Calendar Year (CY) 2024
Phase 2 Network Adequacy Requirements Policy and Technical Guidance

Value-Based Insurance Design (VBID) Model: Hospice Benefit Component

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Executive Summary

The Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model's Hospice Benefit Component contains several key elements, including a phased-in network adequacy policy. The purpose of this document is to provide supplemental technical and policy guidance to participating Medicare Advantage Organizations (MAOs) with plan benefit packages (PBPs) subject to the Phase 2 network adequacy requirements. This document also describes the methodology that the Centers for Medicare & Medicaid Services (CMS) will use to generate quantitative standards of network adequacy for the Hospice Benefit Component for Calendar Year (CY) 2024. This document contains the following sections:

Section 1: Introduction and Background
This section provides an overview of the Hospice Benefit Component's approach to a phased-in network adequacy policy, general background on CMS' current regulations and requirements for network adequacy applicable to all MAOs, and an overview of the full scope of the Phase 2 network adequacy requirements applicable to certain participating MAOs.

Section 2: Quantitative Measurement of Network Adequacy: Model-Specific Minimum Number of Provider (MNP) Requirement
This section provides information regarding which PBPs offered by a participating MAO are subject to the Phase 2 requirements, the quantitative standard of network adequacy for Phase 2, and the methodology CMS will use to calculate and set the quantitative standard. **CMS has also included an overview of CY 2024 updates to the Model-specific MNP requirement.**

Section 3: Partial Counties
This section provides information on how the Model-specific network adequacy requirements apply to CMS' current policy for granting partial county determinations.

Section 4: Determinations of Phase 2 Applicability for PBPs
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This section describes the requirements that participating MAOs in Phase 2 must follow with respect to maintaining their networks over the course of CY 2024 and notifying enrollees if a hospice provider is no longer in-network at any point during CY 2024.

Section 7: Timeline for Publication and Evaluation of CY 2024 Model-Specific MNP Standards
This section describes the timeline of key milestones associated with meeting and maintaining the network adequacy requirements applicable during Phase 2. **CMS strongly encourages all participating MAOs to review this section as CMS has included an updated submission timeline.**

Section 1: Introduction and Background

In CY 2021, with the VBID Model's Hospice Benefit Component, CMS began testing the impact on quality and program expenditures of incorporating the Medicare Part A hospice benefit into the MA program, with the goal of creating a seamless continuum of care in the MA program for Part A and Part B services. Participating MAOs are incorporating the Medicare hospice benefit into MA-covered services while offering comprehensive palliative care services outside the hospice benefit for enrollees with serious illness. In addition, participating MAOs are able to provide individualized, clinically appropriate transitional concurrent care services through in-network providers and to offer hospice-specific supplemental benefits.

Outside of the context of the Hospice Benefit Component, CMS maintains a broader set of regulations and requirements for how all MAOs must form, maintain, and offer access to networks of providers and facilities for plan enrollees (see 42 CFR 422.112(a)(1)(i),[1] 422.101(f)(1), and 422.114(a)(3)(ii)). In the June 2, 2020 Federal Register,[2] CMS published a rule that codified its existing network adequacy methodology and finalized policies that address maximum time and distance standards in rural areas, telehealth, and Certificate of Need (CON) laws. These MA network adequacy rules appear at § 422.116. CMS subsequently published guidance[3] on these network adequacy requirements for MA plans. In April 2022, CMS released the final rule titled, "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" (87 FR 27704), which includes policies regarding the network adequacy standards.[4]

Per § 422.116(a)(2), an MAO "must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility-specialty type." To count toward the minimum number requirement, a provider in the MAO's network must be within the maximum time and distance of at least one beneficiary in the sample census used by CMS. These time and distance standards and minimum number of provider requirements are for certain provider and facility types (listed at § 422.116(b)(1) and (2)), and these standards vary by county type (i.e., large metro, metro, micro, rural, and counties with extreme access considerations (CEAC)). CMS does not currently set MA time and distance or minimum number of provider requirements for hospice providers, since the Medicare hospice benefit has historically been excluded from the Part A benefits that MAOs cover.
As described in the CY 2024 Request for Applications (RFA) for the Hospice Benefit Component,[5] CMS has adopted a phase-in approach for participating MAOs to meet network adequacy standards for

[1] All regulatory cites are to Title 42 of the Code of Federal Regulations unless otherwise noted.
[2] Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (85 FR 33797). Please find the final rule at https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf.
[3] Please find the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance at: https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance01122022.pdf
[4] Please find the final rule here: https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf
[5] Please find the CY 2024 RFA for the Hospice Benefit Component available at the VBID Model website, https://innovation.cms.gov/media/document/cy-2024-rfa-vbid-hospice-benefit-component.

hospice providers over the course of the Model test for the Hospice Benefit Component. This approach allows MAOs and hospice providers to develop provider networks for delivery of hospice benefits while ensuring enrollees maintain access to hospice care as these networks form. CMS first announced in the CY 2023 RFA that there will be only two Phases for PBPs participating in the Hospice Benefit Component. This continues to be the case in CY 2024. PBPs in Phase 1 are herein referred to as "first-year PBPs," and PBPs in Phase 2 are herein referred to as "mature-year PBPs."

In CY 2024, CMS will continue to implement Phase 2 of the Hospice Benefit Component's network adequacy policy for hospice providers. Phase 2 has a quantitative and a qualitative component that will apply to participating MAOs with mature-year PBPs, which are those PBPs that have been participating in the Hospice Benefit Component for at least one year, are applying to participate for a second year, and have largely maintained their service areas. The quantitative component is a requirement for participating MAOs to have a minimum number of hospice providers ("MNP requirement") in the network of the mature-year PBPs that participate in the Hospice Benefit Component. This MNP requirement is similar to the requirement at § 422.116(e) for MA plans generally. Notably, the MNP requirement differs in certain aspects from § 422.116(a)(2), as further described in Section 2 of this document.

In addition to this quantitative component, participating MAOs with any mature-year PBPs are required to describe and attest to a comprehensive strategy for providing adequate access to necessary, appropriate, **equitable**,[6] and high-quality hospice services in all service areas. Each participating MAO with a mature-year PBPs must detail the following information about the MAO's policies and strategies in its CY 2024 applications:

- The MAO's criteria and processes supporting hospice provider network selection, including information related to its approach to monitoring and oversight of quality of care provided by in-network providers;
- The MAO's processes to ensure that each in-network hospice is able to deliver care in a timely manner across all four levels of hospice care;
- The MAO's processes to ensure its hospice provider network has adequate capacity (e.g., average daily census, staffing, access to facilities, etc.) to meet projected demand for hospice across the service area(s) of participating PBPs;
- The MAO's efforts in engaging hospice providers who
    - have a history of serving underserved populations,
    - provide additional value-added services to patients and families,
    - have strong relationships with their local communities, and/or

[6] CMS defines health equity as 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. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. See https://www.cms.gov/pillar/health-equity for additional information.

    - actively collaborate with organizations that may help meet the social needs of enrollees; and
- The MAO's efforts to ensure cultural competency throughout the hospice network.

Please refer to Appendix B of the CY 2024 RFA for the Hospice Benefit Component for the specific application questions that pertain to the Phase 2 comprehensive network development strategy requirement.

Applicability of Other Program Rules and Guidance
Please note that no program rules related to network adequacy standards at 42 CFR Part 422 have been waived for the Model. All MA program guidance, including the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance, remains applicable to participating MAOs and is not changed by this guidance.

Technical Assistance and Future Refinements
Please note that this document describes the MNP methodology and its application for CY 2024 in the Hospice Benefit Component of the VBID Model. CMS is committed to providing any MAO (including those who are not currently participants in the Hospice Benefit Component) and other interested stakeholders additional technical guidance on the process for calculating the MNP numerical values specific to hospice providers. CMS welcomes comments, questions, and requests for technical assistance from all stakeholders on any aspect of this technical guidance. Comments, questions, and requests for technical assistance may be sent by email to VBID@cms.hhs.gov.

Section 2: Quantitative Measurement of Network Adequacy: Model-Specific MNP Requirement

Overview of CY 2024 Model-Specific MNP Requirement

Outside of the context of the Hospice Benefit Component, for acute inpatient hospitals and provider-specialty types, the regulation at § 422.116(e) provides for use of a multi-step formula to calculate the MNP numerical value for every county in an MAO's service area. The formula is designed to take into account historical utilization patterns, MA market penetration rates, and the number of enrollees a typical MAO serves. The MNP numerical value represents *at least* how many in-network providers an MAO must make available to deliver care to enrollees in a particular county.

The Model-specific MNP requirement for hospice providers is derived from existing MA network adequacy requirements throughout § 422.116, with certain key exceptions further described below. In addition, the requirement applies only to certain PBPs known as "mature-year PBPs."

As described in the CY 2024 RFA for the Hospice Benefit Component, participating MAOs with mature-year PBPs must create and maintain networks of hospice providers at the *participating MAO level* (i.e., across all mature-year PBPs offered by the same participating MAO within a county). The Model-specific hospice provider MNP values will be calculated and set for each county in a mature-year PBP's service area; the MNP requirement will then be applied and evaluated at the participating MAO level by totaling the MNP values across all mature-year PBPs in a county for each county in the service area(s) of the

mature-year PBPs. This would apply in cases when multiple mature-year PBPs offer coverage in overlapping service areas. Please see the end of this subsection for an example of how this might apply. There are two factors CMS will review to identify the mature-year PBPs that are subject to the Model-specific MNP requirement:

1. **Length of Participation:** The PBP must have participated in the Hospice Benefit Component for at least one year (i.e., in CY 2021, CY 2022, and/or CY 2023) and be reapplying to participate in CY 2024 **OR** the MAO otherwise has experience participating in the Hospice Benefit Component in CY 2021, CY 2022, and/or CY 2023 through a previously participating PBP; **AND**
2. **Service Area:** The PBP's service area in CY 2024 must be largely the same (e.g., no major service expansions to include service areas in other states) as its service area in the most recent year in which the PBP previously participated in the Hospice Benefit Component (i.e., CY 2021, CY 2022, and/or CY 2023).

NOTE: After MAOs submit their applications, CMS will determine which PBPs in the MAOs' applications meet the two-part definitions above. Please reference Section 4: Determinations of PBP Eligibility for Phase 2 for more information on this process. CMS will send to each MAO these determinations, along with a preliminary data book that identifies the MNP value(s) for the current service areas of the MAOs' mature-year PBPs in early May.

The Model-specific MNP requirement differs from § 422.116(e) in two key aspects:

1. CMS will not apply a time and distance standard in order for a hospice provider to count towards the MNP of a PBP; and
2. CMS will calculate the MNP on a county-by-county basis and not group the calculations based on county-type designations (i.e., large metro, metro, micro, rural, and CEAC).

(1) Applicability of Time and Distance Standards: CMS believes that the application of a time and distance standard for hospice care would not appropriately reflect how and where the vast majority of hospice providers deliver care. For the provider and facility types subject to § 422.116, MAOs must demonstrate that their networks do not unduly burden beneficiaries in terms of travel time and distance to network providers/facilities. However, under the Model, based on utilization patterns and standard practice for a hospice provider to travel to the patient, a time and distance standard would be less relevant.

The four levels of hospice care include routine home care (RHC), general inpatient (GIP), inpatient respite care (IRC), and continuous home care (CHC). GIP and IRC are exclusively delivered in an inpatient setting while RHC and CHC are delivered where the patient currently resides (e.g., patient's home, skilled nursing facility, assisted living facility, etc.). As detailed in CMS' analysis in the proposed FY2022 Hospice Wage Index and Payment Rate Update,[7] 98.5% of all hospice days are provided under the RHC and CHC levels of care. The remaining 1.5% of hospice days are provided under the GIP and IRC levels of care. Based on this utilization pattern, the vast majority of hospice days are delivered under circumstances where the hospice provider travels to the patient to deliver any necessary and

[7] Please find the proposed rule here: https://www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf

appropriate services. Although the IRC and GIP levels of care are delivered in inpatient settings, the network adequacy standards for other inpatient facilities such as acute inpatient hospitals cannot be used to meet the network adequacy standards for hospice providers described in this document.

(2) Applicability of County-type Designations: CMS further believes that calculating the MNP on a county-by-county basis would more appropriately tailor the MNP requirement to the unique needs of the Hospice Benefit Component, the enrollees of the participating MAOs, and the capacity for local hospice providers to provide care to those enrollees. The calculation and application of the MNP requirements grouped on the basis of the county's designation as either large metro, metro, micro, rural, and CEAC would be less appropriate given that the number of mature-year PBPs participating in the Hospice Benefit Component is limited (e.g., the MNP for all counties considered large metro would be calculated using a common set of assumptions for all those counties). Setting a county-by-county standard instead would better capture the unique utilization patterns of the participating MAOs' enrollees within those counties that might otherwise be obscured by a county-type designation approach.

Overview of Updates to the CY 2024 Model-Specific MNP Requirement

For CY 2024, CMS has incorporated three key updates to the Model-specific MNP requirement. One update pertains to the process by which MAOs must submit information demonstrating their compliance with the MNP requirement and two updates pertain to the methodology used to calculate the Model-specific MNP. For the latter, CMS has reviewed the methodology for calculating the CY 2023 Model-Specific MNP requirement in previous guidance[8] to identify improvements and refinements with the goal of improving the reliability and accuracy of the methodology. Below is a summary of these updates.

Update One: Submission Process to Demonstrate Compliance with Model-Specific MNP Requirement
As described in the CY 2024 Hospice Benefit Component RFA, CMS will generally not require participating MAOs to resubmit unchanged information associated with the MNP requirement for the counties in the service areas of mature-year PBPs that previously satisfied the MNP requirement for CY 2023. In some cases, the calculated MNP for a participating MAO in a county may increase year-over-year from CY 2023 to CY 2024 based on updated enrollment and utilization data and/or methodological changes to the process of calculating the MNP values; in these cases, CMS will require a participating MAO to resubmit any information necessary to come into compliance with the MNP requirement. If the calculated MNP for a participating MAO in a county decreases from CY 2023 to CY 2024, participating MAOs with mature-year PBPs in the county are not required to maintain the same number of hospice providers in CY 2024.

Update Two: Rounding the MNP Values at the MAO-Level
In previous guidance, CMS' methodology for deriving the MAO-level MNP involved calculating MNP values for each Phase 2 PBP in the county of the participating MAO's service area. When calculating the MNP values for each Phase 2 PBP, CMS rounded the MNP values up to the nearest whole number. Then,

[8] Please find this guidance here: https://innovation.cms.gov/media/document/vbid-hospice-ph2-nw-adq-guide

once each MNP value for each Phase 2 PBP was rounded, CMS summed these values to derive the MAO-level MNP.

CMS has determined that rounding the MNP values at the PBP-level has created an inflationary effect, which leads to a potential overstating of the number of hospice providers needed to meet the projected demand for hospice care in a given county. Therefore, for the CY 2024 methodology, CMS will round the MNP values at the MAO-level rather at the PBP-level.

For example, a participating MAO has two Phase 2 PBPs in a county whose PBP-level MNP values are 3.3 and 4.4. Under the CY 2023 methodology, the individual PBP-level MNP values would first be rounded up to 4.0 and 5.0, respectively, and summed to derive the MAO-level MNP value of 9. Under the revised CY 2024 methodology, the PBP-level MNP values of 3.3 and 4.4 are first summed together to equal 7.7 and then 7.7 is rounded to the nearest whole number to derive the MAO-level MNP value of 8.

Update Three: Using the Average of Hospices' Average Daily Census (ADC) in a County
In previous guidance, CMS's methodology for deriving the PBP-level MNP involved deriving the median ADC of hospices serving a particular county. The purpose of this derivation is to estimate how many patients a "typical" hospice can provide services to in a given county, which would indicate the local "supply" of hospice care. CMS originally used the median ADC to reduce the potential influence of "outlier" ADCs.

However, upon modeling the impact of using the average of ADCs relative to the impact of using the median of ADCs of hospices serving a particular county, CMS has found that using average ADC better represents the local supply of hospice care. This would in turn create more reliable MNP values. Therefore, CMS will use the average ADC instead of median ADC for the CY 2024 methodology.

Example of Application of Methodology for CY 2024 Participating MAO-Level MNP Requirement

Below is a hypothetical example of how CMS will apply the Model-specific MNP requirement at the participating MAO level:

> A participating MAO has two PBPs subject to the Phase 2 requirements of the Hospice Benefit Component's network adequacy policy: HXXXX-001 and HXXXX-002. HXXXX-001's service area includes County A, County B, and County C. HXXXX-002's service area includes County A and County B.
>
> CMS has determined the PBP-level MNP for HXXXX-001 for hospice providers for County A is 4.5 providers, for County B is 5.0 providers, and for County C is 3.0 providers. CMS has determined the PBP-level MNP for HXXXX-002 for hospice providers for County A is 3.3 providers and County B is 5.1 providers.
>
> The sum of the PBP-level MNP values for County A is 7.8, for County B the sum is 10.1, and for County C the sum is 3.0. After rounding up any numbers as appropriate, the participating MAO-level MNP would be 8 hospice providers for County A, 11 hospice providers in County B, and 3 hospice providers in County C. A hospice provider may serve in multiple counties, and therefore, may be counted toward the MNP requirement in more than one county. However, at least one hospice provider indicated as being in-network must appear as serving that county in the Hospice Provider Supply File, further described below.

Methodology for Derivation of CY 2024 Model-Specific MNP Values at the PBP-Level

To promote transparency and provide all stakeholders, including participating MAOs, with further insight into the Model-specific MNP requirement, below is an overview of the methodology CMS will use to generate the MNP numerical values for all counties within the service areas of the mature-year PBPs.

STEP 1 Establish Claims Data for Use in Calculation

CMS will retrieve all claims for hospice care from all Medicare-certified hospice providers using CY 2022 claims data (i.e., the most recent full calendar year's claims data).

STEP 2 Assign Hospice Providers as Caring for Beneficiaries in Certain Counties and Calculate Average ADC

Step 2A (Define Total Number of Beneficiary Days in a Year for a Hospice)

CMS will analyze the 2022 hospice claims data to determine the total number of hospice days (of any of the four levels of hospice care) provided at the CMS Certification Number (CCN) and county level.[9]

Step 2B (Calculate ADC for Each Hospice in County)

CMS will divide output from Step 2A by 365 and set this value as the CCN's ADC.

Step 2C (Apply 1% Market Penetration Cut- Off Off)

CMS will remove all CCNs from county assignment if they served 1% or less of all hospice beneficiaries served in that county. This restriction aims to remove any hospice providers that do not have a presence in a county. [10,11]

Step 2D (Set Average ADC of Hospices in a County)

CMS will calculate and set the average ADC of hospice providers in a county following the application of the cut-off in Step 2C.

STEP 3 Set PBP-Level Enrollment in County

CMS will retrieve the number of Medicare beneficiaries enrolled in the mature-year PBP in a county of the PBP's service area.

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[9] CMS will designate and assign a hospice at the CCN level as serving a particular county if the hospice served a beneficiary whose address of residence was in the county at the time of the hospice claim.

[10] For example, a Medicare beneficiary's current address of residence could be listed as a county in Virginia; but, the beneficiary choose to travel to receive care from a hospice based in Florida. The claims data would indicate that the Florida-based hospice provided care to a beneficiary in Virginia even though the Florida-based hospice does not have any presence in Virginia.

[11] Please note that the 1% Market Penetration Cut-Off is not a process currently used to set the network adequacy standards outside of the Model. The Model-specific methodology to assign hospice providers to certain counties using a claims-based approach may generate inaccurate assignments, per the above footnote, and thus, based off research and findings from stakeholder feedback and a Technical Advisory Panel, CMS concluded it necessary to apply this cut-off.

STEP 4 Calculate Average Number of PBP Enrollees Using Hospice on Any Given Day

Step 4A (Define PBP Enrollees Who Utilized Hospice in County)

CMS will use the enrollees identified in Step 3 to identify the PBP enrollees who utilized hospice in a county in a year (CY 2022).

Step 4B (Calculate Total Number of PBP Enrollee Days in Hospice in County)

CMS will then calculate the total number of days enrollees in Step 4A had a hospice election.

Step 4C (Calculate Average Number of PBP Enrollees Using Hospice on a Given Day)

CMS will divide the figure from Step 4B by 365. This figure represents the PBP enrollees' historical hospice utilization pattern as the average number of PBP enrollees who had a hospice election on a given day.

STEP 5 Calculate MNP for PBP in County

CMS will divide the figure from Step 4C by the figure from Step 2D.

STEP 6 Calculate MNP for All PBPs in All Counties of Service Areas

CMS will repeat the above steps for all counties in service areas of mature-year PBPs.

NOTE: Once these six steps are complete, CMS will sum all of the PBP-level MNP values for a particular county. Then, in accordance with update two to the Model-specific MNP requirement described above, CMS will round up the sum of these values to derive the MAO-level MNP requirement.

General Note Regarding Availability of Historical Data: CMS will use the most recent calendar year's hospice claims and PBP enrollment data for purposes of deriving the MNP value for each mature-year PBP. For purposes of calculating the CY 2024 MNP values, CMS will use all 2022 Medicare hospice claims data paired with historical enrollment to determine PBP-specific utilization patterns. However, in some scenarios, certain PBPs may not have any historical data for purposes of calculating the MNP value. There are two primary scenarios:

- ***Scenario One:*** A participating MAO may offer a PBP with no historical data for a particular county in its service area but the participating MAO had previously offered a PBP in that same county as part of the Hospice Benefit Component in CY 2022. In this scenario, CMS will assume that enrollment and utilization patterns will remain consistent with existing patterns from 2022 and will not be impacted by the addition of PBPs without historical claims and enrollment data.
- ***Scenario Two:*** A participating MAO may offer a PBP with no historical data for a particular county in its service area and the participating MAO has never offered a PBP in that same county as part of the Hospice Benefit Component in CY 2022. In this scenario, CMS will take into account local patterns of care within the county and neighboring counties, local enrollment patterns within the county and neighboring counties, and any potential MNP requirements in neighboring counties to determine an appropriate MNP requirement.

Example of Application of Methodology for CY 2024 Model-specific MNP Values at the PBP-Level

In this subsection, CMS provides an example of how CMS will calculate the MNP value using a hypothetical participating MAO's PBP HXXXX-001 in "Example" County (see next page). All entities and values are entirely hypothetical.

Background Information

The below is background information to understand application of the CY 2024 MNP methodology.

- PBP HXXXX-001 is a mature-year PBP and has historical enrollment and utilization data available.
- Through claims-based assignment described in Step 2 above (see subsection, "Methodology for Derivation of CY 2024 Model-Specific MNP Values"), Hospice A, Hospice B, Hospice C, Hospice D, Hospice E, and Hospice F serve Medicare beneficiaries in Example County.
- Through claims analysis, Hospice A through Hospice F have provided the following total number of hospice days to Medicare beneficiaries in 2022: Hospice A = 18,250 days; Hospice B = 36,500 days; Hospice C = 54,750 days; Hospice D = 73,000 days; Hospice E = 91,250 days; and Hospice F = 200 days.
- Hospice F has provided hospice care to less than 1% of all Medicare beneficiaries who received hospice care in Example County and therefore does not have 1% or more of market share in that Example County.
- PBP HXXXX-001 has 20,000 enrollees in Example County in 2022.
- Of the 20,000 enrollees in Example County, 400 enrollees elected hospice in 2022.
- Those 400 enrollees were enrolled in hospice care for a combined total of 36,000 days in 2022.

Example Calculation

Step Number	Step Title	Calculation	Step Output/Value
1	Establish Claims Data for Use in Calculation	N/A	N/A
2	Assign Hospice Providers as Caring for Beneficiaries in Certain Counties and Calculate Average ADC		
2A	Define Total Number of Beneficiary Days in a Year for a Hospice	N/A	Hospice A = 18,250; Hospice B = 36,500; Hospice C = 54,750; Hospice D = 73,000; Hospice E = 91,250; Hospice F = 200
2B	Calculate ADC for Each Hospice in Example County	2A divided by 365	Hospice A ADC = 50; Hospice B ADC = 100; Hospice C ADC = 150; Hospice D ADC = 200; Hospice E ADC = 250; Hospice F = 0.55
2C	Apply 1% Market Penetration Cut-Off	N/A	Remove Hospice F from assignment to Example County; Set Hospices A – E as serving Example County with respective ADCs
2D	Set Average ADC of Hospices in Example County	Average of 2B after application of 2C	150
3	Set PBP-Level Enrollment in Example County	N/A	20,000
4	Calculate Average Number of PBP Enrollees Using Hospice on Any Given Day in Example County		
4A	Define PBP Enrollees Who Utilized Hospice in Example County	N/A	400
4B	Calculate Total Number of PBP Enrollee Days in Hospice in Example County	Sum of lengths of stays of 4A	36,000
4C	Calculate Average Number of PBP Enrollees Using Hospice on a Given Day in Example County	4B divided by 365	98.63
5	Calculate MNP for PBP in Example County	4C divided by 2D	0.66

Section 3: Partial Counties

Outside of the context of the Hospice Benefit Component, CMS reviews the networks of MAOs that have full county service areas or partial county service areas. Generally, per § 422.2 (definition of "service area"), the service area of an MA plan must cover a full county (or full counties), but MAOs may request an exception to the county integrity rule to permit an MA plan to use a partial county in the plan service area. CMS may grant this exception, provided that the MAO adequately demonstrates that the partial county is: 1) necessary, 2) nondiscriminatory, and 3) in the best interests of the beneficiaries. CMS may also consider the extent to which the proposed service area mirrors the service area of existing commercial health care plans or MA plans offered by the organization. Additional guidance on this process can be found in the MA and Section 1876 Cost Plan Network Adequacy Guidance.[12]

For purposes of the Hospice Benefit Component and Phase 2 network adequacy requirements for participating MAOs with mature-year PBPs, CMS expects participating MAOs with mature-year PBPs with approved partial county service areas to meet the MNP requirement for those partial counties. These participating MAOs may submit exception requests to the MNP requirement as outlined in Section 5: Exception Requests for CY 2024 Model-specific MNP Requirement. However, the Model-specific requirements outlined in this document do not impact the process MAOs use to submit Partial County Justifications. Additionally, the Model-specific requirements outlined in this document will not impact CMS' broader determination of whether to permit an MA plan to use a partial county service area.

Section 4: Determinations of PBP Eligibility for Phase 2

As mentioned in Section 2: Quantitative Measurement of Network Adequacy: Model-Specific MNP Requirement, after applications for participation in the Hospice Benefit Component for CY 2024 are submitted, CMS will apply a determination process to identify which PBPs are subject to the Phase 2 requirements. The purpose of this section is to further describe the criteria and standards for this process and to accordingly offer more nuance on the originally described two-part definition of a mature-year PBP based on its length of participation and service area.

Length of Participation Determinations

The length of participation criterion is described as a "PBP must have participated in the Hospice Benefit Component for at least one year (i.e., in CY 2021, CY 2022, and/or CY 2023) and be reapplying to participate in CY 2024 **OR** the MAO otherwise has experience participating in the Hospice Benefit Component in CY 2021, CY 2022, and/or CY 2023 through a previously participating PBP." The "or" statement is included to recognize that individual PBPs may enter and exit the Model Component over time, but a participating MAO otherwise may have experience with the Hospice Benefit Component in a particular service area. Therefore, the length of participation requirement will ultimately be determined and applied at the MAO level to capture any potential churn of participating PBPs. Therefore, if an MAO has participated in the Hospice Benefit Component in the same service area for at least one calendar year, any PBPs it offers to participate in the Hospice Benefit Component in the following calendar year

[12] Please find this guidance here: https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance01122022.pdf

will be considered mature-year PBPs. This assumes that the service areas of PBPs remain constant across calendar years.

For example, a participating MAO's PBP HXXXX-001 has been part of the Hospice Benefit Component for CY 2023 and has applied to participate in CY 2024. The service area in which the participating MAO offered coverage to enrollees in PBP-HXXXX-001 in CY 2023 is the same service area in which PBP HXXXX-001 will be offered to enrollees in CY 2024. The participating MAO has also applied to enter PBP HXXXX-002 into the Hospice Benefit Component. PBP HXXXX-002 has the same service area as PBP HXXXX-001. However, CY 2024 will be the first year the participating MAO offers PBP HXXXX-002 as part of the Hospice Benefit Component. In the absence of the previously mentioned "or" statement, PBP HXXXX-002 does not initially meet the definition of a mature-year PBP, but PBP HXXXX-001 does satisfy the definition. Because the participating MAO offered another PBP as part of the Hospice Benefit Component in the same service area in a previous CY (i.e., CY 2023), all PBPs the participating MAO offers as part of the Hospice Benefit Component in that service area in CY 2024 would be considered mature-year PBPs. Accordingly, in this example, PBP HXXXX-002 would be considered a mature-year PBP in CY 2024, even though that particular PBP did not participate in the Hospice Benefit Component in CY 2021, CY 2022, or CY 2023.

Service Area Determinations

The service area criterion is described as "the PBP's service area in CY 2024 must be largely the same (i.e., no major service expansions to include service areas in other states) as its service area in the most recent year in which the PBP previously participated in the Hospice Benefit Component (i.e., CY 2021, CY 2022, and/or CY 2023)." If there is no change in a PBP's service area, CMS will consider the PBP as meeting this criterion. If the PBP reduces its service area and makes no other changes, CMS will generally also consider a PBP as meeting this criterion. CMS will perform further review on a case-by-case basis for service area expansions to determine if a PBP meets this criterion. CMS may consider factors such as (but not limited to) the number and geographic reach of counties part of a service area expansion (e.g., to include other states) and the types of counties that may be included in the expansion relative to the existing service area (e.g., addition of a large metro county in a service area expansion, whereas historically, the PBP's service area only included rural counties).

CMS may find it necessary to adjust the participating MAOs' counties subject to the MNP requirement based on CMS approvals of service area expansions. A participating MAO will not need to meet the MNP requirement for the county/counties that have not been approved by CMS as part of a service area expansion request. If CMS approves a participating MAO's service area expansion and CMS determines the PBP still meets the service area criterion, then the participating MAO must meet the MNP requirement for the county/counties part of the expanded service area. CMS may determine it is necessary to update the MNP data books based on service area expansions. If so, CMS will distribute a second updated version of the MNP data books early June 2023 as further described in Section 7: Timeline for Evaluation and Publication of Model-Specific MNP Standards.

Section 5: Exception Requests for CY 2024 Model-Specific MNP Requirement

Per § 422.116(f)(1), an MAO may request an exception to network adequacy criteria when both of the following occur:

1. Certain providers or facilities listed in the supply file are not available for the organization to meet the network adequacy criteria for a given county and specialty type; **AND**
2. The organization has contracted with other providers and facilities that are located beyond the limits in the time and distance criteria, but are available and accessible to most enrollees, consistent with the local pattern of care.

A similar process and standards for requests and approval of an exception request, with modifications as described below, will be applied in the Hospice Benefit Component of the Model when CMS evaluates participating MAOs for compliance with the Model-specific MNP requirement. Given that CMS has chosen not to adopt a time and distance standard for the Model-specific requirement, participating MAOs with mature-year PBPs must submit exception requests to the Model-specific MNP requirement when at least one of the following is true:

1. The number of contracted providers submitted in the Provider Network File is less than the MNP value provided in the Final MNP Data Book for a county within the service area of a mature-year PBP; or
2. There are no providers from the Hospice Provider Supply File included in the Provider Network File for a county within the service area of a mature-year PBP.

Hospice Provider Supply File: The Hospice Provider Supply File will be generated using the claims-based assignment methodology described in Step 2. The Hospice Provider Supply File includes information on Medicare-certified hospice providers (e.g., name, address, national provider identifier, CCN), and will be provided to CY 2024 MAO applicants. Given the dynamic nature of the market, the file is a resource and may not be a complete depiction of the provider and facility supply available in real-time. MAOs remain responsible for conducting validation of data used to populate their Hospice Provider Network files, including data initially drawn from the Hospice Provider Supple File. MAOs should not rely solely on the Hospice Provider Supply File when establishing networks, as hospice providers' service areas may have changed over time. Therefore, CMS may update the Hospice Provider Supply File periodically to reflect updated hospice provider information and to capture information associated with exception requests. CMS intends to use the Hospice Provider Supply File when validating information submitted on exception requests.

Evaluation of Exception Requests: Per § 422.116(f)(2), CMS will consider the following when evaluating exception requests:

i. The current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;
ii. There are other factors present, in accordance with § 422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and
iii. Approval of the exception is in the best interests of beneficiaries.

In the context of the Hospice Benefit Component of the Model, CMS intends to generally apply the same standards to evaluate and approve requests for exceptions to the hospice MNP requirement. Current CMS guidance provides the following as examples of valid rationales to submit exception requests, which CMS will accept for the Hospice Benefit Component, unless footnoted otherwise.

a) Provider is no longer practicing (e.g., deceased, retired);
b) Does not contract with any organizations or contracts exclusively with another organization;[13]
c) Provider does not provide services at the office/facility address listed in the supply file;[14]
d) Provider does not provide services in the specialty type listed in the supply file;[15]
e) Provider has opted out of Medicare;
f) Sanctioned provider on List of Excluded Individuals and Entities;
g) Use of Original Medicare telehealth providers or mobile providers;[16]
h) Specific patterns of care in a community;
i) Provider may cause beneficiary harm; and
j) Provider is not appropriately credentialed or does not have a Medicare participation agreement as required by § 422.204(b)(3). See also Medicare regulations regarding hospice program conditions of participation at 42 CFR §§ 418.50 through 418.116. MAOs may also review Chapter 6 of the Medicare Managed Care Manual for additional guidance for MAOs regarding provider credentialing for purposes of provider networks.

CMS recognizes that participating MAOs may need time beyond the submission deadline for the exception requests to finalize contract negotiations with hospice providers. Therefore, CMS will also accept, "In the process of negotiating a contract with provider" as a valid rationale for an exception request. Participating MAOs that choose to use this rationale must submit a letter of intent (LOI) signed by the hospice provider indicating that the hospice provider and participating are in negotiations and expect to have an executed contract by no later than January 1, 2024. CMS also recognizes that these negotiations may not always be successful but a LOI should indicate a serious commitment by both parties and only in rare circumstances should these negotiations fail to produce an executed contract by January 1, 2024.

Finally, CMS recognizes that these rationales are not an exhaustive list and will accept "Other" as possible rationale. In cases when a participating MAO selects "Other" as their rationale, the MAO must submit all information and documentation clearly explaining and justifying their rationale.

[13] Hospice providers historically may not have contracted with MAOs given that the Medicare hospice benefit has not been part of the Part A services covered by MAOs. CMS will interpret this Rationale B within this context and will therefore require further evidence that a hospice provider does not contract with any MAOs or contracts exclusively with only one MAO.
[14] CMS will accept exception requests for when the provider does not provide services *in the county* listed in the supply file, rather than "at the office/facility address listed in the supply file."
[15] CMS will generally not accept this rationale because the claims-based assignment process for generating the Supply File captures all providers that are by definition Medicare-certified hospice providers.
[16] CMS will generally not accept this rationale as the sole use of telehealth or mobile providers would not be sufficient to deliver hospice care.

NOTE: CMS will generally not accept an organization's assertion that it cannot meet the Model-specific MNP requirement because of an "inability to contract," meaning it could not successfully negotiate and establish a contract with a hospice provider. The non-interference provision at section 1854(a)(6)(B)(iii) of the Social Security Act ("Act") prohibits CMS from requiring any MAO to contract with a particular hospital, physician, or other entity or individual to furnish items and services or require a particular price structure for payment under such a contract. As such, CMS cannot assume the role of arbitrating or judging the bona fides of contract negotiations between an MAO and available providers or facilities.

The participating MAO must include conclusive evidence in its exception request that the Model-specific MNP requirement cannot be met because of changes to the availability of hospice providers, resulting in insufficient supply. CMS will conduct a series of verification procedures to confirm the reasons for not contracting for hospice providers which are included in a county's exception request; misalignment of a reason with the results of verification may result in CMS' decision not to grant an exception. The organization must also demonstrate that its contracted network of hospice providers included on its Hospice Provider Network files furnishes enrollees with adequate access to covered services and is consistent with or better than the Original Medicare pattern of hospice care for a given county.

Participating MAOs' hospice provider networks must be consistent with local patterns of hospice care. Participating MAOs may demonstrate this consistency with local patterns of hospice care for a county by, for example, contracting with a hospice provider listed in the Hospice Provider Supply File as providing care in that county or an adjacent county. Additionally, MAOs will be required to present narrative explanations of the pattern of care of a given county when submitting an exception request. CMS will not approve an MAO's hospice provider network as meeting the Model-specific MNP requirement for a particular county if none of the contracted providers provide services in any local counties (e.g., contracting with a hospice provider that only delivers care to enrollees in Arlington County, VA to provide hospice services in Montgomery County, PA would not fit the local pattern of hospice care). CMS will closely review network submissions. The timeline for submission of information about hospice provider networks is outlined in Section 7 and is modified from the timeline for other types of provider network reviews.

CMS will notify all participating MAOs with mature-year PBPs (including those who are not granted an exception request) of any network deficiencies and provide an opportunity for the MAO to seek clarification on any identified deficiencies and to submit additional information for CMS' consideration. CMS will provide participating MAOs with final determinations regarding their networks prior to final approval for participation in the Hospice Benefit Component. All participating MAOs with mature-year PBPs must correct any network deficiencies by January 1, 2024.

Section 6: CY 2024 Network Maintenance Requirements

The requirements under § 422.112(a)(1)(i) to maintain and monitor a network of appropriate providers will apply to hospice provider networks for MAOs with mature-year PBPs. CMS will provide additional information through its CY 2024 Monitoring Guidelines on how it will perform network adequacy reviews. For reference, Section 2.4 of the CY 2023 Monitoring Guidelines[17] describes the implementation of the CY 2023 requirements.

Network-Related Communications: Participating MAOs with mature-year PBPs must inform CMS of any provider termination considered to be "significant" 90 days prior to the termination. CMS considers significant changes to hospice provider networks to be those that go beyond individual or limited provider terminations that occur during the routine course of plan operations; affect, or have the potential to affect, a large number of the MAO's hospice enrollees;[18] or would affect the participating MAO's ability to meet MNP requirements for its service area(s).

Participating MAOs with mature-year PBPs must also continue to follow requirements at § 422.111(e) and make a good faith effort to provide written notice of a termination of a contracted hospice provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the hospice provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. CMS will provide additional information through its CY 2024 Communications and Marketing Guidelines on network-related communications, including requirements for provider directories.

Section 7: Timeline for Evaluation and Publication of Model-Specific Minimum Number of Provider (MNP) Standards

The below outlines the timeline for evaluating, publishing, and monitoring compliance with the Model-specific MNP requirement. These steps are further summarized in a table at the end of this section.

Step 1: Release of Policy and Technical Guidance and Provision of Technical Assistance (February 17, 2023 through August 2023)

Following the release of this document, CMS will provide technical assistance to participating MAOs and other interested stakeholders on a rolling basis through August 2023. This technical assistance will include (but is not limited to) support on calculation of the Model-specific MNP requirements, the exception request process, and the submission of CY 2024 Hospice Provider Network Files.

Step 2: Application Due Date (April 14, 2023)

All MAOs interested in participating in the VBID Model, including the Hospice Benefit Component, must submit their applications to CMS by April 14, 2023 (11:59 PM PT). CMS does not expect MAOs subject to the Phase 2 network adequacy requirements to have their CY 2024 hospice provider networks fully formed by the time of application, but they must attest that they will do so by January 1, 2024.

[17] Please find this guidance here: https://innovation.cms.gov/media/document/vbid-cy2023-hospice-monitoring

[18] For the purposes of this Model, CMS defines "a large number of the MAO's hospice enrollees" as ten percent or more of all enrollees in a PBP who have elected hospice.

Step 3: Distribution of Determinations of Mature-Year PBPs and Preliminary MNP Data Books (Mid-May 2023)
Once MAOs submit their applications by April 14, 2023, CMS will determine which PBPs included in the applications meet the definition of a mature-year PBP. In mid-May 2023, CMS will distribute a Preliminary MNP Data Book to each participating MAO with the results of the determination process along with listing out the MNP requirement for each county in the service area of any mature-year PBP. CMS will also distribute the Hospice Provider Supply File to participating MAOs with mature year PBPs.

NOTE: This data book will not be reflective of any finalized service area changes for CY 2024. Therefore, CMS will distribute a Final MNP Data Book in June. However, we **strongly** encourage participating MAOs to review the Preliminary MNP Data Book and begin preparing the documentation necessary to submit an exception request(s) and/or pursue additional contracting efforts using the Preliminary MNP Data Book.

Step 4: Distribution of Final MNP Data Books (Mid-June 2023)
As described in Section 4: Determinations of PBP Eligibility for Phase 2, CMS will distribute Final MNP Data Books to the participating MAOs to reflect service area expansions for CY 2024. CMS will do so no later than mid-June 2023.

Step 5: Submission of CY 2024 Hospice Provider Network Files (Mid-June 2023 through June 30, 2023)
After CMS distributes the Final MNP data books, CMS will begin to accept CY 2024 Hospice Provider Network Files from MAOs with mature year PBPs from mid-June 2023 to June 30, 2023. CMS will provide applicant MAOs with submission instructions in May 2023.

Step 6: Review of Hospice Provider Network Files and Distribution of Pre-Populated Exception Request Forms (July 3, 2023 through July 31, 2023)
After participating MAOs submit their CY 2024 Hospice Provider Network Files, CMS will use those files and the Final MNP Data Books to generate pre-populated exception request forms with all counties that require an exception request because a participating MAO's provider network does not meet the MNP requirements.

Step 7: Submission of Exception Request Forms (August 1, 2023 through August 15, 2023)
After CMS distributes the pre-populated exception request forms, participating MAOs with Phase 2 PBPs will have two weeks to complete and submit any necessary exception requests along with any supporting documentation.

CMS strongly encourages MAOs to engage in this process as soon as possible to ensure adequate time to correct any potential network deficiencies.

Step 8: Verification of Information Submitted in Exception Request Forms (August 16, 2023 through December 31, 2023)
As noted earlier, CMS and its implementation contractor will perform outreach to the participating MAOs and individual hospice providers to verify the quality of the data submitted along with verifying the accuracy of the information. Based on the findings of these outreaches, CMS may reach out to the participating MAOs to re-submit or clarify information.

Step 9: Publication of Public MNP Data Book (October 2023)
CMS will make available a public MNP Data Book that provides all stakeholders with information on the Model-specific MNP requirements for each county in the service areas of the participating MAOs.

Step 10: Full Compliance with Model-Specific MNP Requirement (January 1, 2024)
All participating MAOs with mature-year PBPs must correct any network deficiencies and be in full compliance with the Model-specific MNP requirement by January 1, 2024. CMS will reach out to confirm compliance on a rolling basis.

Step 11: Ongoing Reviews of Hospice Provider Networks (January 2024 – December 2024)
CMS will perform reviews of the hospice provider networks of participating MAOs with mature-year PBPs to ensure compliance with all Model-specific requirements. CMS will distribute additional information on this process through the CY 2024 Monitoring Guidelines.

Timeline for Publication and Evaluation of Model-Specific MNP Standards

Date	Milestone
February 17, 2023	CMS releases the CY 2024 Phase 2 Network Adequacy Requirements: Policy and Technical Guidance document
April 14, 2023	Completed CY 2024 Hospice Benefit Component Application due to CMS by 11:59 PM PT
Mid-May 2023	CMS provides participating MAOs with Preliminary MNP Data Books containing the MNP calculations at the participating MAO level. CMS provides participating MAOs with the Hospice Provider Supply File
June 5, 2023	CY 2023 MA and Part D Bid submission deadline (11:59 PM PT)
Mid-June 2023	CMS provides participating MAOs with Final MNP Data Books containing the MNP calculations at the participating MAO level, reflective of CY 2024 service area changes.
Mid-June 2023 through June 30, 2023	CMS accepts CY 2024 Hospice Provider Network Files from MAOs with mature year PBPs.
July 3, 2023 through July 31, 2023	CMS reviews CY 2024 Hospice Provider Network Files and generates pre-populated exception request forms with all counties that require an exception request because a participating MAO's provider network does not meet the MNP requirements. CMS distributes pre-populated exception request forms.
August 1, 2023 through August 15, 2023	After CMS distributes the pre-populated exception request forms, participating MAOs with Phase 2 PBPs will have two weeks to complete and submit any necessary exception requests along with any supporting documentation.
Mid-August 2023 through December 31, 2023	CMS and its implementation contractor will perform outreach to the participating MAOs and individual hospice providers to verify the quality and accuracy of the exception request form data.
Mid-to-Late September 2023	Contract addenda for Model participation executed and CY 2024 Model Participants announced
October 2023	Public MNP Data Book made available to all stakeholders.
January 1, 2024	CY 2024 performance period of the Hospice Benefit Component of the VBID Model begins All participating MAOs with mature-year PBPs must be in compliance with the MNP requirement.
January 2024-December 2024	CMS will perform ongoing reviews of hospice provider networks to ensure compliance with all Model-specific requirements