all of the plans approved to participate in the hospice benefit component for calendar year 2021. Not all Medicare Advantage plans will be participating; only the ones listed here specifically will offer hospice benefits as part of their benefits packaged for calendar year 2021. This list is only for calendar year 2021; the plans participating may change in calendar year 2022.

In total, there are nine parent organizations offering 53 plan benefit packages across 206 total counties or county equivalents in the U.S. and Puerto Rico.

[00:12:57] You'll see in the spreadsheet that not every county in each impacted state or territory will have a participating plan. And so you can see the county name here and the state name -- the state abbreviation here. You should check to see if the counties that are listed for each state overlap with the area where you provide services. If there is an MAO participating in the service area where you provide care, we encourage you to contact that MAO to ensure that you have all the information you need to submit claims for payment as needed and that you know who to reach out to at that MAO if you have questions on care coordination, payment, or coverage.

[00:13:45] You can contact the MAOs using the information that is listed here in columns K through U. You can see that information here. So this shows hospice network administrative contacts, email and phone number, and then clinical and patient support contacts as well as any other contact information that the plan has provided. There's a point of contact listed -- there are multiple points of contact listed here, but some have also listed their provider services department contact information; you can reach out that way.

[00:14:40] The MAOs will reach out to you, but we'd encourage you to reach out to take this first step towards collaboration. The other key information that I want to point out are the first two columns on the spreadsheet. These are really important. These include the contract and plan benefit package number for each plan. You can see those highlighted in gray here. You'll need this information to match up against any of your patients' MA enrollment information. For now, I'll turn it back over to Sibel to provide an overview of the billings and claims process, another area where we received a number of questions. And as I mentioned before, you may see a little bit of a gray screen here just for a second as I'm getting ready to share the PowerPoint again. All right. I'll turn it over to Sibel.

SIBEL OZCELIK: [00:16:01] Thanks so much, Trudel. So as Trudel mentioned, during our last webinar we received a handful of questions related to the billing and claims process under the model. And so we want to take some time up front to review these steps again here before diving into your questions. And I did see one question about the availability of this slide deck. The slide deck will be made available on the VBID Model website in -- probably closer to mid-to-end of next week. The slides from last week's webinar have been posted, and the recording from last week's webinar will also be posted later this week, once we have the recording and transcript finished. And so, next slide.

[00:16:46] So if you are a hospice provider that has a service area that overlaps with a participating plan service area, you should follow the steps that I'll outline here in the event that you see a Medicare beneficiary enrolled in one of the VBID hospice benefit component participating plan. So on or after January 1, 2021, if you're a hospice provider with an overlapping service area with a participating plan service area, and you see a new patient, you should check -- as a hospice provider, you should check to see if

that patient is part of a plan participating in the model before following the claims and billing procedures that I'll outline here today.

[00:17:25] And the really important point that I want to pause on and stress is that any of the participating plans' enrollees who have a hospice election prior to January 1, 2021 will not be affected by the billing and coverage rules under the model that, you know, we outlined at last week's webinar and again here. Traditional fee-for-service (FFS) Medicare will continue to make payments for those hospice enrollees as in current state. Only for participating plan enrollees with hospice election on or after January 1, 2021, will these new billing and coverage rules apply.

[00:18:01] So in order to properly bill for these patients, hospice providers need to, one, verify Medicare Advantage or MA enrollment -- and the easiest way to do this is by checking your patients' MA membership ID card, as you can see on the screen here. Number two, identify the contract and plan benefits package identification information on the patient's MA membership ID card. As Trudel showed earlier on the spreadsheet, the contract ID will start off with an H number, or -- an H as in Halloween -- followed by four digits. And the plan benefit package ID will follow the contract ID and will be three digits. So it will look something like what's shown here on the slide, the H and the numbers.

[00:18:49] On the other hand, if your patient doesn't have his or her MA membership ID card, and instead hands you his or her Medicare card, you can input information from that card, which is the Medicare Beneficiary Identifier, or the MBI, to look up plan information, leveraging whatever your current Medicare eligibility tool is. And that could be your MAC portal, or Medicare Administrative Contractor, your MAC portal; your MAC Interactive Voice Response system, or MAC IVR; the HIPAA Eligibility Transaction System, more commonly known as HETS; or if you had a billing agency or clearinghouse that you've worked with, as a HETS trading partner, you'll want to check if they also show the contract in PBP or Plan Benefit Package ID number on their plan coverage screen.

[00:19:33] So step three -- next, you'll want to compare that plan information on that tool or that MA membership ID card against the list of participating plans' information as posted on the website by matching up the contact and plan benefit package ID information. Again, as mentioned last week, you don't need to compare counties or any other information; just focus on that H number and the plan benefit package ID information. And step four, if the information matches, you'll want to contact the plan to confirm the eligibility, build that relationship, and, you know, if you have any questions on the billing and claims process then you'll want to ask the plan.

[00:20:16] So next slide. Okay. And once you've confirmed your patient's enrollment in a participating plan, you'll want to submit all our general Medicare notices and claims to both the participating MAO and to your MAC. And this really -- and we'll get into some of these in the questions as well. So this ensures that the MAO can provide timely payment to the hospice provider at original Medicare rates if they're out-of-network and

if they're in-network at whatever rates that they have agreed upon, and that CMS can provide timely and correct payment to the MAO that's participating in the model. Now, if you're an out-of-network hospice provider, you must submit the notice of election to both your MAC and to the MAO. And you should submit them at the same time, with a timely filing window of five days, aligned with current existing process.

[00:21:08] Now, if you're an in-network hospice provider, you may have additional flexibilities around timely filing with the MAO, depending again on your contractual agreement. And for claims, these must also be submitted to your MAC and to the MAO, and they can be submitted at the same time and on the same forms that you used today to submit for payment to your MAC. For out-of-network hospice providers, as long as you've submitted a clean claim, you should receive payment from the MAO within 30 days at least at the original Medicare rates. If you're an in-network provider, again, you may have additional flexibility around the time limits of the patient; it could be much faster, again, based on your contractual agreement. Next slide.

[00:21:55] And much of the information that we've discussed here is also online on the website that Trudel showed earlier. And the content that I just covered is also shown, including the stuff I just walked through -- all the eligibility checks and the billing process dues on our billing and payment page are shown here. Next slide.

[00:22:16] And you can also view this information on the provider checklist, which we just made public yesterday, which we'll also be mailing out to impacted hospice providers or hospice providers that have an overlapping service area with an MA plan service area: that's located right here under -- on the outreach education page. And it shows similar content as what was on the billing and payment page.

[00:22:45] And now we're going to move on to some of the questions that we received during our webinar last week or via email, and then we're going to take some live questions in the chat box, so please start to submit your questions into the Q&A box specifically. Again, we'll answer as many of the commonly asked questions as we can, and if we don't have the opportunity to answer your questions, please follow up with us by reaching out to the VBID mailbox. And we'll also use these questions in the featured FAQ documents on a periodic basis, so please, please, continue to submit your questions. Laurie, I'll turn it over to you to ask us some of the questions that we received last week.

LM: [00:23:29] Thank you, Sibel. Great job. So let's start out with – "do hospice patients elect Medicare Advantage over traditional Medicare, or does Medicare Advantage take the place of traditional Medicare?" Sibel, why don't you take that one?

SO: [00:23:53] Thanks, Laurie. That's a really great question. And perhaps I'll start off with an overview of the MA program or the Medicare Advantage program. So the Medicare Advantage program gives Medicare beneficiaries the option of receiving benefits from private health plans, rather than the traditional fee-for-service Medicare program. Medicare beneficiaries can choose and enroll in MA plans, and enrollment is limited to certain times, such as the annual enrollment period. And all of the MAOs that are

participating in the hospice benefit component are required to follow all existing MA rules that haven't been waived under the model, which means that any beneficiary in a model participating plan has to choose to enroll in that plan, and only in those cases can the MAO participating in the hospice benefit component cover hospice services for that enrollee.

[00:24:45] For all MA plans that are not participating in the model, hospice is not included in the MA benefits package, and is pay by fee-for-service Medicare. And that's what's referred to as the MA or the hospice carve-out, since hospice is carved out of MA.

LM: [00:25:07] Excellent. Thank you, Sibel. Okay, next question. "Has CMS made any decisions about whether this program will be offered in 2022?" Sibel, why don't you take that one as well?

SO: [00:25:24] Thanks, Laurie. So as mentioned earlier, you know, the hospice benefit component and the VBID Model overall is a voluntary model. And so eligible MAOs have to volunteer and be approved by CMS to participate. And so the hospice benefit component is a four-year demo, and we announced this past September that applications will be opened again in 2022. And we aim to release the RFA (Request for Application) later this quarter.

LM: [00:25:56] Excellent. And so Sibel, I assume, you know, the concept of this model going nationwide, meaning -- are all plans participating? As you've described, it is a voluntary model, but, you know, at this point, we have nine plans or MAOs that were selected and approved to participate for the calendar year 2021, with a total of 53 plan benefit packages in limited parts of 13 states and Puerto Rico. We've had lots of interest and questions about '22 and beyond in terms of participation. So that leads us to believe that -- and certainly many people participating in the webinars and the office hours today that are not involved now but are definitely interested in considering for future years.

[00:27:11] Okay. So why don't we take a couple of evaluation-related questions. If, Julia, you would be willing to answer these, I would be grateful. As we said before, Julia's our VBID Model evaluation lead. The first question, Julia, is – "can CMS share what types of metrics will be tracked for evaluation purposes of the model?"

JULIA DRIESSEN: [00:27:46] Yes, sure thing. So to a large extent, we are leaning on the sort of usual cast of characters in the world of sort of hospice metrics, so we'll be looking at things like election rates, and we'll break that out to look at who's electing, where they're electing, and then the timing of that, so that will feed into an analysis of length of stay. We'll also look at live discharges, transfers, revocation rates, visits in the last week of life -- so a slew of variables that capture the experience conditional on electing hospice. We'll be keeping track of unrelated care and other types of utilization post-election.

[00:28:26] And then descriptively, we'll capture some of the upstream aspects and flexibilities of the model by looking at the services that are being provided and what uptake of those looks like.

LM: [00:28:39] Thank you, Julia. So another one asked was, "With regard to the evaluation of beneficiary experience under the VBID Model, will you be adding any additional CAHPS questions to understand these beneficiaries' experience, or will the CAHPS be evaluated against the overall aggregated CAHPS for the agency providing care?"

JD: [00:29:09] Absolutely. So we will be making use of the CAHPS hospice survey in a couple of ways. At this point, we don't anticipate adding questions on to the survey, but we will have that information from hospices at both the level of the beneficiary and then obviously at the agency level. So that will allow kind of a duality in terms of thinking about, on the beneficiary level, sort of attributing overall impact of the model. And then you can imagine being able to use sort of the agency-specific measurements to think about things like in-network and out-of-network and what those networks end up looking like.

LM: [00:29:47] Very helpful. Thank you, Julia. Okay. So another question that came in is, "If I don't see my state listed in the group to date, how quickly will additional states be added?" Trudel, why don't you take that, because you were talking about, you know, participating plans earlier?

TP: [00:30:10] Thank you, Laurie. So the participating plans listed on the VBID Model webpage are the only plans that will be participating for calendar year 2021. We recently announced that we will be accepting applications for additional plans to participate in calendar year 2022, as Sibel just mentioned. So additional states may be added, depending on the MAOs that apply for 2022.

LM: [00:30:40] Thank you, Trudel. Because I think it is really important to reinforce that the -- you know, not all states -- not areas of all the states are involved either. There are pockets throughout the 13 states and Puerto Rico that are covered in the model for this coming year. Okay, so let's move on. "If there is no participating plan in my service area, can I still be impacted by the hospice benefit component of the VBID Model?" Wow, that's a great question. Trudel, why don't I have you answer that one.

TP: [00:31:24] Sure. Thanks, Laurie. So if you're not in the service area of a participating plan, you will likely have little to no impact from the hospice benefit component of the VBID Model for 2021 in comparison to hospice providers providing hospice care in the service areas of participating plans. You don't need to reach out to contract with a participating plan if you don't provide care in that plan services area.

[00:32:53] In the event that a hospice-eligible enrollee travels outside their service area, which could even mean outside his or her home state, and elects hospice care while visiting that state, the plan participating in the hospice benefit component will still cover Part A hospice care that's received by that enrollee at a rate equal to the original Medicare fee-for-service payment for hospice services. It's important to note that enrollees of participating plans can choose any Medicare-certified hospice provider they want, including those that are outside their plan's service area.

[00:32:33] So you should plan to check your patient's Medicare enrollment and coverage and identify whether they are enrolled in a participating plan prior to providing services or billing your Medicare administrative contractor or new patients on or after 1/1/21. And as Sibel mentioned, if you provide hospice services to a patient in a participating plan, you should send all notices and claims both to the participating plan for payment and to the Medicare contractor for informational and operational process and monitoring.

LM: [00:33:11] Thank you, Trudel. Okay, how about this one? This looks like one also for you, Trudel. "Can you tell us the timeframe for the RFA for calendar year 2022? We'd like to reach back out to MAOs in our state and help them guide -- help them on applying." Trudel?

TP: [00:33:36] Sure. Thanks, Laurie. So CMS aims to release the RFA for calendar year 2022 in the next month or two. The timeframe will be similar to last year's, where applications were due in the spring.

LM: [00:33:36] Thank you, Trudel. Next one. "Who handles the appeals process?" Trudel, why don't you take that one as well?

TP: [00:34:06] So the Medicare Advantage appeals process is handled in multiple stages. The first level of appeal is an appeal to the plan. And the appeals and grievances decisions of Medicare Advantage plans are reviewed and audited periodically by CMS. The second level of appeal is an appeal to a Medicare contractor. This contractor can support or reverse the decision of the Medicare Advantage plan.

LM: [00:34:39] Excellent. Okay. How about -- this is a good one. "How do I bill for hospice services under this model?" I'm sorry, Sibel, do you want to take that one?

SO: [00:35:00] Sure. So on -- as I reviewed earlier -- so under the hospice benefit component of the VBID Model, how you as a hospice provider bill depends on whether you have a contract with the participating MA plan or not. So if you have a contract and, you know, you'd be termed an in-network hospice provider, you'd follow the requirements for billing and payment that's agreed to in the contract between you and the participating plan. And if you don't have a contract, otherwise known as, you know, being an out-of-network provider, then you can bill the participating plan in the same way that you bill your MAC, or your Medicare Administrative Contractor, for hospice services.

[00:35:40] And so one thing to note -- regardless of your contractual status, as I had pointed out earlier, you must, must send all of your claims and notices for the enrollees that are in the participating plan to your MAC for informational processing and monitoring. Back to you, Laurie.

LM: [00:36:03] Why don't we -- why don't we build on that one. "What billing requirements do Medicare Advantage plans have?" Sibel, that seems like it would be good for you to take that one as well.

SO: [00:36:17] Thanks, Laurie. So again, it depends on whatever your contractual agreements are. If you're an in-network provider, you need to follow those requirements that are set up between you and the participating plan. And if you don't have a contract, and again, you're an out-of-network provider, then the billing requirements for the participating plan will be the same as the requirements for your MAC for hospice care. And you can find more information on how billing and payment for hospice services work, of course, in the Medicare Claims Processing Manual in Chapter 11.

[00:36:53] And overall, participating plans may have similar requirements for timely submission of notices and the length of time that you have to submit claims, and we really encourage hospice providers to reach out to the MA plans participating in the hospice benefit component to get this level of detail. We've been conducting the outreach as well with the MA plan and hope to put up a resource page where all of the MA plans' billing and guidance is on the VBID Model webpage, so you have it all in one easy place. Laurie?

LM: [00:37:31] Thank you, Sibel. Here's one probably for you, Sibel, as well. "Whom do I contact if I have questions about eligibility and billing?"

SO: [00:37:43] So you'll want to go and use that spreadsheet that Trudel has showed you and contact the participating MA plan with that information to confirm your enrollees' coverage and ask any questions you may have about eligibility and billing.

LM: [00:38:02] Excellent. Thank you. "Have hospice providers expressed concerns surrounding the need to file two claims -- one to the MAC, and one to the MAO? This increases administrative burden and has not been required when working with MAOs for other services." Yeah, Sibel, why don't you take that one? I'm happy to follow up as well.

SO: [00:38:32] Yeah, no, that's a really, really good question. And, you know, we've been hearing this concern from hospice providers as well as hospice EMR vendors. And, you know, for the first year, reporting notices and claims to both CMS and the MA plan allows us at CMS to ensure that there's prompt and appropriate monitoring, which we believe is really critical, given the sensitive nature of hospice care. It also gives MA plans the information that they need to ensure appropriate and timely payments, as well as appropriate tracking of their enrollees to help coordinate care and all of the different services that, you know, we spoke about last week around the hospice supplemental benefits, the transitional concurring care.

[00:39:12] And, you know, we appreciate the input of -- and suggestions to us, and we welcome additional feedback around this on how we can make modifications in future years of the model welcome ideas and innovation here.

LM: [00:39:33] That -- Sibel, great answer. Okay. How about we move to -- "Will the hospice provider be held to a notice-of-election timely submission from the date the

notice of election, or NOE, is submitted to original Medicare and not the Medicare Advantage plan?" Trudel, why don't you take that one?

TP: [00:40:06] Sure. Thanks, Laurie. So the hospice provider will be held to notice of election timely filing requirements for the Medicare contractor, and may be held to notice of election timely filing requirements for the MA plan. You should check with the participating plan, because they may have different requirements.

LM: [00:40:32] Great answer, thank you. Trudel, probably a follow-on question for you: "What method will MA plans use to accept election notices?"

TP: [00:40:47] Great question. Thanks, Laurie. So this is really a question for the participating MAO. If you have one in your area, or otherwise provide care to an enrollee in one of their participating plans, we'll be posting some plan-provided information on our VBID hospice provider webpages that we showed earlier, and -- as it is submitted to us by the MAOs. So you could use that as a resource as well to answer this question.

LM: [00:41:19] Excellent, wow. Another one for you, Trudel. "Can claims and notices be submitted to the MAO and CMS at the same time, or do we need to wait for the Medicare denial before submitting to the MAO?"

TP: [00:41:41] So claims and notices can be submitted to the MAO and CMS at the same time.

LM: [00:41:52] All right, Trudel, stay ready. "Does Medicare have a plan B if payments from MAOs are delayed?"

TP: [00:42:05] Yeah, thanks, Laurie. Okay. So as included in Section 7 of the guidance, and I think Sibel mentioned this earlier, too -- MAOs are required to meet all timely payment regulations and requirements outlined in MA guidance and regulation. And what this means is that all clean claims submitted by an out-of-network provider on original Medicare billing forms must be paid within 30 days. CMS will be monitoring this proactively. We'll also want to hear from hospice providers if timely payments are not being made by MAOs.

LM: [00:42:47] Excellent, thank you. All right, Sibel, get ready. "If a hospice provider has no written agreement, can the hospice provider still provide services to the participating plans' enrollees, but bill the MAO and receive payment at least at the Medicare rate?" Sibel?

SO: [00:43:19] Sorry, Laurie. Okay. So that's correct. So if a hospice provider has no written agreement with the MAO, they're considered to be an out-of-network provider, so they're non-contracted. Participating MAOs must cover the hospice services received by their enrollees at out-of-network -- sorry, at least at original Medicare rates during phase 1 and phase 2 of the model, so during 2021 and 2022.

LM: [00:43:55] All right, great, thank you. That's an important distinction between in-network and out-of-network plans that question gets to. Okay, so, and Sibel, I think this is a good one, a follow-on one for you. "A hospice patient has a Medicare Advantage plan that is participating in VBID -- during open enrollment, the patient chooses a Medicare Advantage plan that does not participate in the VBID model. Who would the hospice provider bill when a patient switches to a Medicare Advantage plan?"

SO: [00:44:44] That's a great question, and I saw another similar one come in a little bit earlier, as to, you know, what happens when a beneficiary changes plans or payers? How is that handled? So if an enrollee switches out of a VBID MA plan, so out of the VBID participating or hospice benefit component participating plan, either during open enrollment or during a special election period, their hospice coverage aligns with the plan that they're actively enrolled with.

[00:45:13] So for example, if a hospice enrollee in a model participating plan covering hospice makes an enrollment request for a non-VBID participating plan, let's just say on December 5 of 2021 for a start date of January 1, 2022, that enrollee's hospice care would continue to be covered by the VBID participating plan until January 1, 2022. After January 1, 2022, existing MA plan rules would apply, given that the enrollee would have switched over to a non-VBID plan, and the enrollee's hospice care would be paid by fee-for-service Medicare in alignment with current existing rules and regulations outside of the model.

LM: [00:46:05] Thank you, Sibel. And, you know, I would point folks to the hospice technical operational guidance document, because we did our best to lay out the different scenarios in which a Medicare Advantage enrollee in a VBID plan that has a hospice carve-in component -- we went through the different scenarios. So that could be a good resource. And definitely if folks want us to, we could go through that in more detail in a future office hour.

[00:46:52] All right, Sibel, I'm going to keep on a trend here within enrollee changes and enrollment changes. "What happens if an enrollee changes during a hospice election, changes plans? Is a new notice of election needed?"

SO: [00:47:15] Yeah, no, that's a great question. And we've received this question also in the VBID mailbox. So if an enrollee changes plans during a hospice election, just as I had previously said, coverage for that enrollee's care depends on whatever his or her current enrollment is. In terms of having to submit a new notice of election, you don't need to submit a new notice of election. You only need to if the enrollee revokes and then re-elects hospice care. And, you know, again, as Laurie had mentioned, I encourage everyone to go take a look at the hospice benefit component technical and operational guidance. We outline the scenarios in Section 3.

[00:47:56] And then, of course, looking at the Medicare Claims Manual and the Policy Manual as well around hospice. Laurie, back to you.

LM: [00:48:12] Excellent, thank you so much. So I think another one also -- sorry, Sibel; this is a good one for you. "If a hospice gets paid by the MAO independently of their claims to Medicare, what will prevent hospices from only billing to the MAO?"

SO: [00:48:36] That's a great question. So CMS and the participating MAOs will be reconciling the hospice data on a quarterly basis. And so we'll be looking at the data that we see through the MACs, and the MAOs will of course be taking a look at that data as well and comparing it against the claims that they have. So if a hospice provider sends claims to an MAO for payment but does not bill CMS, our CMS systems will not be able to appropriately pay the MAO for that hospice enrollee. So given this concern, you know, we've included in the guidance the option for participating MAOs to implement a pre-payment strategy asking hospices who routinely do not submit claims to Medicare to submit their remittance advices or codes from the MACs to the MAO prior to receiving payment.

[00:49:29] So MAOs do have tools, such as, you know, pre-payment or post-payment review, to make sure that this is happening -- that hospice providers are submitting their notices and their claims to Medicare, to their MACs. Laurie, back to you.

LM: [00:49:46] So, Sibel, is it -- yeah. Is it fair to say that the, you know, the quarterly reconciliation data review is a safety net, but what we're trying to do is to provide guidance that says how is a best practice and that it should be handled? Is that a fair way to say that?

SO: [00:50:10] Mm-hmm. Yeah, that's a great way, Laurie.

LM: [00:50:14] All right, good. All right. Next question. Trudel, this looks like a good one for you. "Will we be required to complete the plans' credentialing requirements to see MA patients? Will this be a condition for payment?"

TP: [00:50:35] Sure. Thanks, Laurie. So, no, you don't need to be credentialed with an MAO in order to receive payment out of an out-of-network provider from that MAO. As long as you're a Medicare-certified hospice provider, you only need to submit a clean notice of election and claim in alignment with original Medicare billing methodology.

LM: [00:51:01] That's a great answer, helpful. Thank you. Another one for you, Trudel. "Existing members who remain enrolled --" so, meaning an enrollment-effective date in 2020 -- "in the model participating MAO with the hospice election that are not currently receiving hospice services through original Medicare -- will they continue to receive the hospice benefit through original Medicare?" Trudel?

TP: [00:51:38] Thanks, yeah. This is a great question. So if an enrollee in a participating plan elects hospice prior to January 1, 2021, that hospice enrollee's care continues to be covered by original Medicare or fee-for-service, even after the start of the model. If an enrollee of a participating plan elects hospice on or after January 1, 2021, then they're

covered under the model, and the hospice care will be paid for by their plan -- by the participating plan, rather than by original Medicare. So that's why the election date is really key when you're sort of looking at eligibility for the model.

LM: [00:52:25] Excellent. Yeah, and that's again -- you know, we're going through, trying to get through as many questions as we can -- going to the guidance document, I think it's laid out fairly well in there. Trudel, another one. "How can we find counties --" I'm sorry -- "which counties are participating?" Oh, that's a good question.

TP: [00:52:49] Yeah. So the list that we showed earlier of participating plans, that big Excel sheet -- and that can be found on the VBID provider website under "Participating Plans," as we showed -- it includes county as well as state. So you can use that as a resource to identify if there's a participating plan in your county. And again, please note that not every county in a state with a participating plan will be included in the model, so it's really important to check counties specifically.

LM: [00:53:26] Thank you. Sibel, how about the next question for you. "Will there be a listing of contacts, such as the provider relations department contacts, that hospices can reach out to related to their benefits and payments?"

SO: [00:53:28] Laurie, so the contacts listed on the participating plans page that Trudel has shown, or previewed earlier, are of course the hospice network administrative contact for each plan that's been provided by our model participants. And there might be additional points of contact -- a number of MAOs have listed their provider relations department, and that also can be found in that Excel spreadsheet. If you find any issues with the point of contacts or they're outdated, please don't hesitate to reach out to us so we can outreach to the model participants to ensure that we have the most up-to-date information. And if you're having any troubles reaching out to plans, again, let us know, and we can collect that information and relay it to our partners, our -- the model participants. Laurie, back to you.

LM: [00:54:42] Excellent. Yeah, no, that's a great answer. So we're only going to be able to take just a couple of questions from the chat box. I think many of them have been answered already through the questions we had already received, and I believe my colleague Jane Andrews has been answering a number in the chat box. So we will continue to work with those questions and present more of them in the coming weeks. But one question that's on here that seems really important that I want to get to -- someone asked, "I have a question regarding transitional concurrent care. Is there a recommended timeframe to transition to hospice, such as one month or longer? My thought would be three months but would like to hear other perspectives as well." Sibel, I'm going to ask you to take that question -- I can follow on, but I think just such an important question to be clear on how we think about that.

SO: [00:55:55] Yeah, no, that's a really, really great question. And, you know, I think we -- Doug, Dr. Clarke, has touched on this during our last webinar, and it -- and the way that the model works is that the participating MAOs can develop their strategies around

transitional concurring care with their network providers. And so they're getting feedback from their hospice providers -- and, you know, they might be working with the oncologists, nephrologists, whatnot -- to come up with these strategies around transitional concurrent care. But at a high-level, you know, the guidance that we've put out is that transitional concurrent care, any approach needs to be: A, clinically appropriate for the patient; B, has to reflect the patient and caregivers' needs, most important patients' needs; and, C, has to be well coordinated with the in-network hospice provider and other network treating providers as well.

[00:56:48] And so it really depends -- similar to hospice philosophy -- you know, it depends on a case-by-case basis and what's most appropriate for that patient. And so some MAOs are taking a more, you know, time-limited approach to phasing down on transitional concurrent care as appropriate and in coordination with the patient and the family. Other MAOs are taking, you know, a more targeted approach, in terms of having a specific set of defined conditions and services. So it really depends on the strategy, but most importantly, it depends on the individual. Laurie?

LM: [00:57:27] That's excellent. Thank you so much. And I know we are at time, but if you just want to give -- Dr. Clarke, do you have anything that you would add to what Sibel shared here?

DOUG CLARKE: [00:57:41] No, I think Sibel, as always, covered just about everything. I would re-emphasize the point that -- you know, when I read that question earlier on the one-month versus three-month versus however many months, it can -- I sympathize with that. I think as providers, we like algorithms and we like doing things the right way and looking at the right answer, the right way to do things. But Sibel hit on this, where we're trying to open this up so that, between the plan paying for it, the provider, and most importantly, obviously, the patient and enrollee, really targeting what's important to that provider/patient relationship. And we don't know with any individual patient whether that's going to be or should be one month or three months, but we know that you guys and the patients will figure that out.

LM: [00:58:37] Such a lovely way to end. I'm afraid we have run out of time. I see lots of good questions that continue to come in around billing and claims -- as I say, we'll cull through them and make sure that, if they haven't been answered or if they keep coming in, then, you know, we'll make sure to answer them in future sessions. So with that, I want to thank all of you for your time today and thank all of my colleagues for the hard work to be ready for today's session. Thank you.

END OF AUDIO FILE