

**Instructions for the Calendar Year 2024
Evidence of Coverage and Annual Notice of Change for Medicare Advantage
Organizations Participating in the Hospice Benefit Component of the Value-Based
Insurance Design Model**

Medicare Advantage Organizations (MAOs) participating in the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model for Calendar Year (CY) 2024 will need to make the changes outlined below within the Evidence of Coverage (EOC) Model and Annual Notice of Change (ANOC) Model for their participating plan benefit packages (PBPs) as applicable. Plans should refer to the Centers for Medicare and Medicaid Services (CMS) Communications and Marketing Guidelines, ANOC and EOC model templates, and other CMS documentation for requirements and timelines for providing the EOC and ANOC to prospective enrollees. This document contains all necessary changes to the EOC and ANOC model templates as required for PBPs participating in the VBID Hospice Benefit Component, with references made to relevant chapters and sections that require updates from the CY 2024 HMO-MAPD-ISNP-CSNP EOC and ANOC model templates. Other requirements for the VBID Model and its Hospice Benefit Component are listed in the CY 2024 VBID Model Communications and Marketing Guidelines.

Instructions to Participating Plans Regarding the EOC

Chapter 2, Section 1 of the EOC (Optional)

Within Section 1 of Chapter 2 of the EOC, participating plans may consider adding in contact information for members electing hospice. This includes any numbers for its high-touch care manager program associated with the Hospice Benefit Component.

Chapter 2, Section 4 of the EOC

Within Section 4 of Chapter 2 of the EOC, participating plans must include reference to hospice services. An example is provided below.

Example: You should contact *[insert state-specific QIO name]* in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Chapter 3, Section 2.3 of the EOC

Plans should describe how members access palliative care and hospice providers, including the role (if any) of the primary care provider, palliative care provider, or other specialists in helping members understand the differences between the plan's palliative care program, the Medicare hospice benefit the member may choose to elect, transitional concurrent care that may be available during hospice election, and any specific hospice supplemental benefits, as relevant.

Chapter 4, Section 2.1 of the EOC

Within Section 2.1 of Chapter 4 of the EOC, participating plans should update the section on hospice care within the Medical Benefits Chart to make clear that hospice services and Part A

and Part B services related to terminal prognosis are paid by the participating plan. An example is shared in Table 1. Additionally, within Section 2.1, plans should make the below updates, as applicable:

- In this section, participating plans with hospice provider networks should clearly indicate for each service applicable the difference in cost-sharing at network and out-of-network hospice providers.
- If using Medicare FFS amounts (e.g., for out-of-network hospice cost sharing), participating plans must insert the 2023 Medicare amounts and must insert: “These are 2023 cost sharing amounts and may change for 2024. [Insert plan name] will provide updated rates as soon as they are released.” Member cost-sharing amounts may not be left blank.
- Plans must clearly indicate if any transitional concurrent care benefits are included during hospice election and network parameters around receiving transitional concurrent care (i.e., for in-network providers only) and any prior authorization and referrals related to receiving transitional concurrent care.
- Plans may insert any additional benefits information based on the plan’s approved bid that are not captured in the benefits chart or in the exclusions section, such as around palliative care.
- Plans must describe any restrictive policies, limitations, or monetary limits that might impact a member’s access to services and benefits part of the Hospice Benefit Component within the chart.
- Plans may add references to the list of exclusions in Section 3.1 as appropriate.
- If applicable, participating plans must update the Medical Benefits Chart to include a supplemental benefits chart including a column that details the exact targeted reduced cost sharing amount for each specific service, and/or the additional hospice supplemental benefits being offered.

Table 1. Example of Hospice Section of Medical Benefit Chart

Services that are covered for you	What you must pay when you get these services
<p>Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care 	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid by <i>[insert 2024 plan name]</i>. <i>[Include information about cost-sharing for hospice consultation services if applicable.]</i></p>
<p>When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.</p>	
<p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> <i>[Insert 2024 plan name]</i> will pay for your hospice services and any Part A and Part B services related to your terminal prognosis.</p>	
<p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay cost-sharing according to the plan's rules described in Chapter 3, Section 1.2, "Basic rules for getting your medical care covered by the plan." 	

Services that are covered for you	What you must pay when you get these services
Hospice care (continued)	
<p>For services that are covered by <i>[insert 2024 plan name]</i> but are not covered by Medicare Part A or B: <i>[insert 2024 plan name]</i> will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p>	
<p>For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you're in Medicare-certified hospice</i>).</p>	
<p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p>	
<p><i>[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a member who hasn't elected the hospice benefit but may be considering and be eligible for the hospice benefit, along with their family or caregiver.]</i></p>	

Chapter 5, Section 9.4 of the EOC

Within Section 9.4 of Chapter 5 of the EOC, participating plans should update the description around covered drugs during a hospice election period to indicate that all drugs will be covered. An example is provided below.

Note: participating plans should update this section to reflect process under the VBID Model and to indicate differences in process for in-network and out-of-network hospice providers, if any.

Example: All medically-necessary and appropriate drugs are covered by our plan. If you are enrolled in Medicare hospice and require a drug, such as an anti-nausea, laxative, pain medication or antianxiety, that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

Chapter 9, Section 4.3 of the EOC

Within Section 4.3 of Chapter 9 of the EOC, plans must include reference to hospice services. An example is provided below.

Example: Section 8 of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only:* home health care, skilled nursing facility care, hospice care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

Chapter 9, Section 5.1 of the EOC

Within Section 5.1 of Chapter 9 of the EOC, plans must include reference to hospice services. An example is provided below.

Example: NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read...

Chapter 9, Section 8.1 of the EOC

Within Section 8.1 of Chapter 9 of the EOC, plans must include reference to hospice services. An example is provided below.

Example: When you are getting **home health services, skilled nursing care, hospice care or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

Chapter 9, Section 8.3 of the EOC

Within Step 3 of Section 8.3 of Chapter 9 of the EOC, plans must include reference to hospice services. An example is provided below.

Example: If you decide to keep getting the home health care, or skilled nursing facility care, or hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Chapter 9, Section 8.4 of the EOC

Within Section 8.4 of Chapter 9 of the EOC, plans must include reference to hospice services. An example is provided below.

Example: If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Chapter 9, Section 8.5 of the EOC

Within Step 3 of Section 8.5 of Chapter 9 of the EOC, plans must include reference to hospice services. An example is provided below.

Example: If you continued to get home health care, or skilled nursing facility care, or hospice care, Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Instructions to Participating Plans Regarding the ANOC for CY 2024

Section 2.3 of the ANOC

Within Section 2.3 of the ANOC, participating plans should note a change to its network to include its network of hospice providers for 2024 and ensure that the participating plan's 2024 Provider Directory (in print and/or online) is updated and lists its network of hospice providers, as applicable.

Section 2.4 of the ANOC

Within Section 2.4 of the ANOC, participating plans should update this section to include the hospice supplemental benefits that may be available for some beneficiaries based on election of the hospice benefit, which may be new for CY 2024. Specific to the Hospice Benefit Component, the table must include: (1) all new benefits that will be added for 2024, including any new mandatory hospice supplemental benefits; (2) new/changing limitations or restrictions, including prior authorization and referrals for CY 2024 transitional concurrent care; and (3) all changes in cost-sharing for 2024 for covered medical services, including any differences in-network and out-of-network hospice providers.

If using Medicare FFS amounts (e.g., for out-of-network hospice cost sharing), participating plans must insert the 2023 Medicare amounts and must insert: "These are 2023 cost sharing amounts and may change for 2024. [Insert plan name] will provide updated rates as soon as they are released." Member cost-sharing amounts may not be left blank.

Section 8.1 of the ANOC

Within Section 8.1 of the ANOC, participating plans should include contact information regarding its high-touch care manager program associated with the Hospice Benefit Component, which should be serviced in a way that is clear, immediately available, culturally competent, and knowledgeable about the hospice benefit and choices.