Disclaimer: Humana is participating in the CMMI Hospice VIBD Demonstration

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

**In order to be contracted with Humana for an In-Network status for Hospice VBID CY 2024, a provider must have an executed contract with Humana and undergone required credentialing for contracted status for the program. All other providers servicing Humana eligible plan members in the demonstration footprint will have an Out-of-Network status for CY2024.*

Purpose

This document provides guidance to Hospice providers serving Humana participating members in the Hospice VBID model. The aims of the Hospice Value-Based Insurance Design (VBID) Model Demonstration are as follows:

- Ease care transitions and ensure that hospice-eligible enrollees do not need to choose between curative or hospice care when considering hospice election
- Improve quality and timely access to the Medicare hospice benefit
- Provide the full scope of hospice benefits, as defined in the Social Security Act (Act) at §1861 dd)
- Improve hospice utilization patterns and costs of care related and unrelated to the terminal condition, based on improving the coordination and quality of care and service delivery
- Enable enrollees and 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
- Create an opportunity to provide additional support and value to hospice enrollees through the use of supplemental benefits with in-network hospice provider election
- Encourage use of voluntary consultation by palliative providers upstream of hospice election
- Provide access to palliative care for all eligible members

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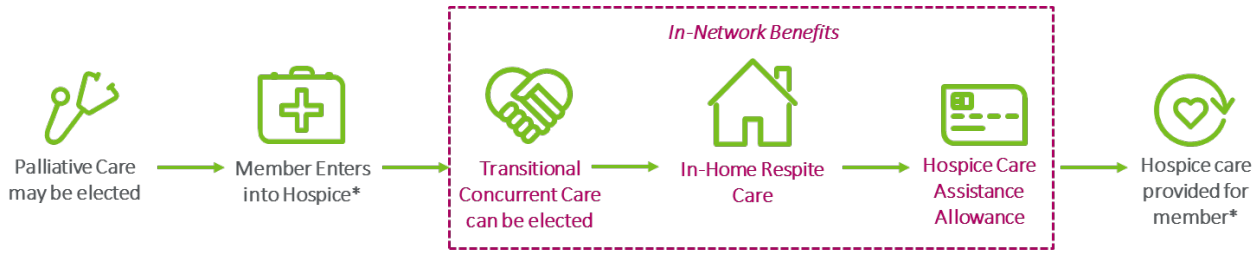
Definitions

- Availity – Online portal where providers can register for access to information on a variety of topics such as eligibility, benefits, referrals, authorizations, claims, and electronic remittances
- EOB – Election of Benefits
- Humana Hospice Centralized Team (HHCT) – The team who will be handling the day-to-day operations of the Hospice VBID Demonstration
- INN – Provider participating in Humana's network (IN-Network)
- MAC – Medicare Administrative Contractor
- NOE – Notice of Election
- NOTR – Notice of Termination/Revocation
- NTUC – Not Taken Under Care
- OON – Provider not participating in Humana's network (Out-Of-Network)
- TCC – Transitional Concurrent Care
- VBID – Value Based Insurance Design

Humana Hospice VBID Model Overview



** The hospice benefit under CMS remains the same for these components*

Humana's Hospice VBID model focuses on creating better continuity for our members between their MA experience and end-of-life care receiving Hospice services.

Humana's Hospice VBID model encompasses a VBID-specific Palliative Care providers that will partner with Humana to proactively identify and outreach to members who may benefit from the support of a Palliative Care Program simultaneous to their MA plan coverage.

Palliative Care providers will support voluntary consultation with our members surrounding hospice readiness and assist in understanding of the benefits available on VBID CY2024 plans.

When a member elects hospice with an in-network provider, they will have access to Transitional Concurrent Care as required by CMS/CMMI and two additional supplemental benefits that are unique to Humana's model: In-home Respite Care, and a $500 Hospice Care Assistance Allowance. All three of these unique and differentiated services will be coordinated by the Hospice team that continues to oversee patient care with the same four levels of hospice care as prescribed by the current Medicare Policy Manual.

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Palliative Care

Palliative care is available to members with advanced illness who have begun a process of progressive and significant decline in their health, to help bridge gaps for those who that are not ready or clinically appropriate for Hospice but need more hands-on assistance than provided by traditional Care Management. The multi-disciplinary palliative care team coordinates directly with the member's Primary Care Physician (PCP) and specialists to manage pain, symptom relief, and clinical interventions. Unlike the Medicare hospice benefit, palliative care does not have a prognosis restriction and may be provided together with curative treatment at any state of a serious illness.

Members are proactively identified by a claims-based algorithm or by direct physician referral.

A requirement of the Hospice VBID Demonstration Model is to ensure that all members on a participating plan, and within the selected model geographies, have access to a Palliative Care provider. For the 2024 plan year, Humana has partnered with select palliative care providers to serve model-participating members.

Palliative Model of Care

- Multidisciplinary team providing in-home and virtual support (MD, NP, RN, Social Worker, and Chaplain)
- Plan of care and treatment based upon patient preferences
- Allows for curative treatment
- Managed relief from symptoms, pain, and stress
- Collaboration with patient's physician/provider team
- Guidance through complex treatment choices
- Advance Care Planning
- Emotional and spiritual support
- 24/7 MD & NP availability
- Voluntary Consultation as appropriate

Palliative Care Coordination

Palliative care offers specialized care to patients facing a serious illness. Palliative Care coordinates closely with a patients existing PCP and specialists. Patients continue to see their PCP and specialists while on service and receiving active treatment. The patient's designated PCP receives a palliative care summary after every palliative care visit.

Top Clinical Interventions during Palliative Care

Advance Care Planning

- Facilitate conversations surrounding complex treatment choices and completion of advance care planning documentation to enable future health decisions

Hospice Orders

- Write orders for patients to enter hospice
- Coordinate hospice orders with PCP and/or specialists

- Communicate the supplemental benefits available with the election of an in-network hospice provider
- Facilitate hospice transition per the members wishes

Medication and Non-medication Orders

- Write prescriptions for medications to treat acute symptoms and exacerbations in order to avoid unnecessary ER visits and/or hospitalizations
  - Most frequent prescriptions for Humana-covered members
    Steroids, opiates, antibiotics, diuretic, anti-nausea, inhalers for COPD, oxygen
  - Most frequent non-medication orders
    Mobile X-ray, durable medical equipment, skilled home health
- Coordinate medication orders with primary care physician (PCP) and/or specialists

Expected Outcomes of Palliative Care

- Significantly reduce risk of hospitalization
- Achieve greater patient and caregiver satisfaction
- Facilitate Advance Care Planning discussions
- Identify member's goals of care and end of life wishes
- Increase quality hospice transitions
- Increase Hospice length of stay

Referral to Palliative Care

Palliative Care services are provided at no extra cost to eligible Humana-covered patients with advanced illnesses. Hospice Providers, PCPs, and Humana medical directors may refer members, including revocations and NTUCs.

*For VBID plan members in **Georgia, Ohio, Colorado and Virginia:***

- Physician sends referral and member's demographic information to **Aspire** via email at referrals@aspirehealthcare.com, by phoning 1-844-232-0500, or by faxing to 1-888-972-4927.

*For VBID plan members in **Colorado:***

- Physician sends referral and member's demographic information to Care Synergy via email at humanapalintake@caresynergynetwork.org, by phoning 1-303-336-1267 or by faxing 1-303-398-2377

*For VBID plan members in **Florida:***

- Physician sends referral and member's demographic information to Harbor Palliative Care Services via email at PalliativeCareConsult@trustbridge.com, by phoning 1-866-640-6804 or by faxing 1-561-863-2806

*For VBID plan members in **Wisconsin**:*

- [For all VBID PBPs in the following counties only: Brown, Calumet, Door, Fond Du Lac, Green Lake, Kewaunee, Manitowoc, Marathon, Marinette, Marquette, Oconto, Outagamie, Shawano, Waupaca, Waushara, Winnebago]

Physician sends referral and member's demographic information to **Unity Support Care Management** via email at referrals@unityhospice.org, or by phoning 1-920-338-1111.

- [For VBID PBPs in all other counties] Physician sends referral and member's demographic information to **Aspire** via email at referrals@aspirehealthcare.com, by phoning 1-844-232-0500, or by faxing to 1-888-972-4927.

*For VBID plan members in **Kentucky**:*

(For PBP H5216-019-000 in the following Kentucky counties only: Anderson, Bourbon, Clark, Fayette, Franklin, Jessamine, Madison, Scott, Woodford)
Physician sends referral and member's demographic information to **Bluegrass Palliative Care** via email at deptofmedicine@bgcarenav.org, by phoning 1-859-278-4869, or by faxing to 1-859-278-7690

- (For all VBID PBPs in the following counties only: Indiana--Clark, Floyd, Harrison; Kentucky, Bullitt, Hardin, Henry, Jefferson, LaRue, Meade, Nelson, Oldham, Shelby, Spencer,)
  Physician sends referral and member's demographic information to **Pallitus Health Partners** via email at referrals@pallitus.org, or by phoning 1-502-719-8910.
- (For all other VBID PBPs and Counties) Physician sends referral and member's demographic information to **Aspire** via email at referrals@aspirehealthcare.com, by phoning 1-844-232-0500, or by faxing to 1-888-972-4927.

Information required for referral:

- Patient's name and date of birth
- Patient's Humana ID number
- Patient's address and phone number
- PCP's name
- Diagnosis
- Referring physician's name and phone number

A patient's participation with palliative care *does not affect* the PCP's billing for any services (if applicable).

Frequently Asked Questions

- **Who is offered palliative care?**
  - Patients within a VBID plan that are proactively identified by a claims-based algorithm OR referred directly by a provider who have advanced illness and are deemed to need additional support. Common diagnoses examples (but not limited to): Advanced Cancer, Advanced CHF (class III-IV), Advanced COPD (stage III-IV), Advanced Dementia, and Geriatric Frailty.
- **If patient is not ready for Hospice care, can they enroll with Palliative care upstream?**
  - A referral can be made to the Palliative Care provider in your market pending a clinical review for appropriateness. Palliative Care can help the member understand their clinical trajectory and illness as they consider electing hospice.

- **Which palliative providers are serving VBID plans in my area?**
    - Please refer to the information above under the "Referral" section to find the appropriate Palliative Care provider in your area and with the appropriate PBP.
- **How will Hospice agency hear from the Palliative Provider?**
    - If a member receiving palliative care is ready to transition to hospice, the palliative Nurse Practitioner or MD will reach out to the local hospice provider selected by the member to initiate the transition. The palliative provider or PCP will write the official order for hospice. 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 member prior to transitioning to hospice?**
    - Any member transitioning to hospice from palliative care will be identified as a VBID member. If the PCP is the ordering physician, VBID identification will need to be validated. However, there may be scenarios where the member received palliative care earlier in their health care journey but are not transitioning directly from an active palliative care episode and therefore palliative care experience would be unknown to the hospice provider at the time of hospice transition. Any questions specific to palliative care utilization can be directed to palliative@humana.com.
- **Will palliative care educate patient on Transitional Concurrent Care?**
    - Palliative care facilitates advance care planning discussions at every visit and as part of education on the hospice benefit. The palliative provider will inform the member of supplemental benefits available through election of an in-network provider (including Transitional Concurrent Care) as well as ensuring the member is aware of out-of-network providers.
- **What patient information or medical records can hospice expect if palliative care was provided to the member prior to entering hospice?**
    - Documentation is dependent upon the ordering provider. If hospice order is coming from the palliative provider, documentation would include hospice qualifying condition, any open gaps in care, current care plan, and recent MD summary. Regardless of whether the palliative provider writes the hospice order, or the PCP/specialist prefers to do it, the interdisciplinary palliative team is involved in the transition to ensure it is seamless for the patient/family. This often includes a joint visit with the hospice admission RN to support continuity of care.
    - If a patient has elected an in-network provider with the intention to receive Transitional Concurrent Care, the palliative provider will include specifics around current care plan goals and advance care planning discussions to the hospice provider as part of the transition.

    - All VBID plan members transitioning to hospice from palliative care include VBID identification as required documentation.

- **How will palliative providers be educated on Humana's In- and Out-Of-Network Providers?**
    - Palliative providers will receive a list of hospice providers participating in Humana's network (by region) and are educated on the in- and out-of-network options available to members when electing a hospice provider.
- **Who should providers contact with additional questions specific to palliative care?**
    - To contact the Humana Palliative Team, email palliative@humana.com.

Voluntary Consultation

A voluntary consultation is an optional outreach to the patient that is a part of the CMMI Hospice VBID model with a purpose of ensuring the member understands the hospice benefit and their coverage options under the Hospice VBID demonstration.

This process recommendation is outlined by CMMI in the RFA and Technical and Operational Guidelines Documents for Hospice VBID Component CY2024, and can be found at innovation.cms.gov/innovation-models/vbid.

For purposes of this demonstration, Humana will leverage existing palliative care providers and processes to offer, when appropriate, patients on palliative care service a voluntary consultation as part of their facilitated advance care planning discussions.

To assist in supporting patients on the end-of-life continuum, Humana has also created a separate option for the consultation process aimed at counseling the individual (and/or caregiver(s)) and representatives regarding hospice and other care options.

If counseling beyond benefit and provider information is needed, the Humana Hospice Centralized Team may answer questions and counsel on options for care. The consultation is voluntary and not a requirement for members in year three of the demonstration.

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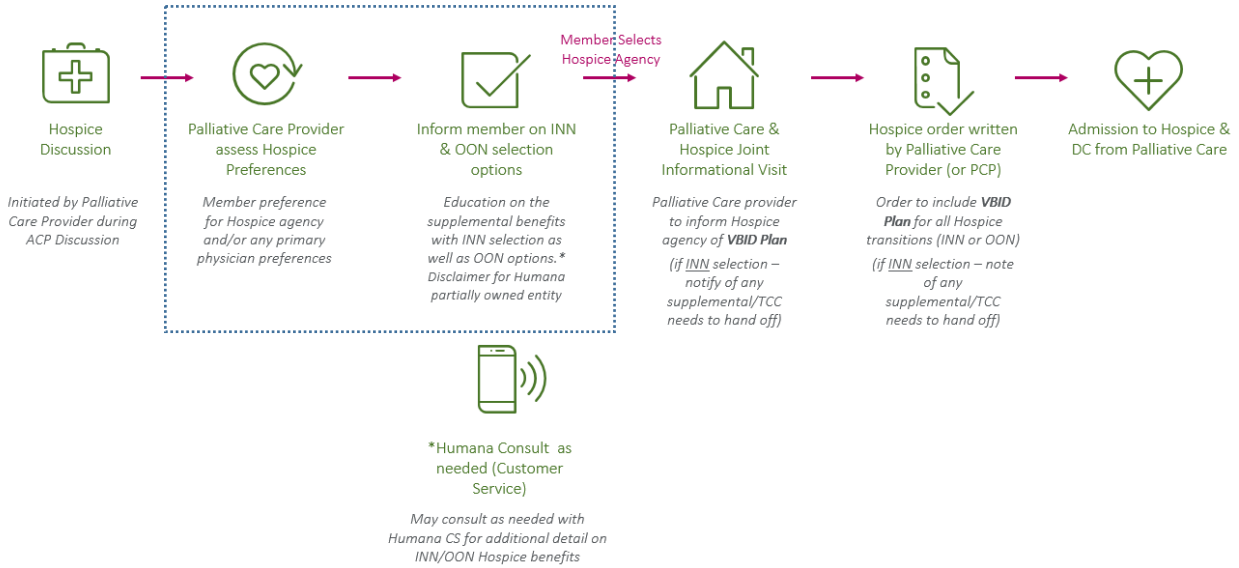
Voluntary Consult Process



Member Eligibility Verification

If the member is in a Humana MA plan and the hospice election date is on or after the date listed in the table below, identify the MA contract number and plan benefit package identification information on the MA enrollment card. It will look like this: H#######. For example, H1234-001. Please refer to the Participating Plans section of this guidance.

Market	Plan Benefit Packages	Benefit Eligibility Date
Louisville, KY / Lexington, KY	HumanaChoice H5216-019-000 (PPO)	1/1/2022 – 12/31/2023
Louisville, KY	Humana Community H1036-236-000 (HMO)	1/1/2023
Kentucky	Humana Gold Plus H5619-071-000 (HMO)	1/1/2023
Atlanta, GA	Humana Gold Plus H4141-015-000 (HMO)	1/1/2021
Atlanta, GA	HumanaChoice H5216-073-000 (PPO)	1/1/2021
Atlanta, GA	Humana Care Extra H5216-239-000 (PPO)	1/1/2022 – 12/31/2023
Georgia	HumanaChoice H5216-203-001 (PPO)	1/1/2023
Macon and Albany, GA	HumanaChoice H5216-203-002 (PPO)	1/1/2023
Georgia	Humana Gold Plus H4141-017-003 (HMO)	1/1/2024
Macon and Albany, GA	Humana Gold Plus H4141-017-005 (HMO)	1/1/2024
Richmond/Tidewater, VA	Humana Gold Plus H6622-004-000 (HMO)	1/1/2021
Richmond/Tidewater, VA	Humana Gold Plus H6622-005-000 (HMO)	1/1/2021 – 12/31/2023
Richmond/Tidewater, VA	HumanaChoice H5216-144-000 (PPO)	1/1/2022

Richmond/Tidewater, VA	HumanaChoice H5216-266-000 (PPO)	1/1/2022 – 12/31/2022
Richmond/Tidewater, VA	Humana Gold Plus H5619-139-001 (HMO)	1/1/2022 – 12/31/2023
Richmond/Tidewater, VA	Humana Gold Plus H5619-139-002 (HMO)	1/1/2022 – 12/31/2023
Richmond/Tidewater, VA	Humana Gold Plus H5619-140-001 (HMO)	1/1/2022 – 12/31/2023
Richmond/Tidewater, VA	Humana Gold Plus H5619-140-002 (HMO)	1/1/2022 – 12/31/2023
Richmond/Tidewater, VA	Humana Gold Plus H5619-157-000 (HMO)	1/1/2024
Cleveland, OH	Humana Cleveland Clinic Preferred H6622-023-000 (HMO)	1/1/2021
Denver, CO	Humana Gold Plus H0028-025-001 (HMO)	1/1/2021
Denver, CO	Humana Gold Plus H0028-025-002 (HMO)	1/1/2021
Denver, CO	Humana Gold Plus H0028-047-000 (HMO)	1/1/2021
Green Bay, WI	Humana Gold Plus H6622-001-000 (HMO)	1/1/2022
Milwaukee/Green Bay, WI	HumanaChoice H5216-252-000 (PPO)	1/1/2023
Milwaukee/Green Bay, WI	HumanaChoice H5216-253-000 (PPO)	1/1/2023
Milwaukee/Madison, WI	Humana Gold Plus H6622-034-000 (HMO)	1/1/2023 – 1/1/2023
Green Bay, WI	HumanaChoice H6622-001-000 (PPO)	1/1/2024
South Florida, FL	HumanaChoice Florida H5216-068-000 (PPO)	1/1/2023

Member eligibility for the Value Based Insurance Design can be verified by calling Humana Customer Service at 1-800-457-4708 (TTY:711) or electronically via Availity to confirm member is enrolled in one of the qualified Plan Benefit Packages and in one of the selected market geographies. Please refer to the Availity Registration and Authentication material located in the Provider Portal (humana.com/hospice) for additional information.

Hospice providers can confirm a member's Medicare eligibility and check for Medicare Advantage (MA) enrollment by using any of the following online tools or services:

- MAC Portal
- MAC Interactive Voice Response (IVR) System
- Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS)
- Billing agencies, clearinghouses, or software vendors

Additionally, if a member is receiving care from a partnered palliative care vendor and receives a referral to your hospice, that member and/or palliative care team should communicate that he or she is a VBID participant.

If a member or provider has questions about implications to VBID benefits due to enrollment or election changes, they may contact the Humana Hospice Centralized Team at 1-800-950-1071 or HHCT_Support@humana.com.

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Benefit Eligibility

Hospice providers should conduct regular and ongoing coverage checks for awareness of member's benefit plan. If a member has a plan change while enrolled in hospice, Humana will continue providing payment for all services including both hospice and non-hospice care, until the enrollee's coverage with a VBID qualifying plan ends. Please refer to the document on Enrollment Plan Changes located on the website.

Provider Notification Process

Providers must submit copies of the Signed Election and Consent statements, completed TCC addendum if utilizing that benefit, and NOTR for live discharge or transfer. Verbal or written communication must be submitted to the Humana Hospice Centralized Team for members who expire. Below is an overview of the process for submission.

Please refer to the Availity Submission Guidelines document in the Provider Portal (humana.com/hospice) for additional step-by-step information regarding notifications to Humana within Availity.

- Hospice providers must notify Humana of member's hospice election by providing Humana with a notification flag in the form of an "authorization" with copies of the signed Medicare Election and Consent Statement attached with the submission.
    - Authorization should be built through Availity as an outpatient authorization with a service type of hospice, **regardless of member's setting for hospice care**. Please do NOT submit an inpatient Hospice authorization to Humana to designate member on-service status for hospice.
    - There will be **no** utilization management review of member's election in hospice and all submissions will receive an automated "approved" status with the submission.
    - The provider will include the member's signed Medicare Election and Consent Statement and Transitional Concurrent Care addendum (if applicable) as attachments in the notification process.
    - Providers are required to submit the authorization and attached documentation within 5 days of member election, consistent with the MAC submission deadlines. Failure to submit notification to Humana timely may result in payment delays as well as provider responsibility for cost of care for days in arrears.
- Please refer to the Availity Submission Guidelines document in the Provider Portal (humana.com/hospice) for more detailed steps and screenshots of submission requirements. Hospices do not need to notify Humana of any changes in level of care. There is no authorization required for level of care changes.
- Hospice providers must also submit a copy of the NOTR to Humana and contact Humana's Hospice Centralized Team to notify them of the discharge date and disposition.
    - A Humana Care Manager will collect key information including the discharge disposition and advise of any outstanding services for unrelated care or supplemental benefits
        - Member revokes
        - Member chooses to transfer to another hospice

        - Member does not meet recertification criteria
        - Member is discharged due to cause
        - Member passes away
    - Please refer to the Availity Submission Guidelines document in the Provider Portal (humana.com/hospice) for more detailed steps and screenshots of submission requirements.

Please note, hospice providers must continue current notifications to MAC for both Notice of Election and claims submission through existing processes and are reminded to complete the signed Medicare Election and Consent Statement and NOTR within the CMS-identified time frames.

Humana Hospice Centralized Team

To ensure that providers and members have a smooth and seamless experience with the Hospice VBID Model, a team of Humana clinicians is available to support the hospice experience for our members and providers. The Humana Hospice Centralized Team (HHCT) is a dedicated team of RNs, an LSW, and an Administration Coordinator who support the daily operations of the VBID Demonstration and the use of the new supplemental benefits.

Upon receiving the signed Medicare Election and Consent Statement and TCC Addendum (if applicable), Humana will assign each member receiving care from a network-participating provider with a Hospice Care Manager. The Hospice Care Manager will outreach to the provider to establish their relationship.

The primary role of the Care Manager will be to support our members' care experience and needs through tight coordination with the Hospice interdisciplinary team. Humana will not establish a separate care plan or goals for members during their Hospice election.

How can I reach Humana's Hospice Centralized Team?
The centralized team can be reached at 1-800-950-1071 from the hours of 8:00 AM EST – 5:00 PM EST Monday-Friday. Voicemails left after working hours will be returned the next business day. During weekends and national holidays, voicemails will be monitored, and calls will be returned based on urgency.

What type of support does Humana's Hospice Centralized Team provide?

- Support Palliative Providers as needed when discussing hospice election with members/caregivers.
- Provide voluntary consultation on inbound calls from members and their approved representatives inquiring about the hospice benefit.
- Case conferences with Hospice Care provider to discuss member's benefits/utilization of benefits, Plan of Care, and any potential barriers. At a minimum, HHCT Care Managers will reach out every 15 days to ensure compliance from providers per CMS Hospice VBID Component Technical and Operational Guidance for Calendar Year 2024.
- An initial case conference will be conducted by the assigned HHCT Care Manager once the hospice authorization has been submitted and received by Humana.

- Oversight of supplemental benefits for both In-Home Respite Care and Care Assistance Allowance. Please refer to the documents with more detailed instructions on the processes' supporting the Hospice supplemental benefits.

Transitional Concurrent Care – Hospice VBID Model Requirement

Transitional Concurrent Care (TCC) discussion may occur once the hospice referral is made. The Hospice Provider will be the coordinator for the Participating Member's consideration of timing and process for Hospice Election consistent with the existing hospice model. The in-network Hospice Provider team will also support the Participating Member and 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.

During this Program the Hospice Provider and Participating Member will also have access to Humana case and care management support. This support will provide assistance as needed to educate Hospice Providers and Participating Members as to what services are available during Transitional Concurrent Care, and answer member-specific questions surrounding use of these services.

Whereas the traditional hospice benefit focuses on non-curative care, Transitional Concurrent Care services will be inclusive of items or services that have been previously contemplated on the Participating Member's plan of care with an existing provider, regardless of their connection to the terminal diagnosis. The goal of the Transitional Concurrent Care is to adequately provide a smooth transition to non-curative care under the existing hospice benefit. This transitional hospice benefit will allow for the Participating Member to have up to 31 days to discontinue curative treatment.

Services that may be provided on a transitional basis are available to help the Participating Member ease into the election of Hospice Care. Services may include but are not limited to, specialist provider visits, internist/PCP visits, access to specialized DME, and treatments for a variety of chronic and acute conditions. The Transitional Concurrent Care services available will be tailored to each Participating Members needs and will be coordinated by the Participating Member's hospice team. Please refer to the Transitional Concurrent Care Decision Tree document in the Provider Portal (humana.com/hospice) for more detailed information regarding which services would qualify under the benefit.

How are Hospice Providers, Members and Referring Providers made aware of Transitional Concurrent Services?
Humana requires a Transitional Concurrent Care Addendum to ensure all parties are notified, in writing, of those conditions, items, services, and drugs that will be covered under the Transitional Concurrent Care model by Humana. It is recommended that this document be shared with other treating healthcare providers, who have been identified to continue curative treatment for the first 31 days after hospice election.

The Humana Hospice Centralized Team will review the signed addendum statement at the initial case conference. The Hospice Provider should add the signed addendum to the authorization via Availity within 5 days of election. Any updates to this document after initial review should be shared with the Humana Hospice Centralized Team.

How does billing and payment for TCC services work?
The provider of the Transitional Concurrent Care service can bill Humana directly for services provided. Plan cost-sharing amounts and plan authorization rules apply. Members should refer to their Evidence of Coverage Chapter 3 pertaining to their plan's coverage for medical services.

Humana may deny coverage for care and services received outside of this established Transitional Concurrent Care addendum. The enrollee may be financially responsible for seeking services outside of this approved course of treatment as prescribed by the hospice provider and Humana.

How are providers educated on these services?
Humana reaches out to providers upstream (PCPs, Specialists, etc.) to inform them of Transitional Concurrent Care benefits available to demonstration eligible members in the market.

What is the process for determining what is covered under TCC? Are any services not covered?
The hospice team should assess medical necessity of care and ensure details are captured on the TCC addendum and then discuss during care conference with their assigned Humana Hospice Care Manager from HHCT. For any questions regarding qualifying services for TCC, refer to the Transitional Concurrent Care Decision Tree document in the Provider Portal (humana.com/hospice) or contact Humana Hospice Centralized Team (1-800-950-1071) to answer member-specific questions surrounding use of this benefit. If Humana approves an inpatient procedure or service as a part of TCC during Hospice, the facility coverage under existing plan rules will apply and be billed directly to Humana. The hospice agency should bill these patient days as RHC-level of care.

How is care coordinated to ensure the member receives TCC during the first 31 days?
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. During this demonstration, the provider and member will also have access to Humana's Hospice Centralized Team who will be able to educate providers and members as to what services are available during Transitional Concurrent Care.

Does the service need authorization from Humana?
Services during the first 31 days of hospice election need authorization from Humana. Humana's Hospice Centralized Team should be notified of the member's Plan of Care during initial Case Conference, which should include a copy of the Transitional Concurrent Care Addendum. The assigned Humana Hospice Centralized Care Manager will communicate with the Hospice Provider as appropriate for the individual member's plan of care to ensure all updates to the care plan are captured, and to ensure tapering of services is occurring appropriately. Hospice providers should outreach to their assigned Humana Hospice Care Manager with any care plan changes at a minimum of every 15 days as required by the Hospice VBID Component Technical and Operational Guidance for Calendar Year 2024.

Hospice Supplemental Benefits

Supplemental benefits are benefits that are covered by Humana at a plan level beyond what is included in the standard plan coverage. Humana created two Hospice-specific supplemental benefits to fulfill the option presented by CMMI as a part of the Hospice VBID Model Component. These supplemental benefits include a $500 Hospice Care Assistance allowance and 40 hours of In-home Respite Care. All Humana plans participating in the Hospice VBID Model have access to both benefits, however, to be

eligible, the member must have elected and be in the process of receiving hospice care from an in-network hospice provider.

Hospice Care Assistance

The benefit must be requested through Humana's Hospice Centralized Team (HHCT). The hospice interdisciplinary care team is accustomed to assisting members with needs either through community resources or insurance benefits.

The $500 supplemental benefit allows for the purchase of goods or services that are not covered by plan benefits or through community resource support.

1. **Understanding the benefit**
    a. The $500 Hospice Care Assistance benefit can be initiated by either the member or Hospice provider.
        i. There is a maximum benefit capped at of $500 per plan year. If the allotted service or good exceeds the available balance of the benefit, Humana will pay the remaining balance of benefit after the member has paid for their portion totaling the full amount of the service/good.
    b. The Hospice Care Assistance benefit can assist members with purchase of goods or services that support quality at end-of-life such as: lawn care services, pest control, pet assistance, meal preparation, etc.
        i. Vendors identified to render goods/services for payment in the benefit request must not be on an exclusion list with OIG/SAM. If the HHCT determines that the service/goods vendor is ineligible for payment, the HHCT will collaborate with the hospice provider in efforts to secure another vendor for the service/good.
        ii. Requests will be reviewed by the HHCT to determine if an existing Humana benefit or community resource can assist with the request, before allocating the Hospice Care Assistance allotment. This in turn will allow for the member Hospice care assistance to be allocated to other health-related services.
        iii. Vendors providing services or goods must be able to accept electronic credit card payments and have the ability (email or fax) to provide a receipt to HHCT.

2. **How to Request Benefit Usage**
    a. 48 hours' notice is required before the desired service date or date of purchase of goods. If 48 hours' notice is not provided, desired date of service/purchase may not be fulfilled.
    b. Contact HHCT to request the benefit, check on remaining balance, submit receipts, and ask other questions as needed:
        1. Phone: 1-800-950-1071
        2. Email:HHCT_Support@humana.com
        3. Fax: 1-502-414-0237
    c. Humana's Hospice Centralized Team will inform the requester if a member has reached the maximum benefit upon request of Hospice Care Assistance benefit.
    d. If a request cannot be fulfilled due to OIG/SAM exclusions and another service/goods provider is unable to be found, HHCT will contact the Hospice provider in efforts to secure another option.
    e. HHCT will follow up with member/provider to ensure services/goods are received after the scheduled date.

Are there any services not covered under this benefit?
Services may not be approved if any of the following apply to the request:

- The vendor is on the Office of the Inspector General (OIG)/System for Award Management (SAM) exclusion list
- The vendor doesn't have ability to accept credit card payment and/or provide electronic receipt
- Other supplemental benefits are available to provide the requested service or meet the member's need
- The request is inappropriate (not relating to a social determinant of health need)

Will Humana provide a list of vendors in the market?
Please refer to the list of vendors provided in the Provider Portal (humana.com/hospice) for contact information. Members, caregivers, and the hospice care team can select a vendor that is not on the list, provided they are not on the OIG/SAM exclusion list.

Will there be notification if a member has utilized their maximum benefit?
Upon request of service, Humana's Hospice Centralized Team will inform the hospice provider how much of the allowance is remaining, including notification if a member has reached their maximum allowance.

In-Home Respite Care Services

In-home Respite Care is defined as the provision of a nursing assistant/hospice aide to support a participating member in their place of residence in lieu of their caregiver. In-Home Respite Care is a supplemental benefit available to the member upon election with an in-network hospice provider. A minimum of a continuous 8-hour period is required per instance if staffed by the hospice provider. Service shall be coordinated by the hospice care team directly with the member/caregiver.
This is a benefit offered only to patients who select an in-network hospice. If a patient has any questions regarding this benefit, please direct them to Humana Customer Service 24/7 at 1-800-457-4708 (TTY:711).

1. **Understanding the Benefit**
    a. 40 hours per plan year are available to eligible members.
        i. The In-Home Respite benefit does not replace the Inpatient Respite level of care as outlined in Chapter 9 of the Medicare Benefit Policy Manual.
        iii. In-Home Respite care must be utilized in 8-hour increments if staffed by the hospice agency. If less than eight hours is desired by the member, the remainder of the 8 hours should be arranged as soon as possible. Encouragement of maximizing the benefit and using the full eight hours per instance is recommended. If the scheduled care is not completed, the hospice provider will work with the member/caregiver to schedule the balance of hours not completed at a mutually agreed upon time.
    b. Provision of the In-Home Respite supplemental benefit is a requirement for In-Network providers when requested by the Humana member or primary caregiver. There are two mutually exclusive options for providing the forty-hour In-Home Respite care supplemental benefit.
        i. The INN provider has the option to provide the IHR utilizing hospice available resources as outlined in the contractual agreement. Under this option the hospice

provider will be responsible for verification of IHR benefit with Humana Hospice Centralized Team (HHCT). The INN provider will be responsible for scheduling, providing, and billing Humana for the requested In-Home Respite hours.

ii. The INN provider has the option to leverage Humana Personal Homecare Services, Humana arranged vendor, to fulfill the IHR benefit. Under this option, Humana Personal Homecare Services will be responsible for verification of IHR benefit with Humana Hospice Centralized Team (HHCT). Humana Personal Homecare Services will be responsible for scheduling, providing, and billing Humana for the requested In-Home Respite hours.

iii. Based on hospice provider feedback, Humana is providing the Humana Personal Homecare Services pathway as an option for a hospice provider to improve administrative efficiency and timely delivery of the In-Home Respite supplemental benefit. In order to maintain a member-centric approach and ensure continuity of In-Home Respite services, it will be necessary for the hospice provider to determine their preferred option at the time of the initial member-specific request for In-Home Respite. This process will assist the hospice provider and Humana to avoid the potential for member confusion and service failures.

iv. A hospice provider may choose between the two options for each Humana Hospice VBID member, but once the option is designated it must remain in effect for the entirety of the forty-hour benefit period for that particular member.

2. Responsibility of the Provider

a. 24/7 oversight by RN of respite staff

b. Tracking of hours, days, and individual providing care

i. Diligent tracking of hours used is required as 40 hours is the maximum benefit per plan year.

ii. Tracked information must be made available to Humana upon request.

c. Humana reserves the right to request In-Home Respite care as a stand-alone service outside of Hospice care.

3. How to Request Benefit Usage

a. How much notice is required?

i. The request must be completed if it is made with 48 hours' advance notice to the hospice provider. If less than 48 hours' notice is provided, the hospice provider has the option to negotiate a different time to provide the care.

b. Contact HHCT to request the benefit, check remaining balance, and ask other questions as needed.

i. Contact info including phone number and email address

1. Phone: 1-800-950-1071
2. E-mail: HHCT_Support@humana.com

c. Humana's Hospice Centralized Team will inform the requestor if a member has reached the maximum benefit upon request of In-Home Respite care.

4. Getting paid for Services

a. Submitting claims

i. The hospice provider should submit claims for in-home respite care separately from hospice claims. A claim for IHR should be submitted separately on a CMS 1500 form using Healthcare Common Procedure Coding System (HCPCS) code T1005 with one unit equaling each eight-hour period at the rates as agreed upon in the contract.

ii. Fields 24J (referring provider NPI) and Field 31 (signature) should be completed with the hospice NPI when submitting claims for In-Home Respite.

iii. In-Home Respite claims should not be billed to the MAC.

b. Rates - contractually specific - reference your contract.
   i. HCPCS Code T1005
   ii. Units and how to bill it
      1. One 8-hour increment is **<u>One Unit.</u>** Hospice Provider agrees to bill one (1) visit, and that one (1) visit shall equal each 8-hour period in which In Home Respite Care services are provided. Hospice Provider may not bill more than 5 visits per plan year.
      2. If the 8-hour period spans two calendar days, the starting date of in-home respite should be reflected on the bill. For example, if coverage begins at 8 p.m. on the first day of the month and ends at 4 a.m. the following day the date of service on the claim will be the day service was initiated.
      3. If Humana Personal Homecare Services has been engaged to cover IHR, payment for services will be made directly by Humana to Humana Personal Homecare Serves. The hospice provider should not submit claims for IHR.

Who is providing this care?
In-home respite care may be administered by the hospice provider or its designee by a nursing assistant (or equivalent). The provider should provide 24-hour oversight and availability of a registered nurse, licensed as required by the state in which the services are being rendered, in the event that a clinical or skilled need arises during the provision of this service.

a. For in-network hospice providers electing to use Humana Personal Homecare Services to administer the benefit, the Humana Hospice Clinical Team will coordinate with the hospice provider case manager for the completion of the In-Home Respite Assignment/Plan of Care to ensure it reflects member's care and service needs.

How many hours of in-home respite care can a member receive?
A member can access up to 40 hours of in-home respite care per plan year while on hospice service with an in-network provider.

What is the process if a member/caregiver wishes to use In-Home Respite?
If a member/caregiver wants to use the in-home respite benefit, a call should be made to Humana's Hospice Centralized Team to inform the member/caregiver has elected to use in-home respite with details on the plan of use (date, hours, etc.)

Will there be notification if a member has reached their maximum benefit?
Humana's Hospice Centralized Team will inform the hospice provider if a member has reached the maximum benefit upon request of in-home respite services.

Does this replace the inpatient respite care (IRC) level of care?
No, this is a standalone benefit and will not affect the member's inpatient respite care utilization or any of the other levels of hospice care.

Billing and Claims

Where do I submit claims?

Disclaimer: Humana is participating in the CMMI Hospice VIBD Demonstration

Claims can be submitted through Humana.com using Humana ID 61101. Providers should submit all claims, encounters and clinical data to Humana by electronic means. Those electronic means accepted as industry standard may include claims clearinghouses or electronic data interface companies used by Humana. Providers using electronic submission must submit all claims to Humana or its designee, as applicable, using the HIPAA-compliant 837 electronic format. Claims must also continue to be submitted to CMS via the MAC. Paper claims should be mailed to Humana Claims, P.O. Box 14601, Lexington, Ky 40512-4601.

How do I sign-up/Use the Availity Web Portal?
Claims can also be submitted directly to Humana using the Availity Web Portal. Please refer to the Availity Registration and Authentication material located in the Provider Portal (humana.com/hospice) for additional information.

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, hospice providers will be reimbursed at the agreed upon rates as outlined in the contract. Hospice providers should not submit any claims to members/caregivers and should continue to submit claims through existing process with their Medicare Administrative Contractor (MAC) for these members. Please note the Remittance Advice from Medicare will reflect a Claims Adjustment Reason Code of 96 and a Remark Code MA 73 to indicate this is a MA VBID patient. Humana will pay clean claims within 30 days of receipt. Please refer to the Hospice VBID Billing Tip Sheet document in the Provider Portal (humana.com/hospice) for additional information and guidance on billing rules that may require a claims adjustment and resubmission.

Does Humana have any caps or limitations on hospice payments?
There are no caps or limitations that will apply on hospice payments during year four of the demonstration period.

Do copays/coinsurance still apply for medications and Inpatient Respite if they are currently part of a member's plan?
Copayments and coinsurance amounts are consistent with existing CMS benefits - 5% of the cost of the drug, but not more than $5 copayment for drugs and biologicals furnished by the hospice on an outpatient basis and 5% coinsurance per day on an inpatient respite care stay.

Does Humana require detailed line-item billing?
Line-item billing will be consistent with benefit manual guidelines. Please refer to the Medicare Claims Processing Manual, Chapter 11 for Hospice Care for additional information.

How do I contact Humana with any billing/payment issues?

Humana Provider Self Service: Benefits/Eligibility, Referrals/Authorizations, Claims, ERA/EFT. Register at www.Availity.com
Humana Claim, Provider Payment Integrity, Code Edit Resolution Process: Claim Payment Inquiry Resolution Guide
Humana Provider Contact Center: Medicare 1.800.457.4708.

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Humana Provider Payment Integrity Customer Service: Clinic Audit, Refund and Recoupments, 1.800.438.7885
Humana Pre-Authorization, Referrals and Notifications: www.Availity.com, 1.800.523.0023

Grievances and Appeals

Do members and caregivers have the ability to 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, authorized representative, and/or physicians are able to submit grievances and appeals for both palliative care and hospice care provided by either in-network or out-of-network providers. Humana will address all concerns on an expedited bases in order to ensure enrollees have timely access to needed care.

If the member makes the decision to appeal a hospice discharge decision and file a BFCC-QIO appeal, the hospice provider should notify the Humana Hospice Centralized Team prior to the discharge.

How does one submit a grievance and/or appeal?
There are two ways 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. Please reference the Provider Claims Dispute Process and Member Grievance/Appeal Process Document located on the Humana.com website

DispatchHealth Hospice Partnership - Acute Injury/Illness In-Home Treatment (Select Markets Only)

Understanding the Partnership and Program Aims
Humana and DispatchHealth have created a partnership to bring same-day-in-home medical care to hospice patients for urgent illnesses and injuries that do not require an emergency department visit. This partnership creates a safe alternative to the ED when an acute medical need arises for the member in-home; avoiding burdensome transitions to facility for treatment. Additional program aims are as follows: reduce the utilization of ambulance transport, reduce potential inpatient utilization and/or revocation of the hospice benefit and increase the patient's final days spent in home.

2024 Partnership Markets
- Denver, Colorado
- Atlanta, Georgia
- Richmond, Virginia *(Not available in Tidewater, VA)*
- Cleveland, Ohio
- Louisville, Kentucky
- South Florida, Florida

Conditions that DispatchHealth Treats
- Bronchitis
- Cellulitis
- CHF exacerbation
- COPD exacerbation
- COVID-19 symptoms
- Falls

- Headache / Migraine
- Influenza
- Nosebleeds
- Pneumonia
- Respiratory distress
- Strains, sprains, and minor fractures
- Urinary infections
- Vertigo
- **And more**

Advanced In-Home Treatment Capabilities
DispatchHealth is able to provide services above the scope of hospice agencies in-home. Some of their advanced capabilities they are able to provide to support hospice member care in the home are as follows:

- Administering IV fluids, medications, and antibiotics
- 12 lead EKG
- Laceration repair (simple to complex) sutures or staples
- Incision and drainage of skin lesions
- Advanced blood laboratory testing on-site
- Catheter insertion (Foley, Coude, suprapubic)
- Bronchodilator administration
- Rapid infectious disease testing (flu, COVID-19, strep, mono)
- **And more**

Is there a Member Co-Pay to Utilize Services?
The co-pay responsibility has been waived for purposes of this partnership. **There is a possibility that the member may receive a co-pay if DispatchHealth uses a Humana-approved 3rd part vendor to provide select in-home treatments (i.e. Imaging or labs)*

How Does Member Election of In-Network or Out-of-Network Hospice Impact Partnership?
Members who elect care with an in-network provider are able to user their Hospice Care Assistance Allowance to pay for any potential vendor partner 3rd party co-pays for services rendered through DispatchHealth.

How do Members and Hospice Agencies Utilize Services?
For purposes of this enhanced partnership, all hospice members are to reach out to their hospice provider to discuss the acute illness/injury prior to engaging DispatchHealth. Hospice providers are to triage, and if able to attend to member's needs timely and acute illness/injury lies within scope of treatment responsibility, hospice agency is to provide services. If Hospice Agency is not able to provide timely care or illness/injury requires advanced capabilities, then Hospice agency is to instruct member to reach out to DispatchHealth or call DispatchHealth on behalf of the member to initiate services.

How to Contact DispatchHealth?
DispatchHealth Humana hospice concierge number **1-855-439-5053** (Hours of operation 8am – 10pm, 7 days a week, including holidays). This phone number is to be used for the Hospice VBID enrolled hospice members only.

What is DispatchHealth's Commitment to Members?
DispatchHealth aims to treat members within 2 hours of outreach. They will notify the member in advance of their arrival.

What if DispatchHealth is Unable to Treat?

If a member calls into DispatchHealth for an issue that they are unable to treat or that is life threatening, they will escalate via the proper channels. For a life-threatening issue, DispatchHealth will call and arrange for ALS ambulance transport to ED. If treatment is out of scope of their services, they will communicate back to hospice agency of their inability to treat, and hospice agency will be required to coordinate needed care for the member.

How long does DispatchHealth Oversee Members Care?
DispatchHealth is only engaged to treat the acute illness/injury and member remains under the hospice agencies care the entire time.

How does the Hospice Agency Stay Apprised of Care Provided?
DispatchHealth will provide all visit notes and laboratory/imaging results with the Humana Hospice Centralized Team within 24 hours of care or receipt of results. The HHCT team will then provide the documentation to the Hospice agency on record.

Advancing Health Equity

What is Health Equity?
According to CMMI Health Equity is "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

How is addressing Health Equity a part of the Hospice VBID Demonstration?
The 2024 RFA has required Humana to describe a detailed strategy for advancing health equity as part of its approach to the Hospice Benefit Component. This included questions regarding identification, addressing, and monitoring inequalities that could occur in the access, outcomes, or member experience while in palliative or hospice care. Additionally, Humana outlined our engagement strategy across members, caregivers, and providers to address any potential inequities. To read more about CMMI's vision of prioritizing health equity please refer to this article.

Who is identified as having inequalities for hospice and palliative care?
CMMI has provided numerous articles in the 2024 RFA to help identify certain underserved populations that are more at risk of inequalities in their healthcare. This population includes, but is not limited to:

- Gender-based and race-based bias in pain assessment and treatment recommendations
- Disparate use of hospice along racial lines
- Gender-based disparities in caregiver burden and their resulting negative impact on the wellbeing of women
- Disparities in the use of palliative and hospice care among the LGBTQ+ population

What is Humana's Health Equity strategy?
Humana is committed to implementing and operationalizing policies and programs that support health equity and eliminate avoidable differences in EOL care experienced by disadvantaged/underserved members. While continuing to evolve our strategy, we plan to use social determinants of health data to identify members with inequalities in both palliative and hospice care. While in palliative care, we will work with providers upstream of potential election to ensure identified members are educated on

hospice care. Once in hospice care, our Hospice Centralized team will collaborate with the member's hospice care teams to ensure identified members are utilizing supplemental benefits unique to this demonstration to help ease any burdens during their EOL care.

Frequently Asked Questions

Do member's and caregivers have 24/7 support line?
The 24/7 customer service line can be reached at 1-800-457-4708 (TTY: 711) and is intended to provide education to caregivers and members to help answer any questions around hospice election, providers and benefits.

To whom at Humana can Providers (Hospice, Referring, etc.) reach out with any questions?
For questions regarding eligibility, network status or member's benefits, please call Humana Customer Service at 1-800-457-4708 (TTY: 711).
For any clinical related questions or questions related to Transitional Concurrent Care or supplemental benefits, providers can reach out directly to Humana's Hospice Centralized Team at 1-800-950-1071 from the hours of 8:00 AM EST – 5:00 PM EST Monday - Friday. Voicemails can be left after working hours and will be returned the next business day. During weekends and national holidays, voicemails will be monitored, and calls will be returned based on urgency.

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

If a member revokes the hospice benefit, or no longer meets criteria, are they eligible to enroll in palliative care?
Humana will apply eligibility criteria to members to ensure they are appropriate for referral back to palliative care after processing termination from the hospice benefit.

What information needs to be provided to Humana during a member's enrollment in Hospice?
Hospices must submit notification to Humana of member having elected hospice care through an outpatient authorization/referral in Availity.com, along with member signed Medicare Election and Consent Statement, TCC, NOE, and NOTR forms. Providers will also submit claims to Humana for payment of hospice care. More details can be found in the Billing Tip Sheet file on the Hospice VBID Provider Portal (humana.com/hospice).

Humana's Hospice Centralized Team may reach out for additional documentation at any point during a member's hospice election to support care needs.

How can I reach out to CMS with any questions?
Please contact VBID@cms.hhs.gov directly with questions about Hospice Value Based Insurance Design Model.

Where can I read/review Humana specific policies?
Please refer to Humana.com/provider to review guidelines and policies. Humana's Provider Manual can be found here.