Value-based Insurance Design (V-BID) Model

Incorporation of the Medicare Hospice Benefit into Medicare Advantage

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NPHI
National Partnership for Hospice Innovation
The not-for-profit voice for advanced illness, hospice, and palliative care

A partnership of community-based non-profit, hospice, palliative, and advanced illness care providers.

Presentation Overview

- **NPHI Overview**
- **Background**
  - Medicare Hospice Benefit
  - Brief history of the "carve-out"
  - V-BID Model (general)
- **Hospice Carve-in Model**
- **Future Considerations**

About NPHI

- The National Partnership for Hospice Innovation (NPHI) is the national voice for community-based, non-profit hospice, palliative care, and advanced illness providers across the country focused on the highest quality, person and family-centered, end-of-life care.

- Our membership includes over 70 members across 30 states serving approximately 32,000 hospice patients on a daily basis.

Background: Medicare Hospice Benefit (MHB)

- Patients are eligible for the benefit if they are certified as having a terminal prognosis with a life expectancy of 6 months or less
- 50% of all Medicare decedents (1.5 million) used hospice in 2017 with an average length of stay of 89 days and median length of stay of 18 days
- Hospices are paid a per-patient daily rate based on the level of care they provide
- Four different levels of care offered through an interdisciplinary team (IDT) distinguished by intensity and location of services:
  - Routine home care (RHC) (98% of all hospice days)
  - Continuous home care (CHC)
  - Inpatient respite care (IRC)
  - General inpatient care (GIP)

Background: Hospice Benefit Carve-Out

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) first established the hospice benefit and the Omnibus Budget Reconciliation Act of 1985 made it a permanent part of Medicare.

TEFRA of 1982 also established managed care plans in Medicare but initially excluded hospice because utilization was low and there was little cost data.

The Balanced Budget Act of 1997 established in statute that hospice is carved out of Medicare managed care.

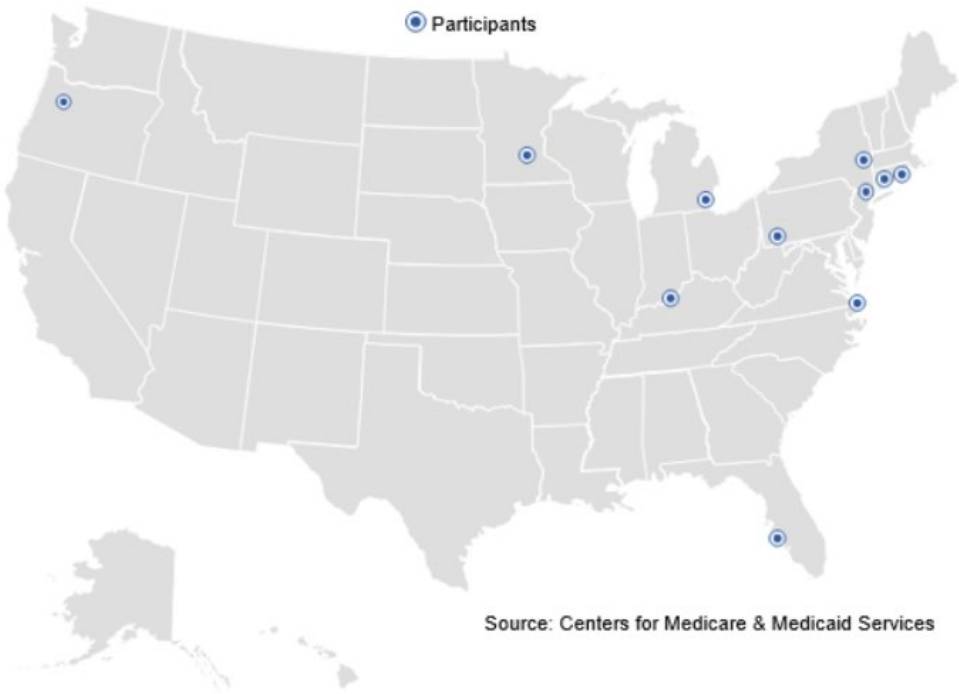
Past Congressional consideration on the carve-in:

- Considered but not adopted under MACRA
- Considered but not adopted under the CHRONIC Care Act

In 2019, CMMI announced it will begin testing a MA carve-in of the MHB under the MA VBID model starting in 2021 through 2024.

Background: V-BID Model (general)

- Model offered since 2017 through Center for Medicare and Medicaid Innovation (CMMI) to test improving outcomes through plan benefit design
- Open to participation across all 50 states through flexibility offered by Congress
- 14 Medicare Advantage plans participating in 2020 offering benefits to over 280,000 beneficiaries



MA VBID Hospice Carve-in

Preserving the Hospice Benefit & Quality Measures

CMS explicitly requires MA plans to provide the MHB as currently defined under statute and regulation, unless it waives certain provisions in future iterations of the Model

- 6-month prognosis
- Four levels of care
- Use of an interdisciplinary care team

CMS will measure plan performance in the following quality domains:

- Palliative Care and Goals of Care Experience
- Enrollee Experience and Care Coordination at End of Life
- Hospice Care Quality and Utilization

Beginning in 2023, it may adjust payments to plans based on the following measures:

- Proportion of Enrollees Admitted to Hospice for Less than 7 Days
- Rate of Lengths of Stay beyond 180 Days
- Transitions from Hospice Care, Followed by Death or Acute Care

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Requirements to Offer Palliative and Transitional Concurrent Care

Palliative Care

- Unlike hospice, palliative care does not require an enrollee to have a life expectancy of six months or less, and palliative care may be provided together with curative treatment at any stage in a serious illness
- Plans must propose their approach for providing access to timely and appropriate palliative care services for their enrollees

Transitional Concurrent Care

- Plans must work with their network of hospice and non-hospice providers to define and provide a set of *concurrent care* services related to a hospice enrollee's terminal condition and related conditions that are appropriate to provide on a transitional basis, aligned with an enrollee's wishes

Network Adequacy & Payment

Network Adequacy

- **Year 1:** Enrollees can see in-network and out-of-network providers; plans are required to pay out-of-network providers at 100% of FFS
- **Year 2:** Enrollees can still see out-of-network providers but may be required to go through a "consultation program"; out-of-network providers are still paid at 100% of FFS
- **Year 3:** CMS will allow plans to use a "traditional" network adequacy approach; plans must have at least one hospice provider in each county

Payment

- **First month of hospice stay:** Standard A/B payment + hospice-specific capitation payment
- **All subsequent months:** Only hospice-specific capitation payment

Future Considerations

- How can hospice providers reach out to plans to demonstrate their value?
- How can hospice providers develop the capacity to manage their relationships with health plans?
- How can plans identify high-quality hospice providers who wish to participate in the carve-in?
- How will health plans set up their palliative and transitional concurrent care programs in collaboration with their network of hospice providers?

Thank you!

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ADVOCATING EXCELLENCE IN ADVANCED ILLNESS, HOSPICE, AND PALLIATIVE CARE