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HOW TO USE THE VBID MODEL

for Hospice and Palliative Care

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To be considered as a participant in the Value-Based Insurance Design (VBID) Model, Medicare Advantage Organizations (MAO) must include in their application how hospice, palliative and transitional/concurrent care will be provided, as well as the hospice-specific supplemental benefits they provide to member patients. These factors position hospice providers as the partner that MAOs need to apply and participate in the Hospice VBID model. According to the Centers for Medicare and Medicaid Services, the 2023 VBID Model includes 52 MAOs in 49 states, the District of Columbia and Puerto Rico. Approximately six million Medicare beneficiaries have opted into Medicare Advantage membership with one of the 52 MAOs. Affecting hospice providers and patients, these numbers are expected to grow in 2024.

The Hospice VBID model is designed to test how MAOs can improve hospice care through strengthened care coordination, collaboration and transparency while achieving the over-arching VBID goals of reducing expenditures, enhancing the quality of care while lowering costs for Medicare Advantage enrollees. CMS provides extensive guidance for the MAOs that are participating in the model. To be a successful provider, hospices must understand the guidance provided to MAOs and use it to develop and leverage a strategy to ensure the continuance of high-quality care and payment for the services provided. To be successful, this strategy must include coordination of care reporting, as well as claims management.

Coordination of Care

Coordination of care, including care plan oversight, with an MAO is vital to the hospice's partnership status. Becoming a preferred provider for an MAO requires hospices to be agile and innovative in their processes of patient care, which includes transitional concurrent care and supplemental benefits.

Transitional concurrent care is designed to enable hospice-eligible patients to continue curative treatment and therapies while they transition to hospice to alleviate the stress and anxiety of ceasing treatments. In compliance with the Hospice Conditions of Participation § 418.56 (e)(5), the hospice must, on an ongoing basis, share information with the MAO providers participating in the patient's concurrent care and members of the IDG. The patient's plan of care should include the concurrent care and it is important to document the required care coordination for each patient encounter.

Supplemental benefits provided by the MAO should be assessed at the time of admission and throughout the process of care. Problems identified should be included in the patient's plan of care to include the supplemental benefit as an intervention.

Claim based supplemental services include:

- Home and bathroom safety devices/modifications
- Over the counter (OTC) benefits (unrelated to the hospice diagnosis and related conditions)
- Support for caregivers
- Meals
- Transportation
- Pest control
- Room and board (outside of the Medicaid Room and Board benefit)
- Other

Data Analytics

To strengthen hospice organizations' partnerships with MAOs, alignment with the CMS required MAO reporting is paramount. Much of the data obtained by the MAO is claim-based but should also be measured by the hospice to ensure accuracy and to measure the quality of care expected by the MAO. Hospices should focus on the beneficiary level, data collection and reporting that includes the domains required by the MAO

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MAO Reporting Requirement	Suggested Activities
Palliative Care and Goals of Care Experience	
• Development of Advance Care Plans	• Document shared patients' advance directive preferences, Advance Directive, No Advance Directive or Full Code, and reflected the preference in the patient's chart and plan of care

• Access to, and use of, Palliative Care	• Diversify services offered to include palliative care.
	  • Partner with advance care practitioner(s).
	  • Establish a palliative care line of service.

• Proportion of Enrollees Admitted to Hospice for less than seven days	• Participate in MAOs' advance care planning initiatives. • Establish relationships with transitional care providers (i.e., oncologists, pulmonologists and dialysis centers). • Provide transitional care education to the hospice team.
Enrollee Experience and Care Coordination at the End of Life	
• Days Spent at Home in the Last Six Months of Life	• Optimize comprehensive assessments to identify spiritual and psychosocial symptoms and pain in addition to physical pain to identify hospitalization risk factors. • Coordinate with MAO to identify supplemental benefits that support the patient in their home. • Maximize skilled nursing, psychosocial and spiritual assessments by increasing visit frequencies.
• Proportion Admitted to the Intensive Care Unit in the Last Days of Life	• Ensure availability of Continuous Home Care and General Inpatient levels of care
Hospice Care Quality and Utilization	
• Pre-Hospice Consultation Process	• Provide 24-hours a day telephone access to experienced clinicians for consultations. • Provide in-person consultations. • Provide communication training for the team to ensure clear and culturally competent education about the hospice benefit and the patients' right to choose.
• Proportion of Lengths of Stay beyond 180 Days	• Begin discharge planning at the time of admission.
• Visits in the Last Days of Life • Transitions from Hospice Care Followed by Acute Care or Death	• Reporting based on Hospice Quality Report Program's Visits in the Last Days of Life and Hospice Care Index Measures • Leverage existing reporting and analytics

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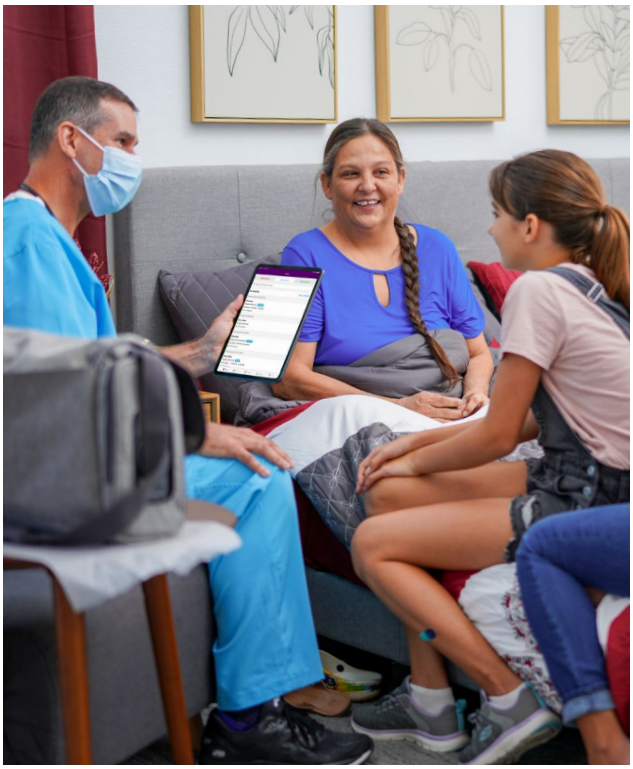
Claims Management

Hospice eligible patients who are enrolled in an MAO retain the right to choose the hospice that provides their care including hospices that are not contracted with the patient's MAO. This provides unique challenges for the non-contracted hospice that, if not addressed, will impact the hospice's accounts receivable.

Eligibility

At the time of referral, the Medicare beneficiary's eligibility should be checked, in addition to identifying the prior or current hospice, to identify if the beneficiary is a member of an MAO. If the beneficiary's Medicare card or MAO membership card is not available, this information can be accessed using online tools and resources or in partnership with the hospice's electronic medical record.



MAO eligibility information includes:

- Patient participation in a MAO plan currently or in the past
- Medicare Advantage Contract Number
- Plan benefit identification information

When MAO membership is identified, the hospice should leverage their process to contact the MAO to confirm past or current membership. When membership is verified, hospice providers should partner with the MAO to ensure compliant coordination of care as well as claims processing.

Claims

MAO contracted and non-contracted hospices will follow multiple steps to ensure that payment for services provided is timely. Non-contracted hospices must submit original Medicare claims to the MAO and be reimbursed according to the Medicare hospice rate for the level(s) of care provided.

Claim Type	Submit to	Notes
Notice of Election	Medicare Advantage Organization and Medicare Administrative Contractor	Within five days of admission
Continuing (contracted with MAO)	Medicare Administrative Contractor	CMS information and data collection
Continuing (not contracted with MAO)	Medicare Administrative Contractor and Medicare Advantage Organization	
Notice of Termination or Revocation	Medicare Administrative Contractor and Medicare Advantage Organization	Within five days of discharge

Contracted hospice providers submitting claims to the Medicare Administrative Contractor should, for each patient that is a member of an MAO, expect to see the following on codes on the Remittance Advice.

- Claim Adjustment Reason Code 96: Non-covered charges.
- Remittance Advice Code MA73: Information remittance associated with a Medicare demonstration. No payment issued under Fee-for-Service Medicare as patient has elected managed care.
- Group code Contractual Obligation: MAOs participating in the VBID model's hospice benefit component will be responsible for coverage of the above services.

The Hospice VBID model was created to see how MAOs can improve hospice care. With CMS providing guidance for MAOs participating in the model, it makes the most sense to these organizations to get involved. To be a successful provider, hospices remember to work with MAOs and understand the guidance provided to them from CMS in order to develop a strategy where all parties can win.

About the Author

Zaundra Ellis is the Vice President of Hospice Professional Services for Axxess. She leverages her many years of expertise in the hospice industry to create a software solution that is easy to use and allows clients to be clinically, administratively and financially compliant. Prior to joining Axxess, Zaundra served as the Executive Director for Kindred Hospice and Heart to Heart hospice organizations across Texas. In this role, she oversaw a hospice house, created and implemented a companywide QAPI program for an organization that served more than 2,500 patients, and used her experience to create operations that improved compliance and maximized reimbursements.

About Axxess

Axxess is the leading technology innovator for healthcare at home, focused on solving the most complex industry challenges. Trusted by more than 9,000 organizations that serve more than 3 million patients worldwide, Axxess offers a complete suite of easy-to-use software solutions that empower home health, home care, hospice, and palliative providers to make healthcare in the home human again. The company's collaborative culture focused on innovation and excellence is recognized nationally as a "Best Place to Work."