CY2021 VBID Hospice Benefit Component – December Office Hours

December 15, 2020

Nate Hoffman:
Thank you for joining the Calendar Year 2021 VBID Hospice Benefit Component December Office Hours. Questions can be submitted through the Q&A panel. Be sure to select all panelists so all today's presenters can see your question. The VBID Model Team will read submitted general questions and provide answers. Some inquiries may require additional research; for those inquiries, the VBID Model Team will investigate them and reply via email. [00:00:38]

At this time, I will turn over the presentation to Laurie McWright, the Deputy Director of CMMI Seamless Care Models Group. Laurie. [00:50:00]

Laurie McWright:
Thank you, Nate, so much. As Nate said, I am Laura McWright and I am the Deputy Director of the Seamless Care Models Group within the CMS Innovation Center, and my group is responsible for a broad set of integrated care delivery models, which focuses on increasing value through the accountable care and direct contracting organizations, transforming primary care, improving access to care for beneficiaries with kidney disease, and innovating in the health plan space. [00:01:25]

So, that's a lot, but we have lots of fun and do incredibly interesting work. Together along with all the other CMS Innovation Center Models, we just in general are focusing on how we can improve quality for beneficiaries we serve while reducing system program costs and of course, cost for beneficiaries. Now today, we have designed a shorter session based on content from questions that we've received that we hope will offer you all some useful background information as you're preparing for implementation. [00:02:05]

And as we look at the calendar, we're rounding the corner a couple of weeks away from Model start, very exciting. So, then we will review some questions that we have received in advance of this session, either via email or that we were unable to get to during our last webinar, and then of course we want to leave time for answering any questions in our live Q&A box here today. We'll of course do our best to get to as many questions as possible. [00:02:41]

We recognize we may not get to everything, but I have staff that are trying to prioritize answers to the questions that are asked most frequently and that we feel like would be the most helpful to the MAOs and hospice providers that are with us today. And please, if we don't get to your question and you're worried that you need a time-sensitive answer, feel free to go ahead and submit that same question to the VBID mailbox as well, and we'll do our best to get you an answer as quickly as possible. [00:03:22]

And now, of course, with any of our technical support, we want to just sort of give the high-level goals that we want to accomplish, and the first is to provide information to all of our Model-participating MAOs and hospice providers in preparation for the beginning of the

model. And for those who are not participating in the Model in this first year, we also aim to provide you all information for planning purposes. [00:03:54]

And finally, we want to make sure that we answer the questions that are out there as much as we can, as I discussed and to point to as many resources, there's a variety out there, to help make participating in the Model now or those considering in the future understand as much as possible and plan for the Model start. [00:04:27]

And so, here with me today I have three colleagues, and two of them will be running point on the overview and the third one answering all the portions of different Qs and As: Sibel Ozcelik, one of the Co-Model Leads for the overall VBID Model; Julia Driessen, the VBID Model Evaluation Lead; and Trudel Pare, a member of the wonderful VBID team who has a business operations and health plan background. Okay, let's see. Next slide. [00:05:10]

And of course, before digging in, we want to put out the disclaimer information that this session is for educational purposes, general information sharing as noted on the slide. Next slide. Next slide. Alright, so before handing it off to Sibel, I just want to acknowledge that I'm really excited to announce that we last week were able to really the 2022 Request for Applications for the Value-Based Insurance Design Model, VBID Model, as well as the Request for Applications for the Hospice Benefit Component of the VBID model. [00:06:03]

And exciting because we were looking to reverse a trend of getting things out in the new year versus the end of the prior year just for planning purposes as much as possible for potential applicants. So, very excited to have that on early in 2021 we will also be opening the online application portal for interested MAOs to submit applications. So, yeah. And of course, we'll continue to provide ongoing implementation support for any of our 2021 participants for hospices and MAOs. [00:06:55]

We're not going away; we're here staying the course with you all. And we're also happy to provide a technical support for folks who were thinking about joining for the calendar year 2022. The application period I believe closes on April 16th as noted here, but don't be strangers. If we can help in any way, we want to make sure that you know that's available, whether you're in the Model currently or thinking about it. [00:07:31]

The other thing I think important to highlight, if you haven't had a chance to review, in the 2022 RFA, we are soliciting specifically feedback and your comments on the sort of network adequacy strategy, which we would begin in 2023. We know that's a big deal on the plan side and on the hospice provider side, and we really want your comments along with questions. You can submit that directly to our team here at VBID@cms.hhs.gov, and that will be on different slides of resources. [00:08:19]

And I think with that exciting news, I want to hand the mic over to Sibel. She's going to talk to you before our Q&A portions about new resources we have for 2021 and go in a little more detail about the thinking on the network adequacy requirements and what kind of questions we'd love you all to think about and as we're thinking through the strategy and we really appreciate sort of feedback from all sectors. So, with that, let's turn it over to Sibel. Thank you. [00:09:02]

Sibel Ozcelik:

Thanks so much, Laurie. Next slide. So, during our last office hours, we walked through a myriad of resources that can be found on the VBID Model and the Hospice Benefit Component pages. And since then, we've added a number of additional resources for MAOs and hospice providers. So, first off, you will be able to find recordings, transcripts, and slides from our last webinar and November Office Hour session on the outreach and education tab of the hospice benefit components webpage. [00:09:37]

The November 2nd webinar provides a general overview of the Technical and Operational Guidance that we released back in the fall. Now, the November Office Hours session provides an in-depth review on how to determine a Medicare beneficiary's eligibly for the Model and billing and claims processing. We'll post the recording, transcript, and slides from today's December Office Hours by the end of next week on that same webpage. [00:10:02]

Second, since November's Office Hours, we worked with our Medicare Administrative Contractors, or MACs, to send out letters with a checklist more than 1,100 hospice providers who have overlapping service areas with participating plans. You can find these letters as well as the checklists online at the links provided on this slide as well as on each of the Home Health and Hospice MAC website. These letters provide key information for hospice providers as they prepare for 2021. [00:10:30]

Third, we have also updated the participating plans tab with additional contact information for participating MAOs. We'll continue to keep that page updated with contact information and MAO-specific resources. For example, on the page now, you can find online webpages that some of the MAOs have actually created to provide additional resources for providers, such as on their operational guidelines, member notification submission information, and details surrounding their billing and claims processing submissions. Next slide. [00:11:03]

Lastly, we're also excited to announce that we made public the 2021 Monitoring Guidelines for the Hospice Benefit Component. The purpose of these guidelines is to provide real time monitoring of the progress of participating MAOs and their in-network and out-of-network providers, in improving access to high-quality hospice care for MA enrollees who elect the hospice benefit. [00:11:25]

At a high-level, the areas and metrics to be monitored build on the 2021 RFA's quality framework and were selected after the most careful review, and with the intent to: protect Medicare beneficiaries enrolled in participating plans, identify opportunities to improve care, and mitigate reporting burden for Model participants and their downstream contracted hospice providers. [00:11:48]

As with all aspects of the Model component, MAO and hospice provider feedback on how to make the monitoring process and measures as effective, efficient, and meaningful is valued, and my team and I look forward to your continued feedback and continued support. Next slide. Now I'll shift focus slightly to cover some content with Trudel before we dive into our Q&A portion of the office hours. [00:12:14]

We've gotten a number of questions related to network design, so I'm going to provide a brief overview of networks, and then Trudel will speak on the structure of out-of-network payments and oversight for 2021. In a big picture under the MA program, generally networks are made up of providers who have contracted with an MA plan to provide services to their

enrollees, and these providers are considered in-network. The providers who don't have a contract with a particular plan are considered out-of-network. [00:12:43]

MAOs and hospice providers can choose to contract together or not, and CMS does not and will not interfere in the contracting process. That said, MAOs must be responsive to hospice providers' outreach to them with request to participate in the hospice network or to enter into a contracting process with the plan. And while MAOs must permit their enrollees with access to any Medicare-certified hospice provider, MAOs are permitted to decline to include a hospice provider or a group of hospice providers in its networks. [00:13:15]

But if an MAO does decline, the MAO must furnish a written notice to the affected provider of the reason for the decision. And overall, and I know we've said this in previous webinars, there are many benefits associated with contracting. For example, in-network providers and plans may negotiate rates that are higher than original Medicare rates, develop more seamless billing and claims processing arrangements, and/or create innovative, value-based arrangements to improve quality of care. [00:13:45]

And under the Model, in-network providers may also work with participating plans to provide additional services with tremendous benefits to their patients, including non-hospice upstream palliative care for enrollees which serious illness, traditional concurrent care, and hospice supplemental benefits. Now I'll go ahead and turn it over to Trudel to provide you all with a brief overview of out-of-network payment rules under the Model. Trudel. [00:14:12]

Trudel Pare:
Thanks so much, Sibel. So, again, my review here only applies to out-of-network providers. If you're an in-network provider, please reach out to the plan that you've contracted with to better understand your contractual arrangements and flexibilities. So, at a high-level and as a reminder, for Calendar Year 2021 and Calendar Year 2022, any Medicare-certified hospice provider, even those who are out of network, can provide general hospice services to hospice enrollees in participating plans. [00:14:50]

And if they do, Medicare-certified hospice providers will receive payment at original Medicare rates. Next slide. You can see that here on the right. MAOs are aware that for out-of-network hospice care, they need to cover the daily per diem rates, including the higher payment rate for the first 60 days of hospice care for Routine Home Care and a reduced payment rate for 61 days and over for Routine Home Care. [00:15:22]

They understand that a service intensity add-on payment may be applicable for services furnished during the last seven days of a patient's life, pending criteria. And that consistent with Medicare Fee-for-Service, out-of-network payments may be made for hospice services provided by a hospice attending physician, nurse practitioner, or physician assistant outside the per diem rate. And payment must be made by the participating plan within 30 days for all clean claims. [00:15:55]

Consistent with Medicare Fee-for-Service, we define clean claim as those with no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment and that otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare. Now, CMS will be monitoring to review for prompt payment. [00:16:21]

And as described in our Monitoring Guidelines in further detail, that we'll be collecting data on the timelines on all hospice claims for services provided to hospice enrollees in the Hospice Benefit Component from in-network and out-of-network providers that meet the definition of clean claims as well as those that do not meet that definition. In terms of utilization review, under the Model, hospice elections and hospice care are not subject to utilization management or prior authorization. [00:16:53]

This means that a participating plan should not require documentation for or review the services, items, and drugs that you provide for hospice care before you provide them. Now that said, MAOs may conduct pre-payment or post-payment review in alignment with existing policy under Original Medicare that MACs use to ensure program integrity. This means that once you submit a claim to the MAO, they may flag it for further review prior to paying it. [00:17:25]

Now, this is intended as a program integrity measure and should not be done on a claim-by-claim basis, but instead in response to some program integrity or beneficiary risk of harm concern that the MAO notices as a trend in a group of claims. Furthermore, these should not be used to create unnecessary burden for hospice providers or impose a barrier to or discourage access to care. For example, an MAO may flag and review claims with a length of stay over 180 days and then ask for supporting documentation regarding the recertification of enrollees. [00:18:06]

Any pre-payment and post-payment review policies that are not aligned with existing CMS guidance for MACs in the Medicare Program Integrity Manual or are not listed in the Calendar Year 2021 VBID Hospice Technical and Operational Guidance must be approved by CMS prior to implementation. And CMS will also be collecting data on all claims subject to pre-payment or post-payment review under the model as part of our monitoring. Okay, so for non-hospice care, and this is really important, plan rules do apply. [00:18:46]

So, what do we mean by non-hospice care? Here, we refer to non-hospice upstream palliative care, so care before a hospice election is made. We also refer to transitional concurrent care, which can only be provided by an in-network provider. Additionally, this refers to care received during a hospice stay that is unrelated to the terminal illness and related conditions and any care post a hospice live discharge. [00:19:17]

So, if a beneficiary has elected hospice and needs non-hospice care unrelated to their terminal illness, he or she could face higher cost-sharing and coverage issues if they seek care from outside the MAO's provider network, as an example. Consequently, it will be important that MAOs and out-of-network hospices work together, communicate and coordinate care in order to minimize the occurrence of this. And this flexibility allows participating plans to really ensure their enrollees receive the most coordinated care possible, which is critically important for hospice beneficiaries. [00:19:56]

Next slide. Thanks. Alright, so now we're going to move on to the Q&A portion of our office hours. 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 question, please follow up with us by reaching out to the VBID mailbox. We'll also use these questions to develop future FAQ documents on a periodic basis. So, please continue to submit your questions. Laurie, turning it back over to you to get us started with some questions. Thank you. [00:20:34]

LM:
Thank you, Trudel. Appreciate it. Okay, so we do have lots of questions, so I was going to divide up just to kind of make it as streamlined as possible for you all, I'm going to ask Sibel to answer a set of questions and then Trudel and Julia. And then if we have questions that come in, we'll definitely get to them at the end and in the mailbox. So, let's go ahead and started out. Sibel, what is utilization management in the context of the Model?

SO:
Okay so, as Trudel shared earlier, under the Model, utilization management is not allowed for hospice care. But in general, outside of the Model, utilization management is a set of tools that's often used by Medicare Advantage, or MA, plans to review the services and the supplies that are being provided to the enrollees for quality assurance and clinical appropriateness. [00:21:47]

One example of that would be prior authorizations where a plan requires providers submit a request to provide certain services to an enrollee before providing those services in order to ensure that the services are medically necessary and aligned with the plan rules. But again, this is not allowed under the Model as it relates to hospice care, given the sensitivities around hospice care, the nature of that care. [00:22:17]

LM:
Thank you, Sibel. Okay, here's a question on rates, which I think will be really helpful for people. Sibel, is there any guidance on rates of reimbursement for in-network hospice providers? For example, are the rates subject to negotiation? Are providers paid at the prevailing Medicare rates like an out-of-network provider, or can it be a lower rate?

SO:
So, the reimbursement rate for an in-network hospice provider is determined based upon the agreed upon contract between that provider and the participating plan. The rate paid to that provider could be aligned with Original Medicare rates or could not be. And again, that's depending on the contract arrangements between the provider and the plan; CMS is not allowed to engage in or influence those negotiations. Back to you, Laurie.

LM:
Yeah, thank you Sibel. So, the general idea there is not designed to disadvantage either party. But with that said, we look to the plans and hospice providers to negotiate what works for both parties. Okay. Will there be any gain or risk sharing for in-network providers based on quality metrics or other metrics? That's a nice follow-on.

SO:
Yeah. This, similarly, it depends on your contract and relationship with the participating plan. And network providers could work with participating plans to develop some sort of gain or risk sharing agreement that center around quality metrics. And the Model does provide flexibilities and opportunities for hospice providers to build those kinds of relationships with MAOs that are participating under the Model. So, we'll just have to see what comes out of the Model, but again, it all depends on those relationships and the contractual arrangement. CMS is not involved in that process.

LM:

Yeah. Thank you, Sibel. So, this next one is about sort of a phased approach for the network strategy. Can beneficiaries go to any hospice and the MA plan need to coordinate with all hospices?

SO:
Yes, beneficiaries may elect and choose any Medicare-certified hospice provider. We also saw a question regarding why MAOs may want to collaborate with smaller, community-based organizations. MAOs might want to work with hospices that are smaller, community-based, or larger and community-based. It really depends on whether the hospice can demonstrate that one, they are providing high-quality care, two, understand it might be really important that the provider themselves understand and demonstrate the understand local community patterns of care, the availability, social services for example that will be really meaningful for hospice enrollees, and three, that they lead in innovation outside of their hospice care and upstream non-hospice palliative care in managing serious illness. [00:25:34]

And then the incentive through such a partnership for MAOs is being able to reduce unwanted, unneeded services and hospitalizations and most importantly, being able to improve member experience and satisfaction by increasing access to high-quality care. So, it's really dependent on some of those characteristics. MAOs may seek to look at other quality metrics of course as well, but I think yes. Laurie, back to you. [00:26:03]

LM:
Yeah, that's great. So, as a sort of bottom line, Sibel, in this area in the sort of initial phases of the model, enrollees of a participating plan can go to any Medicare-certified hospice and the plan must provide payment at 100 percent of the Original Medicare rate to that hospice. And until we work through with you all the network strategy in later years of the Model, that will remain true. Great, okay. So, a little on the timing. So, MAOs are required to work with out-of-network providers during Phase 1 and 2 of the Model, so initial couple of years. What about Phase 3? How might it work then?

SO:
So, the earliest that Phase 3 would be implemented is in 2023. That said, as Laurie had spoken about earlier, we are seeking comment on network design and the definition of network adequacy standards for Phase 3. And we want to hear from all of you on this webinar and others around whether one, a minimum hospice provider ratio is the most appropriate metric or if there's a more appropriate access metric, two, how to develop the minimum hospice provider ratios in each county or service area, three, how the quality and types of care a hospice provider traditionally has provided should apply in setting some sort of network adequacy requirements, and four, considerations for continuing to allow for broad access. [00:27:51]

And this is all outlined in the 2022 RFA, as Laurie had mentioned, where we do have sort of the comment solicitation around network adequacy requirements. And if you have comments or thoughts on these areas or other pieces of network design, we really appreciate and welcome your feedback. And please do submit those to us via our VBID Model inbox. [00:28:14]

LM:
Excellent. Yeah, thank you for the detail there. We'll be sort of broken records with you all until we have good line of sight to how we think best to move forward. Okay. The next

question: Do MAOs need to include out-of-network hospice providers in their provider directory? I think we've gotten this question fairly often.

SO:
Yeah, no, this is a good question. So, MAOs do not have to include out-of-network hospice providers in their provider directory, but as described in Section 4 of the 2021 Technical and Operational Guidance and required by current unwaived MA regulation, plans do have to inform enrollees that they have an out-of-network hospice option.

LM:
Excellent. Yeah, and just what we mean by unwaived, just meaning as a part of the Model, we and our authorities for the Innovation Center, we waive portions of the statute of regulations to conduct our Model test. And so, this was not a piece waived. Okay, so next: For 2021, how is CMS ensuring that MAOs are actually mentioning to enrollees that they can select an out-of-network hospice provider? I think this is probably one of the most important questions we could answer in terms of any protection available. Sibel.

SO:
Yeah, no, it's a good question. And again, it's in the regulation as well as in all the guidance that we've put out that plans do have to inform enrollees of their option to choose an out-of-network provider, and we'll be monitoring patterns of care and beneficiary and provider complaints closely. And again, I encourage all of you to take a look at the 2021 Monitoring Guidelines and provide us with feedback if you think that there are other things that we could be doing. But we feel that we've captured a really robust set of monitoring measures to be able to really ensure that this happens for example.

LM:
Excellent. Yep, thank you. Good answer. Okay, so a little looking forward. If an MAO is approved for the VBID Model Hospice Benefit Component in '21, so the first year, and wants to participate in '22, do they have to reapply?

SO:
So, MAOs that participate in '21 will have to reapply to participate for 2022.

LM:
Excellent. Okay, and then follow on: Are plans permitted to require authorization for service in the first two years of the program? So, in other words, if you're a hospice in-network, would they be permitted to require prior authorization? Another huge beneficiary question. Sibel.

SO:
So, regardless of a hospice provider's network status, meaning regardless of whether you're in-network or out-of-network, participating plans may not have prior authorization requirements for hospice elections or for hospice care in the first two years of the Model. And we'll review again as part of our comment solicitation whether it makes sense for Phase 3 or that third year of the Model. Participating plans may only use pre-payment and post-payment review on hospice claims to help ensure program integrity and beneficiary quality of care. [0032:04]

On the other hand, for non-hospice care, as Trudel had defined a little bit earlier, plans may have prior authorization requirements and that includes for non-hospice upstream palliative care, so before someone has elected hospice, or transitional concurrent care, which could only be provided through in-network providers and for unrelated care during the time that someone's in hospice or post a live discharge from hospice care. [00:32:34]

And we encourage you all to check with the participating plan to understand the rules. If you're an in-network provider you might not have any prior authorization requirements. But again, check with the plan to confirm and understand the rules and work together here. [00:32:51]

LM:
Excellent, okay. Thank you, Sibel. That's a great summary and a lot of information there. Okay, if a product or a service is not related to the hospice prognosis, are these claims to be billed out separately to the MAO? Sibel.

SO:
Yeah, so if you're out-of-network with a participating plan, you should bill the plan as you would bill Original Medicare, including billing the MAO separately for unrelated care. However, again, we have to reiterate this, that plan rules may apply for unrelated care so you may have to submit for prior authorization. [00:33:38]

And if you're in-network with the plan, you should review your contract with the participating plan and discuss any questions that you have with them, as there may be separate billing processes for in-network providers. So again, really important to communicate with the plan to really understand what the plan rules are, what the billing and claims processing procedures are. Back to you, Laurie. [00:34:03]

LM:
Yeah, thank you. So, these next couple of weeks are critical so everybody's ready to go on January 1 in terms of the claims and billing aspects for sure. Okay, this is a good one. Will room and board payments also be processed through the MAO? Sibel.

SO:
Yeah, that is a good question, and we've gotten this a few times. So, hospice room and board charges for beneficiaries are not today payed by Original Medicare, except for inpatient care and up to five days of respite care, as applicable of course. And outside those circumstances, room and board charges while a beneficiary is in hospice care are the responsibility of the beneficiary or if that patient qualifies for Medicaid, the state Medicaid agency. [00:34:58]

And that's still the case under the Model, we're not changing anything there. That said, participating MAOs do have the option to voluntarily cover additional services or items. And we've spoken a little bit about this, and those are the hospice supplemental benefits. Each MAO may have different hospice supplemental benefits and if approved as part of their application and they propose this, they could for example include and cover room and board for hospice enrollees. So again, it depends on the MAO and what they're offering as the hospice supplemental benefits. So, we do encourage you to check them out as well. [00:35:37]

LM:

Yeah, that's really I think an important clarification, Sibel, because it's a little confusing in the sense that there's a small number of days for respite care that would be covered. But then generally speaking, it's not covered as a part of the base benefit but depending on the particular plan that an MAO is offering, it's possible that it would be through a hospice supplemental benefit package. So, that's a lot of pieces there. So, thank you. Alright, so I think a final question for you: Is there any cap risk involved with participating in this program? So, financial cap. Sibel.

SO:
Yeah, yeah, that's a good question we've also gotten a few times. And this is outlined, again, in the 2021 Technical Guidance documents. Payments made to hospice providers by participating plans for care provided to plan's enrollees, so the Medicare Advantages enrollees do not count towards the Medicare Fee-for-Service inpatient or aggregate hospice cap calculations for hospice providers. That said, as aligned with our Monitoring Guidelines, we'll be very closely monitoring length of stay in hospice overall and in GIP-level care as part of our robust monitoring. Thanks, Laurie.

LM:
Excellent. Okay. Thank you so much, Sibel. Now, Trudel, I'm going to put you on the hot seat for the next set of questions if that's okay. First one: What happens to patients that were admitted before January 2021 and are beneficiaries of a participating MAO plan in the Model? Will we have to bill the plan? So, from a hospice perspective, if you have an enrollee that's in a VBID hospice plan before January 1st, 2021, how is that handled? Trudel, could you help answer that?

TP:
Sure. Thanks, Laurie. So, for patients that are enrolled in a plan participating in the Hospice Benefit Component who elected hospice prior to January 1st, 2021, so anytime this month, for example, December 2020, you should continue to bill your MAC as you do currently. The Model is applicable to enrollees who have a hospital election on or after January 1st, 2021 and are enrolled in a participating plan.

LM:
That's great, thank you. Great clarification. Okay, we're on a roll. With plans in the participating model, we are to submit the notices of elections within five days to both Medicare and the participating plan as well as submit claims to them. Is that correct? Trudel.

TP:
Yes, this is correct. So, you should confirm with the participating plan. They have the option to require an NOE submission within five days in alignment with Original Medicare, but they may opt not to enforce this requirement or may have different requirements for in-network providers. Again, you should reach out to the participating plan if you haven't already heard from them.

LM:
Yeah, because this'll make it much clearer when you get your first enrollee who elects to get care in your hospice for sure to have that looked through and understand those requirements for your local plans. Okay. Did I hear correctly that in-network providers do need to submit claims and election notices to Original Medicare? Trudel.

TP:
Thanks, Laurie. So, a good one to confirm. So, all providers regardless of network status, must submit claims to their MAC for patients enrolled in participating plans. However, if you're in-network, the plan may have different rules for claims submission. For example, as we were sort of talking about just a second ago, they may not require you to submit the NOE within five days or they may have an online portal that makes submitting your claims easier. So, you should work the participating plans in your area and review any contracts that you may have.

LM:
Yeah, because that kind of information is likely to be in there if you weren't aware of that piece before signing; I would guess those kinds of details are in there. Excellent. Okay. How does a provider know what the process is for claims and notice of elections submission if they are out of network? And this is definitely a good question to clarify. Trudel.

TP:
Absolutely, thanks Laurie. So, if you're out-of-network and there is a participating plan in your area, the plan should reach out to you to provide you with this information. We also encourage you to reach out with any questions that you have. This should provide you with the information that you need on claims and notice of election submissions in case you get a patient in a participating plan. [00:41:35]

Now, if you don't have a participating plan in your area, we'd still encourage you to check MA eligibility on patients from out of your service area or out-of-state who are travelling and receive care from you. If you see that an enrollee is part of a participating plan, you should plan to reach out to the plan to get information on how to submit your NOE and claims for that patient then. [00:42:00]

LM:
That's a great clarification and we, I believe last office hours and on the webinar, our webinar gave a lot of information on how the eligibility check can be done and I think as Sibel mentioned earlier, hospice providers in the MAO service areas have received information via mail from us on that. So, if that's not clear to you, kind of that piece, please email the VBID mailbox and be in touch with us. [00:42:42]

And we're happy to help you problem-solve around that prior to January because that's a really important piece to make sure that you have that ability for yourselves as hospice providers. So, okay. Next: How will participating plans handle Service Intensity Add-on payments for the month prior to a patient's death? Currently, Medicare MACs automatically adjust those claims. Now, that's a detailed question, but I think an important one. Trudel, can you shed light on that? [00:43:30]

TP:
Sure. So, all plans in the Model are aware of the requirement to make payments to out-of-network providers as Original Medicare would make them, including these Service Intensity Add-on payments. Now, if you're an in-network provider, this should be outlined in your discussions with the plan. And so again, we'd encourage you to talk to the plan.

LM:

Excellent. Okay, thank you. And another sort of important clarification: Our hospices use CMS' direct data entry for election notices. Will plans get election notice data from doing their direct data entry? Trudel.

TP:
Yeah, great question. So, you should plan to send your notice of elections to the plan directly. And there is a 22-to-23-day lag between when you submit the NOE to your MAC and when that NOE reaches the plans through various CMS systems. So, in order to effectively coordinate care, the MAOs need to have this information from you directly a little bit sooner. And so, you should contact the plan, again, to confirm how this information should be submitted.

LM:
Yeah, thank you. Thank you, Trudel. I mean, we at CMS through our MACs want that information for monitoring and tracking, but a direct connection for managing care and supporting the hospice election is really critical. Okay. One on eligibility, I think important. Will the HETS eligibility that reflects enrollment in MAOs show the designation of a VBID contract model? That's such an important question. Trudel.

TP:
Yeah, absolutely. So, the HETS transaction will only show if the patient is enrolled in a Medicare Advantage plan and provide you with identifying information, the contract and PBP numbers, for that plan. You should compare this information with the list of participating plans located on the VBID Model webpage. So that list of participating plans, we also showed in our office hours last month. So, another helpful resource there, which is also on the webpages on the website.

LM:
Also, isn't that the participating plans for hospices in their local areas, that information was also sent to them as well I believe, right? So, you could also match with what you received I believe as well. Okay.

TP:
That's a good point.

LM:
I'm sorry, Trudel, say again?

TP:
Oh, I was just agreeing, yes. It's a great point, thanks Laurie.

LM:
Yeah, sure. Okay. So, a patient could move and get hospice care in a new state that is now out-of-network, even if they were in-network at the beginning? Oh, that's a good one, a good question, yes. Trudel, you want to clarify?

TP:
Yeah, thanks. And that's right, the network status of a patient's care depends on the provider from which they receive that care. So, if the provider is in-network with the patient's plan, then the care received is considered in-network care, and if the provider is out-of-network

with the patient's plan, then the care received is considered out-of-network care. So, Laurie, back to you.

LM:
Sure. Okay. This is another really helpful one I think. Can you clarify the intent of the participating plans' communication requirement? Trudel.

TP:
Yeah, yeah, absolutely. So, there is a requirement within the Calendar Year 2021 VBID Hospice Technical and Operational Guidance that participating plans communicate their participation to hospice providers in their area, which we've been mentioning throughout. Now, this requirement is intended to help inform hospice providers in the impacted areas. While CMS has provided online resources and mailed letters as we described earlier, we know that the participating plans know their service areas and their own operations best. [00:48:34]

And so, this communication to both in- and out-of-network providers can really help establish working relationships and raise awareness about the Model and the plans' participation. And if you haven't received communication, you should receive communication in the near future as we know the MAOs are really diligently working on these. So, Laurie, back to you. [00:48:58]

LM:
Yeah, we really appreciate that. And if you're really concerned about if you haven't received any kind of communication, you can let us know, make sure the contacts are right, etcetera. But you can also try doing it directly as well. Okay, so another question: I am a hospice provider and I've reached out to the local MAO for my county and have not heard anything back. So, to this point, what should I do? Trudel.

TP:
Yeah, so I think this is a really great question and Laurie, I think you really hit it with what you just said for sure. So, I'll just add on a little bit. So, each of the MAOs has several points of contact listed on the webpage. So, as Laurie mentioned, you may want to check to confirm you're reaching out to the right point of contact for the particular question that you have. So, for example, a claims and billing question should go to a claims and billing or to a hospice network contact. [00:50:12]

Some of these contacts also have been updated since being posted as well, so you could check back to see if there's a new point of contact. If a week or two has gone by and you've not received a response or any outreach from the participating MAO, as Laurie mentioned, please let us know. You can reach out to us through the VBID mailbox at VBID@cms.hhs.gov. And what we can do on our end is conduct outreach to the MAO to make them aware of the outreach and to make sure that we have the right contact information up on the website. So, yeah. I think that's it. Back to you, Laurie. [00:50:57]

LM:
Yeah, that's great, Trudel. And because we're not in October/November anymore, it's December, and so we're thinking that most everyone should have heard. And for those that haven't, anything we can do to be helpful; we want to do that. Okay, what date do the MA

plans have to communicate to hospice providers in their area? So, follow on good next steps there. Trudel.

TP:
So, MAOs were likely wrapping up their contracting for 2021 in November/December and will conduct outreach to out-of-network hospices now if they haven't done so. Participating MAOs will likely finish conducting outreach by winter 2021, and we've communicated to Model participants that they may want to try to communicate to hospice providers as early as possible in order to allow providers time to prepare for the beginning of the Model.

LM:
That's fair. Okay, next: Are hospice providers' comprehensive assessments to change for transitional/concurrent care services? This is a good question. Trudel.

TP:
Yeah, so to clarify, transitional concurrent care services should only be provided by in-network providers. So, if you're not in-network with a plan, your process for providing comprehensive assessments and building a plan of care should not change. Now, if a hospice provider is in-network with a participating plan and is providing transitional concurrent care, this should be included in the hospice provider's initial assessment for a hospice enrollee and then routinely updated as part of your patient's plan of care.

LM:
Excellent. Okay. Do all aspects of the Explanation of Benefits, Addendums and Hospice Conditions of Participation remain the same? Love this question. Yep, so, Trudel.

TP:
Yeah. So, the hospice provider Conditions of Participation for Medicare remain the same under the Model. The hospice election statement and existing addenda for hospice care are not changed by the Model. However, in our guidance we communicate that participating plans could work with their in-network hospice providers to consider adding a separate addendum to the hospice election statement detailing services, items, and drugs that the enrollee may receive as part of their transitional concurrent care. [00:53:52]

Under the Model, the Medicare Advantage plan should only provide enrollees with an Explanation of Benefits if there's claims activity to report and enrollees have financial liability for these claims. [00:54:06]

LM:
Excellent. Okay, so want to get to as many of our Qs and As today. Thank you to Trudel and Sibel for answering many questions that we received through other channels but do want to try to at least a few of the current ones from this session. So, when will slides and the transcript be available? Generally speaking, very soon. If people have a time particular, but I know we'll work to get it out as soon as possible. [00:54:47]

Are the current MAOs still accepting provider network contracts? And I think, Trudel, you did a nice answer on that where they're probably finishing up now or done. But I think the quicker you can be in contact, the better on that front. And the next question is a great one: What is the deadline for providing feedback on network requirements? I don't know that we

have a deadline in mind right now, but we absolutely look forward to hearing from you in the near future. [00:55:34]

We anticipate in the coming year that we will set up some sort of more structured feedback sessions, perhaps put out some questions built off of the information in the RFA to kind of guide discussions and make sure that we're able to hear from all of you that are interested. So, Sibel, do you want to take the question on if we have anything to say about if you're reapplying for '22 and in case there's a change in their staff, how would that work? [00:56:50]

SO:
The 2022 RFA has the application questions listed in Appendix B. They're pretty much the same application questions that we had asked last year with a few additions. We'll be making the application portal live by February 1st, and that'll include details about the application questions as well as the financial application similar to last year. So, all of that will be coming out soon.

LM:
Okay, and one last question. I know we're at the top of the hour, but I think so important. Are we saying palliative the care is automatically considered out-of-network, or is just for providers considered out-of-network? And absolutely not, I mean, palliative care is an essential element of the Hospice Benefit Component. And I think it's a more nuanced discussion than we have time for today depending on what kind of benefits, if palliative care can occur before, during the hospice benefit election. So, okay, with that, I think we need to sign off. Thank you. We have a set of resources that we'll be posting, and we will look forward to continued conversations. Thank you.

END OF AUDIO FILE