Disclaimer: Vantage Health Plan is participating in the CMMI VBID Hospice Carve-in Demonstration

Value-Based Insurance Design (VBID) Model Hospice Benefit Component Operational Guidelines for In-Network Hospice Providers*

*To be considered a Vantage Health Plan participating hospice provider, a provider must have an executed contract with Vantage Health Plan and undergo required credentialing. A non-participating hospice provider may become a participating provider at any point during a calendar year.

Purpose

This document serves to provide guidance to Hospice providers serving Vantage Health Plan members in the Hospice VBID model. The intent of the Hospice Value-Based Insurance Design (VBID) Model Demonstration is to:

- Provide the full scope of and ensure timely access to the Medicare hospice benefit
- Improve hospice utilization patterns and reduce costs of care related and unrelated to the terminal condition
- Enable seamless coordination of care, reduce duplication, and enhance quality of care
- Maintain broad choice and improve access to hospice care
- Ease care transitions and ensure that hospice-eligible members do not need to choose between curative or hospice care when considering hospice election
- Enable members, their families, and caregivers to experience the benefits of hospice care over a more appropriate period of time as aligned with their wishes and the member's needs
- Promote care transparency and quality through actionable, meaningful measures
- Reduce avoidable medical spend during final months of life, driven by expanded access to palliative care and earlier election of Hospice

CMMI Hospice VBID Broad policy goals

**The demonstration is scheduled to run from Jan 1, 2021 through Dec 2024*

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Definitions

- VBID – Value-Based Insurance Design
- MAC – Medicare Administrative Contractor
- OON – Provider not participating in the Vantage Health Plan network (Out-of-Network)
- INN – Provider participating in Vantage Health Plan network (In-Network)
- NOE- Notice of Election
- NOTR – Notice of Termination/Revocation
- TCC- Transitional Concurrent Care
- CMMI- Centers for Medicare and Medicaid Innovation
- ACM- Advanced Care Management
- IDT- Interdisciplinary Team

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VBID Model - Hospice Benefit Overview

Beginning on January 1, 2023, Vantage Health Plan will be participating in the Medicare hospice benefit in their benefits package as part of a CMS Innovation Center Model.

Under the Model, the participating MAOs are responsible for coverage and payment of all services covered by original Medicare, including hospice.

These changes only apply to patients who elect to begin hospice care on or after January 1, 2023 and are enrolled in the specific MAO and plan(s) participating in VBID Hospice Benefit Component in 2023. This information may change annually.

Vantage Health Plan's Hospice VBID model focuses on early identification of members who may benefit from improved care coordination between their Medicare Advantage experience and end-of-life care receiving Hospice. Our model encompasses an Advanced Care Management program that proactively identifies and outreaches to members who may benefit from the support of a palliative care and other services simultaneous to their MA plan coverage.

The Advanced Care Management program will provide palliative care services, support voluntary consultation with our members surrounding hospice readiness, and assist in understanding the benefits available on VBID-eligible 2023 plans.

When a member elects hospice with an in-network provider, they will have access to transitional concurrent care (TCC) as required by CMS/CMMI. TCC will be coordinated by the in-network Hospice provider that continues to oversee patient care with the same four levels of hospice care as prescribed by the current Medicare Policy Manual. TCC is offered to members receiving care from an in-network hospice provider only.

Vantage Health Plan Resources

Website: https://www.vantagehealthplan.com/physicians/comfortcare
Contacts:

Hospice Network Administrative Contact	Email Address	Business Phone Number
Clint Mercer - Contracting	cmercer@vhpla.com	318.998.3434
Lynne LeBlanc - Clinical	lleblanc@vhpla.com	318.998.3261

CMS Resources

Website:

https://bit.ly/VBIDhospice

https://innovation.cms.gov/innovation-models/vbid-hospice-benefit-overview

Email: Providers may email VBID@cms.hhs.gov with any additional questions.

Future Materials and Support:

- CMS will also be conducting outreach to hospice providers providing care in Model Component service areas to help them understand their role in the Model component and their next steps.
- CMS will provide technical support webinars and Q&A sessions from the past and schedule ongoing events as needed.

Participating Plans

Arkansas

•Parent Organization: Louisiana Health Service & Indemnity Company

•Offering 1 plan in these counties in Arkansas, including:

(1) **Vantage DUAL PLUS (HMO-POS D-SNP) (H2722-003)** offered in Arkansas, Ashley, Benton, Bradley, Calhoun, Carroll, Chicot, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Cross, Dallas, Desha, Drew, Franklin, Garland, Grant, Greene, Hot Spring, Independence, Jackson, Jefferson, Johnson, Lafayette, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Phillips, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff and Yell.

Louisiana

•Parent Organization: Louisiana Health Service & Indemnity Company

•Offering 1 plan in these parishes in Louisiana, including:

(1) **Vantage DUAL PLUS (HMO-POS D-SNP) (H5576-019)** offered in all parishes in Louisiana.

Mississippi

•Parent Organization: Louisiana Health Service & Indemnity Company

•Offering 1 plan in these counties in Mississippi, including:

(1) **Vantage DUAL PLUS (HMO-POS D-SNP) (H7163-003)** offered in Adams, Amite, Attala, Bolivar, Calhoun, Carroll, Choctaw, Claiborne, Clarke, Coahoma, Copiah, Covington, Franklin, George, Greene, Hancock, Harrison, Hinds, Holmes, Humphreys, Issaquena, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Lawrence, Leake, Leflore, Lincoln, Madison, Marion, Montgomery, Newton, Panola, Pearl River, Perry, Pike, Quitman, Rankin, Scott, Sharkey, Simpson, Smith, Stone, Sunflower, Tallahatchie, Tunica, Walthall, Warren, Wayne, Webster, Wilkinson, Yalobusha, and Yazoo.

***Additional States and Plans that you may see if a Medicare beneficiary moves from one state to another location and does not update their address with Medicare can be found here: https://innovation.cms.gov/innovation-models/vbid-hospice-benefit-participating-plans**

Advanced Care Management

A requirement of the Hospice VBID Demonstration Model is to ensure that all members on a participating plan have access to palliative care. Vantage Health Plan offers a nurse practitioner-led community and home-based palliative care program to manage and support acute, complex, vulnerable members. Unlike the Medicare hospice benefit, palliative care does not have a prognosis restriction and may be provided alongside curative treatment at any stage of a serious illness.

The Advanced Care Management program centers on a member support structure that activates an interdisciplinary care team to provide home-based and telephonic support for members with advancing illness who are approaching end-of-life. A nurse practitioner will coordinate care, collaborating closely with interdisciplinary team members, as well as the member/family, the member's PCP and any specialists involved in their care, to ensure a member-driven approach and informed decision-making regarding treatment and care options, including hospice.

Advanced Care Management Model of Care

Services address gaps in care as well as the following impacts on end-of-life care:

- Increase comfort, reduce pain
- Reduce avoidable admissions and readmissions
- Trust in knowing care is being carefully coordinated
- Advance care planning discussions that offer peace of mind
- Improved quality of life
- Member and caregiver satisfaction
- Safety in the patient's environment

Advanced Care Management Services

- Multidisciplinary team providing in-home and telehealth support (NP, RN, and Social Worker)
- Management of relief of symptoms, pain, and stress
- 24/7 telephonic support
- Emotional and spiritual support
- Collaboration with patient's treatment team (e.g., PCP, specialists)
- Linkages to community-based organizations/resources
- Curative treatment included for chronic illnesses

Top Clinical Interventions during Advanced Care Management

- Comprehensive in-home care assessment by a Nurse Practitioner
- Care planning and goals of care discussions
- Facilitate conversations surrounding treatment choices and completion of advance care planning documentation
- Coordination with Primary Care Physicians and specialists
- Pain assessment and symptom management
- Medication reconciliation
- Evaluation of additional in-home Nurse Practitioner visits for members with acute changes

Hospice Orders

- Write referral for patients to enter hospice
- Coordinate hospice orders with PCP and/or specialists
- Communicate hospice provider options
- Facilitate hospice transitions per the members' wishes

Expected Outcomes of Advanced Care Management

- Significantly reduce risk of hospitalization
- Enhance patient and caregiver satisfaction
- Address advance care planning

Advanced Care Management frequently asked questions

- **Who is offered Advanced Care Management?**
  - Members within a VBID plan that are identified by a claims-based algorithm OR referred by a provider or care manager, OR self-referred, who have an advanced illness that deems them to need additional in-home support. The following criteria is used to help determine appropriateness for palliative care:
    - One or more serious illness diagnoses, middle-to-late stage
    - Multiple co-morbidities
    - Cognitive or functional decline
    - Need for pain and/or symptom management related to chronic/ life limiting condition
    - Psycho-social and/or spiritual distress of both member and caregivers related to chronic/life limiting condition
    - Need for advance care planning (including advanced directives) and clarification of health care goals for member and caregivers
    - Members with end stage illness who have declined the Hospice benefit
    - Recent ER or Hospitalization in last 90 days
    - Multiple hospital admissions or ER visits over the past year

- **If a patient is not ready for Hospice care, can they enroll with Advanced Care Management for palliative care services upstream?**
  - A referral can be made to the Advanced Care Management program pending clinical review for appropriateness. Palliative Care can assist the member and caregiver in understanding their clinical trajectory and illness as they consider electing hospice.
  - Physicians can send referral and patient's demographic information via email to **ACMReferrals@compassus.com**

  Information required for referral:
  - Patient's name and date of birth
  - Patient's Vantage Health Plan ID number (if available)
  - Patient's address and phone number
  - PCP's name
  - Primary caregiver information, if available
  - Diagnosis
  - Referring physician's name and phone number

- **How will hospice agencies expect to hear from the Vantage Health Plan Advanced Care Management provider?**
  - If a member receiving palliative care is ready to transition to hospice, a member of the care team will reach out to the local hospice provider selected by the member to initiate the transition. The palliative team will communicate to the hospice provider if the member is a VBID participant.

- **Will hospice agencies know if palliative care was provided to the VBID members prior to transitioning to hospice?**
  - Members transitioning from palliative care to hospice will be identified as a VBID member, as applicable. However, there may be scenarios where the member received palliative care earlier in their care journey but are not transitioning directly from an active palliative care program enrollment and therefore palliative care experience would be unknown to the hospice provider at the time of hospice transition.

- **Will Advanced Care Management educate patients on Transitional Concurrent Care?**
  - Advanced Care Management palliative care services facilitate advance care planning discussions and revisits discussions depending on the needs of the member, and as part of education on the hospice benefit. The palliative provider will inform the member and caregiver of transitional concurrent care and will ensure the member and caregiver is aware of both in-network and out-of-network hospice provider options.

Transitional Concurrent Care – Hospice VBID Model Requirement

Transitional Concurrent Care (TCC) are services that help provide a transition to hospice care and include a phasing out of specific curative treatment over time. TCC requires authorization and is available for up to one month for patients who elect hospice with an **in-network** hospice provider. Transitional Concurrent Care discussions may occur once the hospice referral is made. If the member is enrolled in Advanced Care Management prior to transition to hospice, the Advanced Care Management provider will support the member and family/caregiver in understanding when transitional concurrent care may be appropriate and beneficial to a member's entry to hospice. The hospice provider will coordinate with the referring physician and other members of the existing care team to define a plan for the tapering of care and services.

The following services will be made available on a transitional basis for up to one month after the member enters Hospice, as agreed upon and identified in the member's care team and the in-network hospice provider:

CCS Code 2016/17 *CCS=Clinical Classifications Software*	**Recommended coverage for each condition**
Cancer	Radiation for pain/palliative care (Vantage Health Plan currently 1-2 treatments), blood transfusions, paracentesis, IV antibiotics, and total parenteral nutrition (TPN) (as negotiated)
Cardiac	Depending on symptoms: Diuretics, nitrates, opioids for comfort care; PT, Internal defibrillators
Dementia	Pain management via nonpharmacologic and pharmacologic approaches; antimicrobials only with adequate clinical evidence and orally, when possible, nonpharmacologic incontinence treatment
Other	IV antibiotics
Respiratory	Case by case basis: chest tubes, CPAP/BiPAP and ventilator support (if unable to extubate); Oxygen and inhalers, nonpharmacologic and pharmacologic interventions to help with anxiety and difficulty breathing
Stroke	N/A
Chronic Kidney Disease	Hemo/peritoneal dialysis for palliation.

Does transitional concurrent care require authorization?
Authorization is required for transitional concurrent care. The Utilization Management team provides support to ensure concurrent care services as well as other services included in the member's plan of care are carried out via authorization for services in accordance with the Vantage Health Plan Utilization Management benefit policies.

Members that elect hospice are still permitted to receive acute services unrelated to the hospice diagnosis and these should not be viewed as transitional concurrent care
(IE: fall and break a hip, acute services are permitted as this is not related to the Hospice Diagnosis).

How does billing and payment for TCC services work?
The provider of the transitional concurrent care service can bill Vantage Health Plan directly for the services provided. Plan authorization rules apply. Members should refer to their Evidence of Coverage pertaining to their plan's coverage for medical services.

What is the plan to educate providers about these services?
Vantage Health Plan will proactively identify and outreach to providers upstream (PCPs, Specialists, etc.) to inform them of TCC benefits that will be made available to VBID demonstration eligible members.

How is care coordinated to ensure the member receives TCC during the first month?
The hospice provider will coordinate with the referring provider and other members of the existing care team to define a plan for the tapering of care and services.

Does the service need authorization from Vantage Health Plan?
Services during the first month post-hospice election require authorization from Vantage Health Plan. Hospice providers should outreach to the health plan with any care plan changes at a minimum every 15 days as required by the Hospice VBID Component Technical and Operational Guidance. To reach the health plan utilization management department, call 1-888-823-1910.

Member eligibility verification for hospice

If the patient is a Vantage Health Plan member on or after Jan 1, 2023, identify the MA contract number and plan benefit package identification information on the MA enrollment card.

Hospice providers can confirm a member's eligibility with Vantage Health Plan by calling 1-888-823-1910 or through the provider portal if registered.

- Reminder: Check the effective and termination dates to ensure the patient's enrollment in the participating plan is for 2023

Hospice providers should conduct regular and ongoing benefit coverage checks or awareness of member's benefit plan. If a member has a plan change while enrolled in hospice, Vantage Health Plan will continue providing payment for all services including both hospice and non-hospice care until the enrollee's coverage with the plan ends.

Hospice Provider Notification Process

Hospice Providers must submit copies of the Notice of Election (NOE) and NOTR to Vantage Health Plan consistent with requirements in the VBID Model Hospice Component Technical and Operational Guidelines supplied by CMS. Below is an overview of the process for submission.

- Hospice providers must notify Vantage Health Plan of member's hospice election (NOE) by faxing a copy of the documentation to 318-807-1115.

- Hospice providers must also submit a copy of the NOTR to Vantage Health Plan to notify of the discharge date and disposition, which include any of the following:
  - Member revokes
  - Member chooses to transfer to another hospice
  - Member does not meet recertification criteria

- Member is discharged due to cause
- Member passes away

- Additional guidance on submission of NOE and/or NOTR
  - Hospice providers must email the documents using the same naming convention on the subject line such as 'Hospice NOE' or 'Hospice NOTR' with member name or member ID. This will allow for timely processing of the document.

Billing and Claims

Where do I submit claims?
Claims must be submitted to Vantage Health Plan. A copy of claims must also be submitted to the appropriate Medicare Administrative Contractor (MAC). If claims are only submitted to Medicare, the claim will be denied due to VBID participation. One suggestion is to use an information-only claim type to submit to Medicare, as a duplicate to the claim submitted to Vantage Health Plan.

Claims may be submitted by electronic submission or hard copy.

For hard copy (paper) claim submissions; please mail to:

Vantage Health Plan
130 DeSiard Street, Suite 300
Monroe, LA 71201

Are there any changes to the four levels of care and regulations regarding the four levels by CMS as they currently exist?
There are no changes to the four levels of care as they are currently being administered by the Centers for Medicare & Medicaid Services (CMS).

What is the process for claims reimbursement?
After timely submission of claims as outlined in the contract, INN hospice providers will be reimbursed at the rates outlined in the contract and non-contracted providers will be reimbursed at the Medicare rate. Hospice providers should not submit any claims to members/caregivers and should continue to submit claims through existing processes with their Medicare Administrative Contractor (MAC) for these members. Vantage Health Plan will pay clean claims within 30 days of receipt.

Will copays/coinsurance still apply for medications and inpatient respite if they are currently part of a member's plan?
Please refer to the Vantage provider portal for plan specific copays/coinsurance information. To sign up for the portal, please visit our website at https://www.vantagehealthplan.com/

Grievances and Appeals

Can members and caregivers submit grievances and appeals?
The grievance/appeal process applies to members of Medicare Advantage plans who are dissatisfied with the healthcare services received, or any aspect of the plan, or who have received an adverse determination. Throughout the course of the demonstration, members or authorized representatives may submit grievances and appeals for both palliative care and hospice care provided by either in-network or out-of-network providers. Vantage Health Plan will address all concerns on an expedited basis to ensure enrollees have timely access to needed care.

How does a member or caregiver submit a grievance and/or appeal?
There are two ways for a member or caregiver to submit a grievance and/or appeal. The first is by calling the telephone number associated with the member's membership plan (found on the back of their ID card), and the second is via written correspondence. Patients and/or caregivers should be instructed to review the member handbook for information on how to file a grievance or appeal.

Provider Claims Disputes

What is the process for submitting a claims dispute?
Providers can submit a claim payment inquiry related to the adjustment of a claim by submitting a formal letter to:

Vantage Health Plan
Attn: Appeals
130 DeSiard Street, Suite 300
Monroe, Louisiana 71201

Providers may also fax letters to (318) 361-2170/Attention: Appeals.

Frequently Asked Questions

Who can providers contact at Vantage Health Plan with any questions?
For questions regarding eligibility, network status, case management, clinical documentation, or contracting, please call the Vantage Health Plan Contact Center at 1-888-823-1910, Monday-Friday 8:00 a.m.to 8:00 p.m.

Will hospices continue to submit HIS Data?
Yes. There will be no changes to the current Hospice Item Set (HIS) submission process.

Can out-of-network hospice agencies provide care?
Out-of-network providers can provide care to members. For more information on Hospice VBID, please visit our website at https://www.vantagehealthplan.com/ for more information.

If a member revokes the hospice benefit, or no longer meets criteria, are they eligible to enroll in Advanced Care Management?
Vantage Health Plan will apply eligibility criteria to members to ensure they are appropriate for referral back to Advanced Care Management after processing termination from the hospice benefit.

What information needs to be provided to Vantage Health Plan during a member's enrollment in Hospice?
Hospices must submit notification to Vantage Health Plan of member having elected hospice care along with member NOE, TCC, and NOTR forms. Providers will also submit claims to TMG for payment of hospice care.

How can I reach out to CMS with questions?
Please contact VBID@cms.hhs.gov directly with questions about Hospice Value Based Insurance Design Model.
* Vantage Health Plan reserves the right to terminate or suspend providers who are sanctioned or added to the CMS preclusion list.

Hospice Provider Checklist

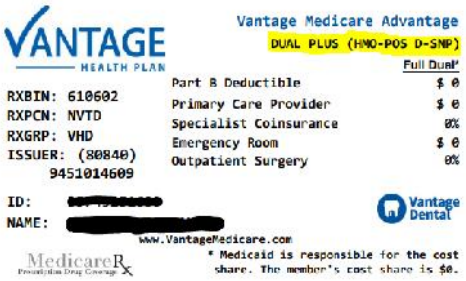
To help providers with this change to Medicare Hospice, CMS created a Hospice Provider Checklist and we have adapted it to further assist you.

Follow these steps to assure accurate patient information:

Additional Support and Information can be found here: [VBID Model Hospice Benefit Component Overview | CMS Innovation Center]

STEP 1: Confirm your patient's Medicare eligibility and check for Medicare Advantage enrollment.

- If your patient shows you a Medicare Advantage enrollment card, an example of a MA Membership ID card is shown below for illustrative purposes, move to Step 2.



- If your patient shows you a Medicare card with a Medicare Beneficiary Identifier (MBI), follow your normal process and run an MVP in eSolutions, then move to Step 2.
- Reminder: Check the effective and termination dates to ensure the patient's enrollment in the participating plan is for 2023

STEP 2: Locate the Contract and Plan ID or Plan Name

- The following plan names are included for 2023: **Dual Plus (HMO-POS D-SNP)**
  - If the patient gave you their Medicare Advantage card, the location is shown on the above card example.
- If using the MVP look to the Medicare Advantage section, under Plan Code, confirm the Contract and Plan Code will look like this: H####-###. For example, **H5576-019, H2722-003 or H7163-003.**

STEP 3: Compare the information from Step 2 with the list of participating plans.

- If this information matches, your patient is in the VBID Model.
  - If you do not have a copy of the patients Medicare Advantage card, you **must** now obtain a copy of their Medicare Advantage Card.

- If the plan code is not one of the participating plans, the patient is not in the VBID Model.

If you match this information to a patient whose hospice election began on or after January 1, 2022, and they are enrolled in a returning plan, your patient is in the Model.

If you match this information to a patient whose hospice election began on or after January 1, 2023, and they are enrolled in a new plan, your patient is in the Model.

STEP 4: Check the billing and claims processes for the specific participating plan.

STEP 5: Submit all notices and hospice claims to **both your MAC and the participating MAO**