Value-Based Insurance Design Model

Frequently Asked Questions

October 2023

Overview

Q1: What is the Centers for Medicare and Medicaid Services (CMS) Hospice Value-Based Insurance Design Model (VBID)?

A1: The Hospice VBID Model Demonstration aims to ease care transitions and ensure that hospice-eligible enrollees do not need to choose between curative or hospice care when considering hospice election. It also improves quality care and timely access to the Medicare hospice benefit.

Through the CMS Hospice VBID Demonstration, Highmark designed a specialized hospice program for specific MA members that will provide greater care coordination and offer:

- The full scope of Medicare hospice benefits and services, including:
  - Services from a hospice-employed physician/nurse practitioner/other physician type
  - Nursing care
  - Medical equipment
  - Medical supplies
  - Drugs to manage pain and symptoms
  - Hospice aide and homemaker services
  - Physical therapy
  - Occupational therapy
  - Speech-language pathology services
  - Medical social services
  - Dietary counseling
  - Spiritual counseling
  - Individual and family grief and loss counseling before and after the patient's death
- A supplemental hospice benefit that covers 36 hours of non-skilled in-home respite care for the caregiver, including:
  - Hands-on assistance with daily living activities
  - Homemaker services and instrumental activities of daily living
  - Supervision/or assistance when performing tasks independently

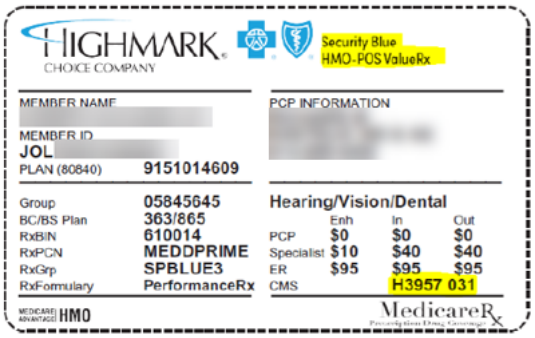
Highmark will continue to cover unrelated supplemental and Part D drug claims.

Q2: Which Highmark members qualify for VBID?

A2: All Highmark Security Blue ValueRx members who have a terminal diagnosis and two physicians certifying their life expectancy is six months or less. To join the Security Blue ValueRx plan, the member must reside in one of the following 11 counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Green, Indiana, Lawrence, Washington, or Westmoreland.

Q3: How do I identify a Highmark member?

A3: Highmark Security Blue ValueRx members will have the product name in the top right corner and the CMS contract number and plan benefit package number in the lower right of their ID Card. (See screenshot on the next page)



Q4: Who can perform non-skilled services as part of the supplemental benefit?

A4: Any hospice providers who would like to use their Home Health Aides to provide VBID Hospice care as it relates to the supplemental benefit must:

- Be credentialed to perform those services, and
- Sign a contract to do so.

Q5: How do I refer a member to an approved vendor for the hospice benefit?

A5: To refer the caregiver to an in-network hospice provider, the caregiver must call the Customer Service number on the back of the member's ID card.

Q6: How much of the member's care am I expected to coordinate, and how should I notify members of needed services?

A6: You are responsible to coordinate with the member, caregiver, and the member's current non-hospice providers within five business days for all needed services.

Q7: What required documents need to be submitted to CMS and Highmark as a participant in the Hospice VBID Pilot?

A7: The following documents must be submitted to CMS and Highmark via the Helion portal:

- **Noticed of Election (NOE):** must be submitted within five calendar days of the member's effective election date for the hospice benefit.
- **Notice of Termination/Revocation (NOTR):** must be submitted when a member terminates or revokes hospice care.
- **Notice of Change (NOC):** must be submitted if a member transfers to a different hospice provider.

Q8: Will I be required to coordinate the member's Transitional Concurrent Care (TCC) with Highmark as a participant in the Hospice VBID pilot?

A8: Highmark does not require providers to coordinate concurrent supportive services for ongoing symptom management and control. It is up to your discretion if you want to coordinate these services for the member.

VBID Hospice Enrollment, Transfers, and Terminations

Q1: How do I bill Security Blue ValueRx members who elected hospice prior to January 1, 2023, and are still in their hospice election period in 2023?

A1: When billing 2023 claims, continue to bill Original Medicare directly for all hospice-related services and unrelated Part A and B benefits. Bill Highmark for all supplemental and unrelated Part D benefits.

Q2: How do I bill Security Blue ValueRx members who elected hospice prior to January 1, 2023, continued their hospice election in 2023, and revoked and re-elected hospice in 2023?

A2: When billing 2023 claims, continue to bill Original Medicare directly for all hospice-related services and unrelated Part A and B benefits. Bill Highmark for all supplemental and unrelated Part D benefits.
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A2: Bill Highmark for all supplemental and unrelated Part D benefits through the member's revocation date.

Once the member re-elects hospice, submit claims for hospice-related services to Original Medicare and Highmark. CMS will maintain a record of services performed, and Highmark will process the claim. You must also submit the member's Notice of Election (NOE) from 2023 to Highmark for our records via the Helion Portal.

Q3: What non-billing actions must I take if a Security Blue ValueRx hospice member revokes/terminates hospice care and then re-elects hospice?

A3: You must submit a Notice of Termination/Revocation to CMS and Highmark. Once the member re-elects the hospice benefit, submit another Notice of Election with the re-election date to CMS and Highmark.

Q4: What if my Security Blue ValueRx hospice member enrolls in another plan outside of Highmark that participates in VBID hospice during their hospice election period?

A4: The member will still be in an active hospice election period without a disruption to their treatment. All continuing hospice care will be processed through the new VBID hospice plan, not Highmark.

Q5: What if the Security Blue ValueRx hospice member I treat enrolls in a different Highmark MA plan that does not provide the VBID hospice benefit?

A5: When the member requests to change their plan, the member will be required to follow the new MA plan's rules. Once enrolled in the new MA plan, the member will not be eligible for the hospice benefit through Highmark. Submit hospice-related claims to Original Medicare instead of Highmark.

Q6: What if my patient voluntarily disenrolls from Security Blue ValueRx and returns to Original Medicare while in an active hospice election?

A6: Once the member re-enrolls in Original Medicare, submit hospice-related claims to CMS. CMS will process and cover all hospice-related claims, and unrelated Part A and B claims. Highmark will only cover unrelated supplemental and Part D benefits.

Q7: What if a hospice patient currently enrolled with Original Medicare enrolls in Security Blue ValueRx?

A7: Continue to bill Original Medicare directly for all hospice-related services and unrelated Part A and B benefits. Bill Highmark for all supplemental and unrelated Part D benefits.

Q8: What if my Security Blue ValueRx member moves to a county outside of the Security Blue ValueRx service area?

A8: Members must permanently reside within the Security Blue ValueRx service area for plan participation. If a member moves out of the service area for more than six months, they can no longer stay in the Security Blue ValueRx plan. If the member is moving for **less than six months**, they may continue enrollment in the Security Blue ValueRx plan.

VBID Hospice Billing

Q1: How do the member’s other providers bill for services unrelated to the terminal illness when performed during the member’s hospice election period?

A1: **Non-Hospice Facilities:** must bill unrelated services with a 07 condition code. The GW modifier can also be used alongside the 07 condition code when appropriate.

Professional providers: must use the GV modifier for any services that are related to hospice care and the GW modifier for services unrelated to hospice care.

Q2: How will hospice-related drugs prescribed for the member's terminal illness and provided during the member's hospice election period be processed and paid?

A2: Hospice providers must continue to coordinate and pay for all hospice-related drugs for Part A and Part D benefits for members.

Q3: How do I bill for the appropriate level of care?

A3: Hospice providers should follow the same billing requirements that are in place today under Medicare. When submitting a hospice VBID claim to Highmark, it must mirror the CMS claim and **include all discipline visit codes and medications** captured by CMS for informational purposes (see example below). Click here to see the requirements.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0651	Routine Home Care	Q5001	022423	5	952.75		
2	0551	Hospice RN Admission	G0299	022423	9	170.00		
3	0250	Non-Injectible Drug		022523	90	18.55		
4	0250	Non-Injectible Drug		022523	8	13.35		
5	0250	Non-Injectible Drug		022523	15	10.67		
6	0250	Non-Injectible Drug		022523	4	8.80		
7	0250	Non-Injectible Drug		022523	2	42.41		
8	0250	Non-Injectible Drug		022523	2	47.96		
9	0551	SN Skilled Visit	G0299	022523	4	170.00		
10	0551	SN Skilled Visit	G0299	022723	5	170.00		
11								

Q4: Who should I contact with questions regarding claim denials, payments, etc.?

A4: If you are NaviNet®- or Availity®-enabled, submit your questions through NaviNet or Availity. If you are not, call the Provider Service Center at **866-517-8585**. The service team will research and resolve the issue.

Q5: How should I submit claims?

A5: You can submit claims one of three ways:

- Electronically through the electronic data interface (EDI)
- Electronically through NaviNet or Availity *(you must be portal-enabled)*
- Mail Paper Claim to:
  Highmark
  PO Box 890062
  Camp Hill, PA 17089

Q6: How should I submit a 'corrected' claim?

A6: When submitting a 'corrected' claim, the following should be documented:

1500 Claims

- Frequency Code (Box 22) = 7
- Original Ref No (Box) = Original Claim Number
- The total list of **all services** including those that were originally billed AND those that were not previously included

UB Claims

- Type of Bill Type (Box 4) with Frequency Code 7 = XX7
- Document Control Number (Box 64) = Original Claim Number
- The total list of **all services** including those that were originally billed AND those that were not previously included

Q7: What should I do when I get the rejection code E1349 – *"In order to be reimbursed, these hospice services must include all associated skilled nursing visits. Therefore, no payment can be made. Please resubmit with the correct information."?*

A7: If the claim is for a date range of 14 days or more and contains the Revenue Code of 0651 but no corresponding Skilled Nursing codes (0550-0552 or 0559), you must submit a corrected claim and include all associated Skilled Nursing codes in order to receive payment. Also include Medical Social Service (0561) and Home Health Aide (0571) codes that may have been performed but incorrectly excluded from the claim.

Q8: How can I get SIA reimbursement for the second-to-the-last claim that was already filed when the last seven days of member's life is split between two months?

A8: In order to get reimbursed for the second-to-the-last claim, you must submit a corrected claim (see above on how to submit) with the Occurrence Code of 55 and the correct Status.

Q9: When should I submit to my local Blues plan?

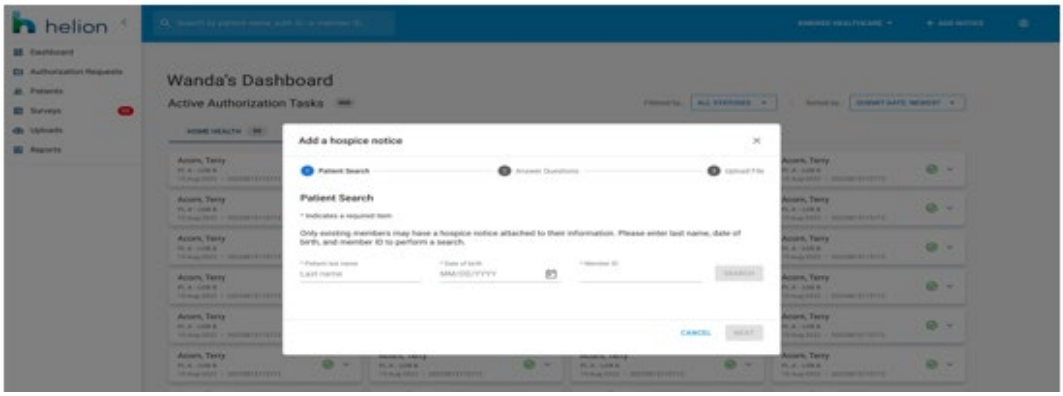
A9:
- When not contracted with Highmark and not in our service area
- When contracted with Highmark but not in our service area or a contiguous county

Helion ARC

Q1: How do I locate patients within the Helion Arc?

A1: Enter all required (*) fields as indicated: Last Name, First Name; Date of Birth (MM/DD/YYYY) and Member ID – a unique identifier to the patient found on their Highmark ID Card.

IMPORTANT: When entering the Member ID number, do not add the alpha prefix at the beginning of the Member ID (ex.123456789).

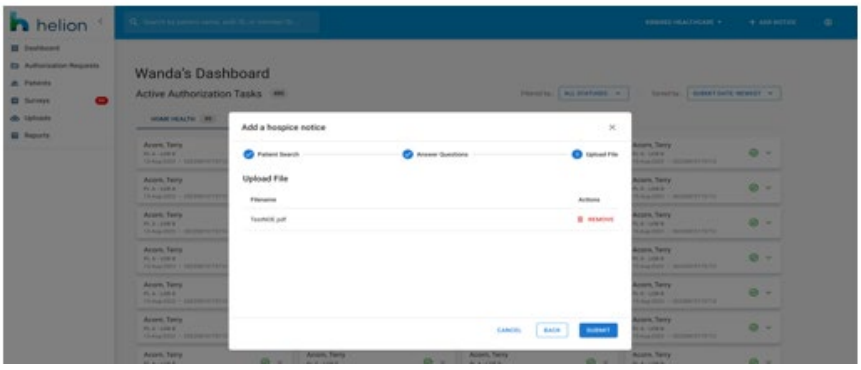


Q2: Can I remove notices from the Helion Arc?

A2: The Helion Arc does allow you to remove the NOE/NOTR/Transfer Notice after the upload section within the portal if the upload is not submitted.

You can select the highlighted **REMOVE** option near the uploaded document before selecting the **SUBMIT** button.

Once you upload your document and hit the **SUBMIT** button, you cannot remove that notice. You will have to submit a ticket to the Helion Help Desk to have it removed.



Q3: Where can I submit questions?

A3: Please submit questions through the Helion Service Desk portal.

Q4: How do I access the Helion Arc?

A4: Bookmark the web address based on your facility/agency:

- Delaware: click here.
- Pennsylvania: click here.
- West Virginia: click here.

Supported browsers: Microsoft Edge, Google Chrome, Apple Safari, Mozilla Firefox.

Internet Explorer is no longer supported.

More Information

Q1: Where can I find more information?

A1: Click here for instructions for member eligibility checks, the 2023 VBID participating plans, plan benefit packages and service areas, and directions for submitting claims.

For other questions, you can use the following contacts:

- Hospice Network Administrative & Clinical/Patient Support Contact:
  - HelionNetworkOperations@helionhealthcare.com
  - Monica.Valeri@helionhealthcare.com
  - Neyrissa.Bodnar@helionhealthcare.com
  - Phone: **412-544-8069**
- VBID Hospice Benefit Contact:
  - Anthony.Zambino@highmark.com

Phone: **302-421-3122**

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