



Value-Based Insurance Design Model Incorporation of the Medicare Hospice Benefit into Medicare Advantage

CY 2021 Request for Applications

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2. Background and General Information

The Centers for Medicare & Medicaid Services (CMS) Innovation Center is seeking applications from eligible Medicare Advantage Organizations (MAOs) to participate in the component incorporating the Medicare hospice benefit into Medicare Advantage (MA) of the Value-Based Insurance Design (VBID) Model (“hospice benefit component”) for Calendar Year (CY) 2021. The CMS Innovation Center will provide separate application guidance for MAOs interested in offering the other components of the VBID Model for CY 2021; this Request for Applications (RFA) is only for the hospice benefit component of the Model. MAOs interested in participating in the hospice benefit component are required to comply with the Model requirements for the Wellness and Health Care Planning (WHP) component as well.¹

Through the hospice benefit component, CMS is testing the impact on payment and service delivery of incorporating the Medicare Part A hospice benefit with the goal of creating a seamless care continuum in the MA program for Part A and Part B services. For MAOs that volunteer to be part of the Model, CMS will evaluate the impact on cost and quality of care for MA enrollees, including how the Model improves quality and timely access to the hospice benefit, and the enabling of innovation through fostering partnerships between MAOs and hospice providers.

1.1. Summary of Medicare Hospice Benefit Component and Request for Applications

This RFA provides background information for interested MAOs on the Medicare hospice benefit, statutory and regulatory definitions for hospice care, and the scope of the hospice benefit component. In section two of this RFA, and summarized in this section, CMS sets out the specific quality, network, and payment policies being tested as part of the hospice benefit component of the Model for CY 2021. Sections three, four, and five set out model requirements, a high-level description of the Model component evaluation, and the application process for the Model component.

In participating in this component of the Model, MAOs will incorporate the current Medicare hospice benefit into MAO covered benefits in combination with offering palliative care services outside the hospice benefit for enrollees with serious illness and providing individualized transitional concurrent care services, as described in Sections 2.1-2.3 of this document. MAOs will be paid a hospice capitation as set out at Section 2.7, and will provide services in alignment with quality improvement goals set out at Section 2.5 and the network adequacy structure set out at Section 2.6.

The six main elements of this demonstration are as follows:

First, participating plans must provide the full scope of hospice benefits, as defined in the Social Security Act (Act) at § 1861(dd). Participating MAOs’ enrollees receiving hospice benefits must meet the statutory definition of “terminally ill,” as set out in the Act at § 1861(dd)(3)(A). Through contracting hospices, MAOs must work with an interdisciplinary care team (IDT) at § 1861(dd)(2)(B), and provide the four levels of hospice care set out in CMS regulations at 42 CFR § 418.302(c). Additionally, the choice to elect or revoke

¹ The VBID Model requires applicants (including organizations that previously participated in the Model) to “submit, receive approval for, and comply with a strategy regarding the delivery of timely [WHP] services, including advance care planning (ACP) services, to all enrollees” as a condition of receiving any program waiver under the Model. For more detail on the WHP component of the Model, Please see the VBID Model Website for the CY 2021 VBID Model RFA (available soon): <https://innovation.cms.gov/initiatives/vbid/>.

the hospice benefit will remain exclusively with a participating MAO's enrollee (or his or her representative), as set out in the Act at § 1812(d) and in CMS regulations at 42 CFR §§ 418.24 and 418.28.

Second, in addition to hospice services, CMS will require participating MAOs to have a strategy around access and delivery of palliative care services for enrollees with serious illness who are either not eligible for or who have chosen not to receive hospice services. While MAOs may define the criteria enrollees must meet to receive these palliative care services, participating MAOs must provide coverage of, by furnishing, arranging for, or making payment for, these palliative care services that are covered by Medicare Part A or Part B as set out in the Act at § 1852 in a way that is neutral to total Parts A and B expenditures.

Third, to ease care transitions and ensure hospice-eligible beneficiaries are able to access and receive the full benefits of hospice care, participating MAOs must work with in-network hospice providers and non-hospice providers to make available the transitional concurrent care services necessary to address continuing care needs, as clinically appropriate, for the treatment of hospice enrollees' terminal conditions. Any transitional concurrent care must be appropriate and reflective of patients' needs and wishes as identified in their plans of care and coordinated among hospice providers, MAOs, and other treating providers.

Fourth, to provide transparency and improved beneficiary, family, and caregiver experience with end-of-life care, CMS will monitor the performance of participating MAOs and aggregate performance of MAOs across this component of the Model, based on the following quality domains: (i) Palliative Care and Goals of Care Experience; (ii) Enrollee Experience and Care Coordination at End of Life; and (iii) Hospice Care Quality and Utilization. CMS has intentionally selected measures that present improvement opportunities relevant to enrollees' care and quality of life, are clinically meaningful, and are aligned with CMS's broader quality measurement strategy.

Fifth, in order to ensure access to hospice providers, for CY 2021, all participating MAOs must cover hospice services furnished by both in-network and out-of-network providers. Consistent with 42 CFR § 422.214, participating MAOs must pay non-contracted hospice providers at a rate equal to the Original Medicare Fee-For-Service (FFS) payment for hospice services. Additionally, cost sharing for hospice services may be no higher than the cost sharing in Original Medicare for hospice benefits.

Finally, participating MAOs will be paid a monthly hospice capitation payment for each month that an enrollee elects hospice. The monthly hospice capitation payment rate is based on both related and unrelated costs paid by the FFS payment system for all beneficiaries who elect hospice care. For the first month only, an adjustment will be applied to the hospice capitation payment rate to ensure the capitation payment rate more closely reflects beneficiary experience in hospice.

In sum, CMS believes the policies being tested through this Model represent an opportunity for Medicare beneficiaries who choose MA and elect hospice, as well as their families and caregivers, to experience a more seamless transition to hospice care, if aligned with their wishes, with improved coordination of care.

1.2. Medicare Hospice Benefit Component for CY 2021

CMS is exercising its Section 1115A authority to grant limited program waivers to participating MAOs that volunteer to be part of the hospice benefit component of the Model, in order to test the impact on the service delivery of hospice care by incorporating the Medicare hospice benefit into MA. CMS's

fundamental aim through testing the hospice benefit component of the Model is to improve access to high-quality hospice care for Medicare beneficiaries who elect the hospice benefit.

Participating MAOs that volunteer to be part of the hospice benefit component will include the Medicare hospice benefit as one of the Original Medicare services offered through and managed by the MA plan. MAOs will work with their network of high-quality providers to improve service delivery by offering access to: (1) palliative care services for enrollees who are not yet hospice eligible or eligible but choose not to elect hospice; (2) transitional concurrent care for those enrollees who elect hospice; and (3) more consistent, higher quality, and standardized hospice care.

CMS will test the impact on hospice utilization patterns and costs of care related and unrelated to the terminal condition and related conditions based on the Model's approach to improving the coordination and quality of care and service delivery. Further, CMS hopes that through improved coordination of care by participating MAOs (also called Model Plan Benefit Packages (PBP)), as well as the Model component's focus on palliative and transitional concurrent care, the median length of hospice stay will increase, very short and long lengths of stay will decrease, and enrollees and their families and caregivers will be able to experience the benefits of hospice care over a more appropriate period of time as aligned with their wishes and the patient's needs.

Broadly, the hospice benefit component of the Model aligns with both CMS's strategic goal of putting patients first and the CMS Innovation Center's portfolio of models that take steps to expand appropriate access to palliative and hospice care, such as the Medicare Care Choices Model (MCCM), the Seriously Ill Population (SIP) component of the Primary Care First (PCF) Model, and the Direct Contracting (DC) Model.

Consistent with the Model component's fundamental aim, hospice care furnished under the Model must meet all statutory and regulatory requirements of the Medicare hospice benefit as outlined at § 1861(dd) of the Social Security Act (the "Act") and codified at 42 CFR Part 418, except where explicitly waived in Section 1.6 below. More specifically, the statutory and regulatory requirements governing the hospice benefit in the Original Medicare program will apply to MAOs furnishing the hospice benefit component of the VBID Model. Consistent with that, the following terms are used the same way for this Model component as they are used in Original Medicare and the standards and requirements inherent in these definitions also apply:

- **Palliative Care:** Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (42 CFR § 418.3);
- **Terminally Ill:** Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course (42 CFR § 418.3);
- **Hospice Election:** Hospice election means that voluntarily, eligible individuals may make an election to receive hospice care (42 CFR § 418.24). The content of the hospice election statement must also be consistent with the Fiscal Year (FY) 2020 Hospice Wage Index Final Rule (84 FR 38484), which requires the hospice to provide, at the request of the patient or their representative, an addendum that includes information aimed at increasing coverage transparency for patients under a hospice

election. In addition, the election statement must conform to any subsequent changes to the regulation made during the course of the demonstration period;

- **Hospice Care:** Hospice care means a comprehensive set of services (described at § 1861(dd)(1) of the Act) that are identified and coordinated by an interdisciplinary care team to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care (42 CFR § 418.3);
- **Covered Hospice Items and Services:** Covered hospice items and services include core and non-core services. With the exception of physician services, substantially all core services must be provided directly by hospice employees on a routine basis. These services must be provided in a manner consistent with acceptable standards of practice. Core services include physician, nursing, medical social services, counseling, bereavement, and spiritual services (42 CFR § 418.64). Nursing services, physician services, and drugs and biologicals must be made routinely available on a 24-hour basis seven days per week. In addition to the hospice core services, the following services must be provided by the hospice and only by the hospice as part of its agreement with the MAO, either directly or under arrangements, to meet the needs of the patient and family as part of non-core services: Physical and occupational therapy and speech-language pathology services; hospice aide services; homemaker services; volunteers; medical supplies (including drugs and biologicals) and use of medical appliances related to the terminal illness and related conditions; and short-term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management (42 CFR §§ 418.70-418.78; 418.100));
- **Per Diem Rate Categories of Hospice Care:** Per diem rate categories encompass the following four categories of hospice care and include all of the hospice services and items needed for the palliation and management of the beneficiary's terminal condition as required at § 1861(dd)(1) of the Act: (i) routine home care (RHC); (ii) continuous home care (CHC); (iii) general inpatient care (GIP); and (iv) inpatient respite care (IRC) (42 CFR § 418.302). These four levels of hospice care are distinguished by the intensity and location of the services provided. A CMS review of claims over the last 10 years shows that RHC, which is the basic level of care under the hospice benefit, remains the highest utilized level of care, accounting for an average of 97.6 percent of total hospice days; GIP accounting for 1.7 percent of total hospice days; CHC accounting for 0.4 percent of total hospice days; and, IRC accounting for 0.3 percent of total hospice days.² If, in the judgment of the hospice IDT, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for GIP, a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to his or her home and continue to receive RHC. Limited, short-term, intermittent, IRC is also available because of the absence or need for relief of the family or other caregivers. Additionally, an individual can receive CHC during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. Continuous home

² Proposed Rule, "Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (84 FR 17570, April 25, 2019).

care may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with CMS regulations at § 418.204. For any given patient, the type of care can vary throughout the hospice stay, as the patient's needs change;

- **Hospice Election Period:** Hospice election period refers to the period in which an individual may elect to receive hospice care during one or more of the following election periods: (i) initial 90-day period; (ii) subsequent 90-day period; and (iii) unlimited number of subsequent 60-day periods. The periods of care are available in the order listed and may be elected separately at different times. Initiation of an election period prior to the beginning of the patient's third election period, and prior to each subsequent election period requires a hospice physician or hospice nurse practitioner to have a face-to-face encounter with the patient. The certifying physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms (42 CFR § 418.22); and
- **Hospice Revocation:** Hospice revocation refers to the right of beneficiaries to revoke their hospice election at any time during an election period. Upon revocation, a beneficiary is no longer covered under Medicare for hospice care and resumes Medicare coverage of benefits waived upon election (42 CFR § 418.24(c)(2)).

Model Geography

Eligible MA plan types in all states and territories may apply to participate in this component of the VBI Model for CY 2021. (See Section 3.1: Eligibility Requirements).

Model Performance Period

The hospice benefit component of the Model will be tested through 2024. CMS is only announcing an application period for CY 2021 at this time for the hospice benefit component.

1.3. Model Background

Section 122 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248 enacted on September 3, 1982) expanded the scope of Medicare benefits by authorizing coverage of hospice care for terminally ill beneficiaries and permitted an individual to elect hospice care, in lieu of certain other benefits, during two periods of 90 days each and one subsequent period of 30 days during the individual's lifetime.³ Further, the law defined hospice care as including items and services furnished to the terminally ill in their homes, on an outpatient basis, and on a short-term inpatient basis. The Balanced Budget Act of

³ H.R. 4961 -Tax Equity and Fiscal Responsibility Act of 1982. Retrieved from <https://www.congress.gov/bill/97th-congress/house-bill/4961>

1997 (BBA) restructured the hospice care benefit periods to include an unlimited number of subsequent periods of 60 days each in lieu of one subsequent period of 30 days.⁴

Hospice care is a holistic, comprehensive approach to treatment that recognizes that the impending death of an individual with terminal illness warrants a change in focus from curative care to palliative care for symptom management and relief of pain. Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit, with the goal of hospice care to help terminally ill individuals remain primarily in the home environment and continue life with minimal disruption to normal activities.⁵ Upon election of the Medicare hospice benefit, beneficiaries waive all rights to Medicare payment for services related to the treatment of the individual's condition for which a diagnosis of terminal illness has been made, except when provided by the designated hospice, or another hospice under arrangements made by the designated hospice, or attending physician. Because of the significance of this decision, the terminally ill individual must elect hospice care in order to receive services under the Medicare hospice benefit.

As noted in the 1983 Health Care Financing Administration (HCFA) (now known as CMS) Proposed and Final Rules "Medicare Program; Hospice Care" (48 FR 38146 and 48 FR 56008, respectively), CMS recognizes that an individual's terminal condition is often not caused by a single diagnosis, but also includes other conditions or illnesses and that treatment of those related conditions is considered a hospice service.^{6,7} Further, in the 1983 Hospice final rule (48 FR 56010 through 56011), CMS stated the general view that beneficiaries' waiver of curative treatment required by the law is a broad one and that hospices are required to provide "virtually all the care that is needed by terminally ill patients."⁸

Despite this clear policy objective, in the FY 2016 Hospice Final Rule, CMS discussed an analysis of claims of Medicare-covered services, drugs, supplies, and durable medical equipment (DME) that appeared to be related to the principal diagnosis but were billed separately to other parts of the Medicare program.⁹ CMS noted that these case studies and analyses highlighted the potential inappropriate systematic "unbundling" of the Medicare hospice benefit by some hospice providers. In FY 2017, CMS found that Medicare paid over \$900 million for non-hospice items and services under Parts A, B, and D for

⁴ H.R. 2015 – Balanced Budget Act of 1997. Retrieved from <https://www.congress.gov/105/plaws/publ33/PLAW-105publ33.pdf>

⁵ Proposed Rule CMS-1714-P. CMS FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. Retrieved from <https://www.federalregister.gov/documents/2019/04/25/2019-08143/medicare-program-fy-2020-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting>

⁶ 48 FR 38146 – Health Care Financing Administration. Medicare Program; Hospice Care. Proposed Rule. Retrieved from https://s3.amazonaws.com/archives.federalregister.gov/issue_slice/1983/8/22/38142-38175.pdf

⁷ 48 FR 56008 – Health Care Financing Administration. Medicare Program; Hospice Care. Final Rule. Retrieved from https://s3.amazonaws.com/archives.federalregister.gov/issue_slice/1983/12/16/55981-56024.pdf

⁸ 48 FR 56010-56011 – Health Care Financing Administration. Medicare Program; Hospice Care. Final Rule.

Retrieved from https://s3.amazonaws.com/archives.federalregister.gov/issue_slice/1983/12/16/55981-56024.pdf

⁹ CMS Final Rule FY2016 Hospice Payment Rates and Wage Index (80 FR 47141). August 6, 2015. Retrieved from <https://www.federalregister.gov/documents/2015/08/06/2015-19033/medicare-program-fy-2016-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting>

beneficiaries during their hospice elections.¹⁰ Additionally, on the basis of their sample results, the Department of Health and Human Services Office of Inspector General (OIG) recently estimated Part D total cost was \$160.8 million for Part D drugs that hospice organizations should have furnished as part of the Part A hospice benefit, for which the Part A payment is made. Additionally, although hospices told OIG they (the hospice) should not have paid for the drugs associated with the remaining \$261.9 million of the \$422.7 million Part D total cost for drugs during a hospice election, a review of CMS communications with hospices and sponsors between 2012 and 2016 indicates otherwise—hospice organizations or hospice beneficiaries likely should have paid for many of these drugs, not Part D.¹¹ These two patterns result in CMS potentially paying twice, once through the hospice per diem payment and again for the Part A and B claim or the Part D claim. Furthermore, this unbundling by some hospice providers results in direct costs to beneficiaries. In FY 2017, CMS found that for Parts A and B, the beneficiary cost-sharing amounts in FY 2017 totaled approximately \$138 million and for Part D, the beneficiary cost sharing totaled approximately \$68.6 million (83 FR 20946 through 20947). Overall, some hospice providers' patterns of care are resulting in a substantial financial burden on terminally ill individuals and their families and caregivers for drugs and services that potentially should have been covered by hospice, and therefore subject to the cost-sharing limits applicable to hospice benefits under Part A.

Originally, in 1983, CMS set payment rates for each of the four levels of hospice care based on an early CMS hospice demonstration that included 26 hospice providers. CMS has noted on multiple occasions that there has been little change in the hospice payment structure since the benefit's inception, including maintaining the initial four levels of hospice care. Today, this original per diem payment structure largely remains the same with some adjustments; a few are noted below:

- Beginning January 1, 2016, using the hospice payment reform authority under section 1814(i)(6) of the Act, Medicare changed how it pays for RHC. There are now two RHC base payment rates: a higher rate for days 1 to 60 and a lower rate for days 61 and beyond.
- In addition, Medicare makes additional payments for registered nurse and social worker visits that are provided during the last seven days of life, which are made above and beyond the RHC per diem amount.
- Using the hospice payment reform authority under section 1814(i)(6) of the Act, section III.A.3 of the FY 2020 Hospice Final Rule (84 FR 38484, August 6, 2019) rebased the FY 2020 per diem payment rates for CHC, IRC, and GIP levels of care and reduced RHC payment amounts for FY 2020 in order to maintain overall budget neutrality.

Further, while hospice care is a covered Medicare Part A benefit, the MA program – formerly known as Medicare+Choice program – does not include risk or financial accountability for providing the Medicare

¹⁰ Proposed Rule CMS-1692-P. CMS FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. Retrieved from <https://www.federalregister.gov/documents/2018/05/08/2018-08773/medicare-program-fy-2019-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting>

¹¹ HHS OIG. Medicare Part D is still paying millions for drugs already paid for under the Part A hospice benefit. Retrieved from <https://oig.hhs.gov/oas/reports/region6/61708004.asp>

hospice benefit as part of MA plan obligations.¹² Specifically, the BBA provided that if an individual enrolled in a Medicare+Choice program elected to receive hospice care from a particular hospice program, payment for that hospice care is made to the hospice program by the Secretary, while payment for services not related to the individual's terminal illness and related conditions may be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service.¹³ As codified at 42 CFR § 422.320(c)(2) and (3), during the time the hospice election is in effect, CMS' monthly capitation payment to the MAO is reduced to the sum of (i) an amount equal to the beneficiary rebate for the MA plan, as described in § 422.304(a)(3) or to zero for plans with no beneficiary rebate, described at § 422.304(a)(2); and (ii) the amount of the monthly prescription drug payment described in § 423.315 (if any).

In addition, CMS pays through the Medicare program (subject to the usual rules of payment) (i) the hospice program for hospice care furnished to the Medicare enrollee; and (ii) the MA organization, provider, or supplier for other Medicare-covered services to the enrollee. In March 2014, the Medicare Payment Advisory Commission (MedPAC), which provides the U.S. Congress with analysis and policy advice on the Medicare program, recommended including hospice in the MA benefit package. MedPAC stated it believes a goal of the MA program is to move from fragmented payment arrangements to an integrated and coordinated benefit package, and that the current hospice carve out is inconsistent with this goal.¹⁴

MedPAC further stated that broadening the bundle of services for which MA plans are accountable gives MAOs the incentive to consider the needs of their members more completely and to provide better-coordinated care to meet those needs, while also incentivizing MAOs to develop innovative benefit designs for people with serious illnesses. MedPAC noted that including hospice in the MA benefit package would align the financial risk policies of Accountable Care Organizations, who are at risk for hospice spending, and MAOs, who currently are not. Additionally, MedPAC stated another potential benefit of including hospice is that MAOs may more broadly develop programs aimed at improving end-of-life care and care for patients with serious illness by offering concurrent hospice and conventional care, as well as palliative care and shared decision-making services. Finally, MedPAC's recommendation noted including hospice in MA could simplify the complex coverage issues concerning related and unrelated care, and financial responsibility for that care, for MA enrollees.

In alignment with MedPAC and other stakeholders, through this voluntary Model component, CMS is testing the impact on cost and quality of care when one entity – the participating MAO – is financially responsible and accountable for managing its enrollees' full continuum of care, including hospice.

1.4. Statutory Authority

Section 1115A of the Social Security Act (the Act) (42 U.S.C. § 1315a, added by Section 3021 of the Patient Protection and Affordable Care Act) authorizes CMS to test innovative healthcare payment and service

¹² Section 1852(a) of the Act carves hospice out of the services MA plans must cover. See also H.R. 2015. Balanced Budget Act (BBA) of 1997. Retrieved from <https://www.congress.gov/105/plaws/publ33/PLAW-105publ33.pdf>

¹³ The specific statutory provisions added by the BBA of 1997 that address this include § 1852(a) which provides that MA plans do not cover hospice and § 1853(h)(2) which provides the payment rules for hospice services provided to MA enrollees.

¹⁴ MedPAC. The Medicare Advantage program: Status report. Chapter 13. Retrieved from http://www.medpac.gov/docs/default-source/reports/mar14_ch13.pdf

delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

1.5. Waiver Authority

Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). For this Model, and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act.

No fraud and abuse waivers are being issued in this document; fraud and abuse waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this RFA, all parties must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the VBID Model. Any such waiver would apply solely to the VBID Model and could differ in scope or design from waivers granted for other programs or models, or those described below.

1.6. Medicare Program and Payment Waivers

In support of the Model, the Secretary intends to waive certain Title XVIII provisions and their implementing rules, to the extent described below and as necessary to conduct the tests described in this RFA. No program or payment waivers of any kind are being issued in this document, which merely describes the waivers contemplated at this time for the Model; waivers, if any, would be set forth in Model documentation (such as an appendix to the contractual addendum for participation in the Model). To be waived to the extent necessary to permit MAOs to offer the hospice benefit to MA enrollees subject to the terms of the Model:

- Section 1852(a)(1) of the Act, to the extent necessary, to remove the exclusion of hospice care from the scope of coverage of Part A and Part B benefits that MAOs must cover so that MAOs participating in this component of the VBID Model may cover hospice benefits consistent with the scope of coverage under Part A;
- 42 CFR § 422.320 with respect to payment to permit payment to participating MAOs as provided under the hospice component of the VBID Model;
- Section 1854(a)(6) of the Act, and provisions in 42 CFR § 422, subpart F that limit the basic bid to benefits covered under Original Medicare in order to permit the basic bid to include the costs of concurrent care by MAOs participating in this component of the VBID Model;
- Section 1812(d)(2)(A)(ii)(I) of the Act, to the extent necessary, with respect to waiver of payment for treatment of the individual's condition(s) with respect to which the diagnosis of terminal illness has been made, so that transitional, concurrent care required as part of the Model may be treated as a Part A and B benefit as described in Section 2.3;
- Uniformity and Accessibility of Benefits: To be waived to the extent necessary to permit organizations to offer supplemental benefits to the targeted enrollee population, rather than to all enrollees, subject to the terms of the Model. The targeted enrollee population may be identified based on (i) hospice election AND (i) one or more chronic conditions, or (ii) low income status (LIS) eligibility or (iii) a combination of both these health conditions and socioeconomic statuses.
 - Sections 1852(d)(1)(A) and 1854(c) of the Act [42 USC § 1395w-22(d)(1)(A) and § 1395w-24(c)];

- 42 CFR. §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.102(a)(2), 422.254(b)(2), 422.262(c)(1); and
- Section 1860D–2(a) of the Act [42 USC § 1395w-102(a)]; and 42 CFR. §§ 423.104(b)(2), 423.265(c).
- Uniform Cost-Sharing Requirements for MA Plans: To be waived to the extent necessary to offer reductions in cost sharing to the targeted enrollee population, but not to all enrollees, consistent with the terms of the Model. The targeted enrollee population may be identified based on (i) hospice election AND (i) one or more chronic conditions, or (ii) low income status (LIS) eligibility or (iii) a combination of both these health conditions and socioeconomic statuses.
 - Sections 1852(d)(1)(A) and 1854(c) of the Act [42 USC § 1395w-22(d)(1)(A) and § 1395w-24(c)]
 - 42 CFR. §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.254(b)(2), 422.262(c)(1); and
 - Section 1860D–2(a) of the Act [42 USC § 1395w-102(a)]; and 42 CFR. §§ 423.104(b)(2) & 423.265(c).
- Requirements for Supplemental Benefits to Permit Coverage by a Participating MA Plan of Supplemental Benefits that are not Primarily Health Related: To be waived to the extent necessary to allow plans to offer to certain enrollees additional supplemental benefits that are “non-primarily health related” supplemental benefits subject to the terms of the Model. Such supplemental benefits must have a reasonable expectation of maintaining or slowing the progressive decline of the health or overall function of the enrollee with regard to the chronic condition or socioeconomic status of the targeted enrollee population during hospice election. The targeted enrollee population may be identified based on (i) hospice election AND (i) one or more chronic conditions, or (ii) LIS eligibility, or (iii) a combination of both these health condition and socioeconomic statuses. In using one or more chronic conditions to identify eligible enrollees, an applicant may propose for CMS consideration and approval a targeted population that does not meet the statutory definition of “chronically ill enrollee” in section 1852(a)(3)(D)(iii).
 - Section 1852(a)(3)(D)(i), (ii)(I) and (iii) of the Act [42 USC §§ 1395w– 22(a)(3)(D)(i), (ii)(I) and (iii)] and any implementing regulations.

CMS is not proposing to waive Title XVIII’s anti-discrimination provisions and does not believe such a waiver is necessary for the Model test. Participating organizations are required to implement the Model components in a non-discriminatory manner.

Program waivers, once issued, (1) are each contingent on compliance with the terms and conditions of the Model test, including the contractual addendum for participation in the Model test and documents incorporated therein; (2) are granted on a case-by-case basis, only to the extent necessary to implement an MAO’s approved application for participation; (3) are granted only to MAOs as to those MA plans (or PBPs) for which CMS has approved an application; and (4) are granted only for the term of participation in the Model set out in the addendum. CMS reserves the right to revoke one or more of the Title XVIII waivers or to suspend model testing (or both) at any point. All other (i.e., non-waived) requirements under the MA program and Titles XI and XVIII of the Act will continue to apply and be enforced. Further, for participating MAOs, MA program requirements (e.g., regulations in 42 CFR Part 422) regarding basic benefits will apply to hospice benefits under the terms of this Model component.

3. Incorporating the Medicare Hospice Benefit into Medicare Advantage

Beginning in CY 2021, the VBID Model will test the incorporation of the Medicare hospice benefit into MA to test a more seamless care continuum, in addition to the other components of the VBID Model.¹⁵ Combined, these components allow CMS to broadly test payment and service delivery reform in the MA program to improve quality while maintaining or reducing costs. Participation in the Model and the hospice benefit component is voluntary for eligible MAOs. All MAOs applying to participate in this component of the Model to offer the hospice benefit must indicate in their applications projections of any changes in medical costs and non-benefit expenditures due to the MAO's participation in the hospice benefit component. The costs of services provided while an enrollee is under a hospice election must not be included in the pricing of the A/B bid.

All Model participating MAOs must meet the WHP requirements of the VBID Model for CY 2021, including MAOs participating in only the hospice component of the Model. In addition, and in alignment with the WHP requirement of the VBID Model, a participating MAO must ensure that it develops and implements a systematic approach to advance care planning for enrollees with serious illness who are either not eligible for or who have chosen not to receive hospice services, consistent with 42 CFR § 422.128, so that all enrollees in the participating MA plan(s) are offered a timely opportunity for WHP. CMS recommends MAOs interested in participating in the hospice benefit component review the WHP section of the RFA for the other components of the VBID Model for CY 2021; that RFA will be available soon on the VBID Model Website here: <https://innovation.cms.gov/initiatives/vbid/>. **Maintaining the Medicare Hospice Benefit**

Under the hospice benefit component, and consistent with current programmatic rules for all other items and services under Original Medicare, participating MAOs must provide the full Medicare hospice benefit as specified in current law and regulation, except as explicitly waived to allow for the Model test (See Section 1.6: Medicare Program and Payment Waivers). Participating MAOs are not permitted to “unbundle” the collection of benefits (services and items) that a hospice provider must furnish under Medicare Part A (section 1861(dd) of the Act), including the use of an IDT and the four levels of hospice care. Participating MAOs must use Medicare-participating hospice providers. Furthermore, only a hospice provider may furnish these hospice services; participating MAOs do not have the option of designing alternative ways of furnishing these hospice services to enrollees who elect hospice. In this model test, CMS deems hospice providers to be “first tier entities” with the participating MAO, as defined in 42 CFR § 422.2, for purposes of other MA requirements (such as § 422.503), and MAOs must have written agreements with hospice providers.

Of importance, regulations at 42 CFR § 418.56(c) require that hospices provide all services necessary for the palliation and management of the terminal illness and related conditions. As it relates to the Model, through testing the incorporation of the Medicare hospice benefit into MA, CMS expects participating MAOs to work collaboratively with its in-network hospice providers to ensure coordination of care and that all necessary services are provided. To help achieve this aim, Model-participating MAOs must track service utilization and payment for Part A and B services and Part D drugs given to hospice enrollees outside the hospice benefit so that MAOs and CMS can independently determine whether hospices’

¹⁵ Please see the VBID Model Website for the CY 2021 VBID Model RFA (*coming soon*): <https://innovation.cms.gov/initiatives/vbid/>

decisions that specific items or services were “unrelated” were appropriate (See Section 3.3: Model Monitoring and Data Collection).

2.2. Palliative Care

Enrollees living with serious illness and who have begun a process of progressive and significant decline may benefit from palliative care either prior to their becoming eligible for the Medicare hospice benefit, or, when eligible, their choosing not to elect hospice. Unlike hospice, palliative care does not require an enrollee to have a life expectancy of six months or less, and may be provided together with curative treatment at any stage in a serious illness. To help those living with serious illness and their families and caregivers address physical, psychosocial, social and spiritual needs, many palliative care programs are provided through an interdisciplinary team.

The goal of palliative care is to improve quality of life for those living with serious illness and their families and caregivers by providing specialized medical care, support and relief from the symptoms and stress of a serious illness, while allowing the necessary space and time for enrollees to understand their care choices and decide on a plan of care that best reflects their needs and wishes. Such an approach facilitates awareness of care choices and patient, family, and caregiver-centered shared decision making. If the enrollee meets the hospice eligibility criteria, an enrollee with a serious illness who is receiving palliative care may choose to transition to hospice care.

Consistent with other CMS Innovation Center models testing the effect of providers identifying and caring for high-need, seriously ill beneficiaries, as part of this Model component, CMS is testing how best MAOs can identify enrollees in progressive and significant decline and then make comprehensive palliative care services outside the hospice benefit (consistent with coverage of such services under Medicare Parts A and B) available to them. In their applications, MAOs must propose their approach for providing access to timely and appropriate palliative care services for their enrollees. Specifically, participating MAOs must include:

- how palliative care resources will be targeted to any appropriate sub-population(s);
- how care will be coordinated for enrollees, including how providers will develop an individualized plan of care inclusive of all relevant services and providers;
- how continuing care will be provided to enrollees to meet their needs as their illness advances and as enrollees’ needs change based on participating MAOs’ providers’ continuing care assessments;
- how advance care planning will be offered through the WHP requirement of the Model;
- how medical, counseling, and social services will be made available as clinically necessary and appropriate; and
- how a seamless transition from palliative care to hospice services will be provided for beneficiaries who wish to elect hospice.

The availability of these palliative care services must be clearly described in the application and participating MAOs must implement these services consistent with the MAO’s policies and procedures and in agreement with accepted clinical guidelines. As the above services are largely medical services covered under Original Medicare, participating MAOs must project associated medical service utilization related to its program in its Parts A and B bid. Based on the nature of the services offered, CMS does not expect participating MAOs to factor in a net increase in the A/B bid.

In April 2018, CMS provided guidance that home-based palliative care services not covered under Original Medicare may be covered as a supplemental benefit.¹⁶ Specifically, this guidance continues to apply to stand-alone services provided to enrollees with serious illness who are not eligible for hospice services (e.g., stand-alone palliative nursing and social work services in the home not covered by Medicare Part A or Part B). MAOs may continue to offer these stand-alone, home-based services that are supplemental to Original Medicare as a supplemental benefit if they choose. This guidance is provided for demonstration purposes to supplement and clarify other CMS bid guidance. Participating MAOs must follow all CMS bid instructions in submitting their CY 2021 bids.

2.3. Transitional Concurrent Care

As set out in the Act at § 1812(d)(2) and reflected at 42 CFR § 418.24(d)(2), beneficiaries who elect hospice care waive all rights to have payment made for any services “related to the treatment of the individual’s condition with respect to which a diagnosis of terminal illness has been made” except for services provided by the beneficiary’s designated hospice, or another hospice under arrangements made by their designated hospice or the individual’s attending physician (if the attending physician is not an employee of their designated hospice). As a result, by electing hospice, beneficiaries generally waive Medicare coverage for services that are considered curative in favor of receiving services that are more palliative in nature. Due, potentially in part to this choice between curative and palliative care, only approximately half of all Medicare beneficiaries elect the Medicare Hospice benefit at the end of life, and those who do elect hospice often do so too late in their disease trajectory to experience the full benefits of hospice care.

The overall goal of encouraging MAO collaboration with non-hospice and hospice providers to arrange for the provision of concurrent care and related services on a transitional basis is to support more consistent use of these services, in light of current variation in provider beliefs and practices related to the provision of concurrent care (including those services that may be difficult to distinguish between curative and palliative). For example, a transitional continuation or phasing out of treatments such as chemotherapy services, blood transfusions, or dialysis may permit an enrollee to conclude or phase out over time a course of therapy while concurrently receiving hospice care and services. The provision of transitional concurrent care under the Model does not change the necessary criteria for hospice benefit eligibility or the requirement that the designated hospice provider provide all services and levels of care available under the hospice benefit.

To ease care transitions and ensure that hospice-eligible enrollees face a less stark transition and choice between foregoing either curative or hospice care, as part of the Model, participating MAOs must work with their network of high-quality hospice providers, as well as non-hospice providers, to define and provide a set of concurrent care services related to a hospice enrollee’s terminal condition and related conditions that are appropriate to provide on a transitional basis, aligned with an enrollee’s wishes and provided by a non-hospice provider. Similarly, the demonstration permits MAOs and hospice organizations to work together to arrange for the provision of similar concurrent services provided on a transitional basis by an in-network hospice provider, as long as those services are within the hospice’s

¹⁶ CMS HPMS Memo. Reinterpretation of “Primarily Health Related” for Supplemental Benefits. April 27, 2018. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27.html?DLPage=1&DLEntries=100&DLSort=1&DLSortDir=ascending>

clinical scope, even where such services would not be provided by the hospice under current regulation because they could be viewed as mainly curative in nature.

As part of providing transitional concurrent care, MAOs must establish transparent guidelines and processes for enrollees to access concurrent care at their in-network providers. These processes must include provisions for hospice providers to work in conjunction with non-hospice providers to develop a plan of care that clearly identifies the concurrent care services the enrollee will receive as the enrollee transitions into hospice, and the specific services and items or services that are being foregone (if any). The plan of care should clearly specify how the hospice will ensure coordination among all hospice and non-hospice providers.

As part of these processes, MAOs must work with their networks to have policies and procedures for coverage of concurrent care that are standardized, administratively simple, and consistent for all enrollees. Importantly, all MAO network providers and care management teams must work closely with the MAO's network of hospice providers to facilitate the transition of services from those directed towards a cure to those directed towards support and palliation.

Given the importance of care and financial coordination between the participating MAO, hospice providers, and potentially non-hospice providers in the provision of concurrent care, MAOs must limit the availability of concurrent care services to MA enrollees who elect an in-network hospice provider as their designated hospice. Participating MAOs must cover the full hospice benefit out-of-network (that is, all out-of-network services necessary for the palliation and management of the terminal illness and related conditions that hospices provide as set out in regulations at 42 CFR § 418.56(c) at Original Medicare rates). As such, we note nothing in this demonstration prohibits hospices, whether operating on an in- or out-of-network basis with a given MAO, from continuing to provide services to a beneficiary that are intended to be palliative in nature even if they would otherwise potentially be viewed as curative to the extent allowed under current regulation. In CMS's review of applications, we will expect MAOs to demonstrate or otherwise provide assurances that in-network hospices are able to continue providing these palliative-focused services at the same levels that pre-existed the demonstration. Overall, MAOs interested in participating in the hospice benefit component must describe their approach to concurrent care and their associated processes within their application, which will be reviewed and approved by CMS.

Participating MAOs will continue to be paid the A/B services capitation payment (that is, the MA capitation payment) for the month of hospice election (See Section 2.7: Model Payments) in addition to a hospice capitation payment developed and paid under the Model. Given the transitional role of concurrent care, MAOs must factor in both the A/B capitation payment as well as care that would have been utilized but was not due to an enrollee's decision to elect hospice in thinking of how to account for any costs associated with providing transitional concurrent care. Based on these factors, CMS expects that the A/B bid amount should not be increased due to the offer of transitional concurrent care services outlined in this section and will monitor the bid for any increases.

Overall, through enabling network hospice providers and MAOs to innovate and offer plans of care that include concurrent care services, which will often be naturally time-bound and reflect more of a transitional-type of care as enrollees move from seeking curative to palliative treatments, MA enrollees who elect to utilize their hospice benefit will experience a more compassionate and smoother transition into hospice. CMS believes that transparent, compassionate care discussions and plans will enable enrollees and their families and caregivers to make shared and informed decisions about the election of

hospice in the context of a clear understanding of what services are and are not included and over what time period.

2.4. Hospice Supplemental Benefits in the VBID Model

Consistent with the overall VBID Model, participating MAOs may offer a broad set of mandatory supplemental benefits for enrollees that elect hospice in addition to mandatory supplemental benefits offered to all enrollees in the MA plan; such supplemental benefits must be specified in the MAO's application for CMS review and approval. CMS recognizes that the set of items and services that a hospice enrollee may benefit from could be broad, depending on the hospice enrollee's individual circumstances. Thus, CMS will allow participating MAOs to identify additional items and services that extend beyond Original Medicare hospice care, as well as set a specific dollar amount for the aggregate coverage of the set of items and services that may be provided to enrollees receiving hospice care. MAOs would then be in a position to work with their in-network hospice providers and enrollees to identify the items and services that a specific enrollee who has elected hospice has access to. In offering these supplemental benefits, MAOs must clearly identify the items and services restricted to hospice enrollees, as well as any use of care managers or other approaches based on objective standards that allow for the provision of these supplemental benefits for enrollees that have elected hospice.

CMS will review and approve or reject applicants' proposals for interventions based on a sound evidence base, and would expect MAOs to provide documentation of such upon request, the theory of action, estimated number of targeted enrollees, and potential to improve quality of care and/or decrease costs. Interested organizations are encouraged to work with CMS as part of the application process to discuss the specifics of their proposed interventions, including targeting methodology.

Some examples of these supplemental benefits may include:

- Coverage of primarily health-related services and items (that is, services and items that ameliorate the functional/psychological impact of hospice enrollees' health conditions and/or reduce avoidable emergency and healthcare utilization). These could include adult day care services, home and bathroom safety devices and modifications, support for caregivers of enrollees, over-the-counter (OTC) benefits, care services, meals, transportation, and other items. MAOs should refer to additional guidance within the Medicare Managed Care Manual, Chapter 4.
- Coverage of non-primarily health related services and items to address social determinants of health that have a reasonable expectation to maintain or slow the progressive decline of the health or overall function of an enrollee, based solely on socioeconomic status. These could include, but are not limited to, meals (beyond the current allowable limits), utilities, legal aid (e.g., to obtain or maintain shelter), personal care items, linens, clothing, pest control, service animal expenses, and other items.
- Coverage of non-primarily health related benefits of room and board within a hospice residential facility or equivalent residential facility may be included for enrollees that need custodial care (e.g., no caregiver at home or without safe discharge location) and do not have access to those services through their Medicare benefit or any other benefit. Such coverage must have a reasonable expectation to (1) address social determinants of health, specifically circumstances where enrollees are eligible for and wish to remain in hospice care but otherwise feel compelled to revoke their election due to residence-related coverage or financial reasons and (2) reduce potentially subsequent avoidable Emergency Department (ED) visits and hospital admissions resulting from revocation.

- Reductions in cost sharing for necessary care received unrelated to the treatment of an enrollee's terminal illness and related conditions received during hospice election.
- Reductions in cost sharing for unrelated covered Part D drugs that an enrollee receives during hospice election.

Given the importance of care and financial coordination between the participating MAO and hospice providers in the provision of Model hospice supplemental benefits triggered by hospice election, participating MAOs may limit the set of items and services provided as Model supplemental benefits to MA enrollees who elect an in-network hospice provider and in that event, must clearly indicate that such hospice supplemental benefits are limited to enrollees who choose in-network providers. However, other supplemental benefits for which the enrollee is already eligible prior to hospice election will continue to be provided to that enrollee.

2.5. Care Transparency for Beneficiaries, Families, and Caregivers

In order to ensure MA enrollees' experience at the end-of-life and in hospice is safe, high-quality, and appropriate, as well as to create transparency for enrollees and their families and caregivers, CMS will monitor and benchmark enrollee experience and provider quality at the start of the Model component and over time to track enrollee access to care and care paths, including palliative care and hospice care for those enrollees who elect hospice. Specifically, CMS will monitor the impact of the Model on the following quality domains: (i) Palliative Care and Goals of Care Experience; (ii) Enrollee Experience and Care Coordination at End of Life; and (iii) Hospice Care Quality and Utilization. CMS has intentionally selected measures that present improvement opportunities relevant to beneficiaries, are clinically meaningful, and are aligned with CMS's broader quality measurement strategy. These domains were selected to address key improvement opportunities – relevant to beneficiaries who choose hospice and those who do not, and their families and caregivers – and to limit reporting burden for providers and MAOs mainly by using CMS analyses of claims and enrollment data. CMS may monitor for additional impacts on quality, beneficiary safety, and potential discrimination beyond the domains described below. Additionally, CMS reserves the right to change the transparency and monitoring measure set based on Agency needs, if a measure is determined to no longer be valid, or if an otherwise valid measure cannot be reasonably applied to a MAOs' enrollee population.

For MAOs that participate in the hospice benefit component for both CY 2021 and CY 2022, beginning in CY 2023, CMS anticipates making a quality payment adjustment for MAOs based on performance relative to a quality benchmark of selected measures. CMS anticipates the following measures, at a minimum, would be utilized in a quality benchmark: (i) Proportion of Enrollees Admitted to Hospice for Less than 7 Days; (ii) Rate of Lengths of Stay beyond 180 Days; and (iii) Transitions from Hospice Care, Followed by Death or Acute Care. CMS may consider additional measures such as Days Spent at Home in the Last Six Months of Life and Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life. Any potential positive quality payment adjustment will be dependent on Model outcomes in CY 2021 and CY 2022 sufficient to ensure savings to Medicare, and will be tied directly to the quality aims of the Model, based on the domains' underlying measures that CMS deems reliable and critical to improving beneficiary care. CMS will provide future detail and guidance on the availability of any quality payment adjustments in future RFAs.

Palliative Care and Goals of Care Experience

CMS will monitor the impact of the Model on how MAOs, hospices, and others focus on the provision of appropriate and timely palliative care services for enrollees with serious illness who are either not eligible for hospice or are hospice-eligible but have chosen not to elect hospice. The Model will monitor the below measures to (1) verify that MA enrollees' goals of care are captured over time to reflect that plans of care change and care needs may increase; (2) verify MA enrollees receive access to and use palliative care services (as appropriate); and (3) evaluate whether an improved continuum of care improves the timeliness of appropriate hospice election.

1. Development of Advance Care Plans (ACPs) and Wellness and Health Care Planning (WHP)

In alignment with the VBI Model's required WHP component, MAOs must develop systems to improve the offer of ACPs for enrollees with serious illness. CMS will require MAOs to report the percentage of enrollees who: (i) have an ACP or surrogate decision maker documented in the medical record; (ii) have documentation that an ACP was discussed but the patient did not wish or was not able to name a surrogate decision maker; or (iii) no record exists of either an offer or acceptance of an ACP. This is consistent with current National Quality Foundation (NQF) endorsed measures #326.

2. Access to, and use of, Palliative Care

CMS believes access to palliative care is an important part of care coordination and the continuum of care. To assess access to and use of palliative care, CMS will work with participating MAOs to capture enrollee experience with respect to palliative care in the current state and during the Model period. CMS will look at the specific population receiving palliative care as well as the types and durations of palliative care received, the reason(s) and timeliness of palliative care election (e.g., post-hospitalization), and the election rate of hospice care for those who received palliative care.

3. Proportion of Enrollees Admitted to Hospice for Less than 7 Days

Although the use of hospice and other palliative care services at the end of life has increased, many patients are enrolled in hospice for less than 7 days before their death, which limits the benefit they may gain from these services. The existing evidence-base demonstrates that patients enrolled in hospice experienced better quality of life and a reduction in resource use such as hospital admissions and aggressive end of life care – benefits that increased the longer patients are enrolled in hospice.¹⁷ To evaluate whether integration of palliative care services and access to transitional concurrent care improves the timeliness of optimal hospice election, CMS will assess the percentage of enrollees who elect hospice less than 7 days prior to their death. While the results will be grounded in the context of patterns of care for different regions, CMS expects that improved coordination between MAOs and network providers will lead to care that better supports patients and families and is more consistent with their wishes by decreasing late hospice elections.

Enrollee Experience and Care Coordination at End of Life

CMS is testing different service delivery approaches with the goal of improving MA enrollees' experiences at the end-of-life, including better coordination across the continuum of care and concordance with patient preferences for place and types of care received. This includes both enrollees who elect, and enrollees who do not elect, hospice. The Model will monitor the below measures:

¹⁷ Langton, J. M., B. Blanch, et al. (2014). "Retrospective studies of end-of-life resource utilization and costs in cancer care using health administrative data: a systematic review." *Palliat Med* 28(10): 1167-1196.
 Lee, Y. J., J. H. Yang, et al. (2015). "Association between the duration of palliative care service and survival in terminal cancer patients." *Support Care Cancer* 23(4): 1057-1062.

4. Days Spent at Home in Last Six Months of Life

Since its inception, the Medicare Hospice Benefit has placed a strong emphasis on care in the home setting. As stated in the August 22, 1983 proposed rule entitled "Medicare Program; Hospice Care" (48 FR 38146), "the hospice experience in the United States has placed emphasis on home care. It offers physician services, specialized nursing services, and other forms of care in the home to enable the terminally ill individual to remain at home in the company of family and friends as long as possible." This is codified in the regulations which provide continuous home care services as needed with the goal of maintaining the patient in the home and the GIP level of care only for temporary crises which cannot be managed at home.

At the end of life, and consistent across different demographics and regions, most enrollees prioritize spending days at home rather than at health care facilities. Research has used days at home in the last six months of life as a patient-centered measure calculated using administrative data. Thus, CMS will assess the number of days within the last six months of life that participating MAOs' enrollees utilized acute care services (i.e., inpatient days in an acute care facility, an inpatient rehabilitation facility, a skilled nursing facility, or an inpatient hospice unit).

5. Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life

ICU admissions may be a proxy to gauge the types and levels of care provided to patients with terminal illnesses. This measure will examine the extent that different approaches to delivering timely and appropriate advance care planning, palliative care, transitional concurrent care and hospice services as part coordinated, patient-centered and evolving care changes the types and levels of care received by enrollees at the end of life.

Hospice Care Quality and Utilization

As noted, CMS's fundamental aim through testing the Medicare hospice benefit component is to improve access to high quality hospice care for MA enrollees who elect the hospice benefit. CMS will assess MAOs and both their network and out-of-network hospice providers on the following measures:

6. Proportion of Lengths of Stay beyond 180 Days

Hospice lengths of stay beyond 180 days may indicate specific practice patterns of care that do not reflect appropriate use of the Medicare hospice benefit. Accordingly, CMS will monitor lengths of stay for enrollees that elect hospice beyond 180 days, differences in lengths of stay between in-network and out-of-network providers, and any trend differences between related party lengths of stays and non-related party lengths of stay.

7. Transitions from Hospice Care, Followed by Death or Acute Care

Concerns over live discharges that are followed by patient death in a short time window or those that result in burdensome transitions and negative outcomes such as hospitalization or Emergency Department use are not new. Avoiding unnecessary hospital and Emergency Department (ED) admissions and re-admissions was identified by NQF as a high priority measurement opportunity for hospice. In addition, MedPAC suggests that while there are many reasons for live discharges, including patient preference driven revocations, problematic patterns of live discharges followed by negative outcomes could signal a quality of care issue. Thus, CMS will monitor for number of live discharges (including those initiated by the hospice and those initiated by the enrollee (such as when the enrollee revokes his or her

hospice enrollment) followed by a death within 30 days or a transfer to another hospice, inpatient, ED, or observation visit stays within seven days.

8. Visits in the Last Days of Life

To help identify high-quality hospice care, CMS will monitor and identify the number, length, and type of hospice care visits received in the last three days of life for an enrollee. CMS will assess the documented care provided by MAO network hospices and out-of-network hospices in the last three days of life. CMS requires MAOs to monitor and report this data to CMS and have transparent policies in place with in-network hospice providers regarding access to hospice care visits.

9. Experience of Care Measures

To assess consumer and family experiences with hospice care, CMS will assess the following specific experience of hospice care measures available in the current Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey: (i) caregiver's perception of the timeliness of receiving help; (ii) the adequacy of training for families to care for the patient; (iii) the help received for pain and symptoms; and (iv) net promoter score-like survey question pulled from the CAHPS Hospice Survey around the extent to which the patient's caregiver would recommend the hospice. Survey results will be gathered from hospice participation in the CAHPS Hospice Survey as in general, all Medicare-certified hospices must participate in the CAHPS Hospice Survey.

Part D Duplicative Drug Utilization

CMS will quantify and monitor Part D covered drug utilization patterns and prescription drug event data for enrollees that elect hospice. CMS will assess Part D prescription drug event (PDE) data for participating MAOs relative to non-participating MAOs and beneficiaries in Original Medicare. CMS will assess different factors such as specific hospice providers, MAOs, and hospice diagnoses as part of assessing the impact of the Model component on decreasing duplicative payment for Part D covered drugs. As cited above, OIG found that this duplication and fragmentation results in costs for beneficiaries and their families, as well as Medicare, that should have been covered by the hospice provider as related to the terminal illness or related conditions.

10. Unrelated Care Utilization

CMS will monitor the MAO encounter data to determine spending for unrelated care and will monitor any changes to unrelated care patterns of service delivery and cost consistent with the model's goal of reducing care fragmentation. Overtime, this measure is an important payment safeguard as the capitated payment rates paid under this Model reflect a combined payment rate of related and unrelated spending (see Section 2.7: Model Payments). Accordingly, CMS will quantify and monitor the amount of utilization and spending for services provided during hospice election unrelated to a participating MAO's enrollee's terminal condition and related conditions.

CMS will also work with MAOs, enrollees, and their families and caregivers, in developing additional measures to monitor 24/7 access to care. Beyond these measures, CMS reserves the right under the Model to develop additional performance and quality measures.

2.6. Ensuring Beneficiary Access to a Network of High-Quality Hospice Providers

Access and Availability Rules for Coordinated Care Plans for Hospice Providers

Because hospice providers are largely a new provider type for MAO networks (outside those, for instance, that may have contracted for the delivery of palliative care services outside the Medicare hospice benefit), CMS has adopted a phase-in approach for MAOs to develop and meet network adequacy standards for hospice providers over the first two years of the model. This approach allows MAOs and hospice providers to develop networks while still ensuring enrollees maintain adequate access to safe hospice care choices as networks form. Additionally, MAOs should focus on ways that easily allow hospice providers seeking to be in-network to proactively share information on the services, quality, and levels of care the provider offers today.

The three phases, outlined below after a summary of current MA program network regulations, are designed to foster the development of meaningful networks by MAOs and hospice providers that further access to hospice and its comprehensive scope of services, inclusive of hospice care's focus on the community and volunteerism that is central to many hospice providers today. Given the role hospice care plays in both a beneficiary's life, but also their family's and caregiver's, networks focused on cost, a "de-bundling" of services, or lower quality over time are fundamentally not aligned with the spirit and or stated aims of the Model component or of the hospice benefit.

Current MA Program Networks: CMS regulations at 42 CFR § 422.112(a) and 42 CFR § 422.114(a) require that MAOs maintain and continuously monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. MAOs must provide enrollees' health care services through a contracted network of providers that is geographically accessible and consistent with local community patterns of care. Currently, MAOs may specify the providers through whom enrollees may obtain services if it ensures that all covered benefits – including Part A and Part B benefits and supplemental benefits contracted for, by, or on behalf of Medicare enrollees - are available and accessible under the coordinated care requirements. Further, CMS regulations at 42 CFR § 422.204(b) require that providers of services, as defined in section 1861 of the Act, that furnish Original Medicare benefits must have a participation agreement with Medicare in order to be in the MAO's network; hospice programs are providers of services as that term is defined in section 1861 of the Act. While MAOs have considerable discretion to select the providers with whom to contract in order to build high-performing, high-quality provider networks, MAOs must ensure that all clinical and non-clinical services are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds, consistent with 42 CFR § 422.112(a)(8). In relation to hospice, while hospice providers are not one of the provider types that MAOs include in their networks under current program requirements, MAOs must inform each Medicare enrollee eligible to select hospice care about the availability of hospice care as defined in 42 CFR § 422.320.

Phase 1: For CY 2021 and CY 2022, to meet network adequacy requirements for hospice providers, a first year Model participant must offer access to in-network hospice providers as well as out-of-network hospice providers except those not allowed by the MAO due to posing risk of harm to enrollees as described below. While enrollees must be able to access covered hospice care from any allowed

Medicare-certified hospice provider, CMS encourages MAOs to implement a voluntary consultation process aimed at engaging enrollees in understanding their care choices and both in-network and out-of-network hospice provider options prior to their accessing an out-of-network hospice. In implementing any type of consultation service, MAOs must ensure the experience takes the form of a high-touch care manager accessible by phone and other means available 24/7 to all enrollees and serviced in a way that is clear, immediately available, culturally competent, and knowledgeable about the hospice benefit and choices.

Phase 2: For CY 2022, MAOs that participated in CY 2021 may, based on having the benefit of CY 2021 experience, implement a formal version of the consultation program outlined above beginning on January 1, 2022. An MAO utilizing a formal consultation program could require an enrollee to have a consult prior to accessing an out-of-network hospice provider. To be clear, an enrollee must be able to access covered hospice services through either in-network or out-of-network hospice providers, but the MAO can require that the enrollee connect with the MAO prior to utilizing an out-of-network provider.

Participating MAOs will be required to inform any enrollee who requests to access out-of-network hospice providers (except those not allowed by the MAO due to posing risk of harm to enrollees as described below) of their ability to do so and may not require written confirmation or supporting documentation from the enrollee or his/her representative as a precondition for seeking care from an out-of-network hospice provider. Additionally, participating MAOs must communicate to enrollees that they will not be able to access applicable hospice supplemental benefits or transitional concurrent care services from out-of-network hospice providers.

For enrollees that utilize an out-of-network provider, a participating MAO is required to cover these services and to make payment at the same amount that the hospice provider would receive from Original Medicare for covered hospice services in order to ensure enrollees are not balanced billed. As a provider of services, as defined in section 1861(u) of the Act, a hospice provider is subject to section 1866(a)(1)(O) of the Act and 42 CFR § 422.114(b); thus, a hospice provider must accept the Original Medicare amount as payment in full when it furnishes Medicare-covered services to MA enrollees but does not have a contract or other agreement in place to set the payment amount. While CMS expects that participating MAOs will make every effort to fully communicate care options to patients and their families early in the care planning process, including the benefits and reasons to select an in-network hospice provider, the participating MAO must clearly inform the enrollee that payment will be made on their behalf to allowable out-of-network hospice providers that have participation agreements with Medicare.

Phase 3: For CY 2023 and on, CMS will permit MAOs participating in the Model to use a more traditional MA program network approach. While HMOs may choose to offer a hospice-specific point of service benefit for enrollees to still have access to out-of-network providers, CMS will require participating MAOs to meet model-specific network adequacy requirements based on aligning with the network adequacy requirements for current specialty types that are not subject to time and distance parameters, whereby there must be at least one Medicare-certified hospice that will provide access to beneficiaries across the entire county of application and provide the full range of covered services. In developing these requirements, CMS will look to learn from the early experience of both MAOs and in-network hospice providers in defining network adequacy.

Overall, coupled with the payment policy outlined in Section 2.7, this phase-in approach for network adequacy seeks to strike the balance of ensuring enrollees maintain access to hospice care as MAOs

develop networks with the incentives for high-quality hospice providers and MAOs to develop relationships and agreements for the provision of hospice care within a service area. Over both the short- and long-term, CMS believes developing high-quality hospice provider networks is critical for care coordination and management across the care continuum of palliative care, transitional or concurrent care, and then, for those who choose, hospice care.

In-Network and Out-of-Network Cost Sharing: Participating MAOs may not charge higher cost sharing for hospice services provided in-network or out-of-network than those levels permitted under Original Medicare. As under Original Medicare, an enrollee who has elected hospice has no deductible and is responsible for the following applicable coinsurance amounts, which are relatively small, pursuant to Section 1813 of the Act, 42 U.S.C. § 1395e:

1. Coinsurance on outpatient drugs and biologicals: a coinsurance amount equal to 5 percent of the reasonable cost of the drug or biological to the hospice, but not more than \$5, for each prescription furnished on an outpatient basis. The individual is not liable for any coinsurance for hospice-related drugs or biologicals provided while he or she is receiving general inpatient care or respite care. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The drug copayment schedule will be reviewed for reasonableness and approved by CMS; and
2. Coinsurance on inpatient respite care: a coinsurance amount equal to 5 percent of the national Medicare respite care rate, after adjusting the national rate for local wage differences (which is not counted toward the hospital deductible, but is limited to the same amount).

No other coinsurance or deductibles may be imposed for hospice services furnished to enrollees during the period of an election, regardless of the setting of the services. MAOs must count toward the maximum out-of-pocket (MOOP) limit those amounts the individual enrollee is responsible for. Effectively, this means that, for enrollees who elect hospice who have minimal beneficiary cost sharing, the MOOP limit will rarely be reached. MAOs must still track out-of-pocket spending for these enrollees.

Currently and under the Model component, when MA enrollees get services unrelated to their terminal condition and related conditions from Medicare FFS providers, they are subject to the Original Medicare 20 percent coinsurance. Alternatively, an MA enrollee who needs treatment unrelated to the terminal condition and related conditions may choose services through their MA plan at the plan cost-sharing level.

Network Provider Limitations to Ensure Beneficiary Safety: Beyond the application of the usual limitations on MAOs at 42 CFR §§ 422.222 and 422.224 that prohibit payment to providers on CMS's preclusion list and OIG's exclusion list, subject to CMS approval, participating MAOs may propose to exclude hospice providers that meet any one or more of the following criteria, based on the past three years in which data are available, if the hospice provider:

1. was found through publicly available data or sources to pose a risk for beneficiary harm; and/or
2. consistently has not offered all four levels of hospice care, infrequently provided physician services, or rarely provided care on weekends.

Participating MAOs may also propose to CMS to exclude an available hospice provider if the provider does not respond to the MAOs' credentialing attempts that the hospice provider does or does not meet the above network exclusion criteria.

General Payment Requirements: A participating MAO cannot require prior authorization or implement other utilization management protocols that create inappropriate barriers to medically necessary and time-sensitive hospice care as it relates to hospice election and authorizations for levels of care and changes between levels of hospice care. However, in line with OIG's recommendations in 2016 to CMS,¹⁸ subject to CMS approval, participating MAOs may implement appropriate program integrity safeguards in line with the MAO's policies and procedures. For example, MAOs could implement the following prepayment review policies:

- A prepayment review strategy to ensure that their out-of-network hospice providers are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D.
- A prepayment review to address long lengths of stay (for example, greater than 180 days) to assess whether recertification was appropriate.

CMS will track complaints or other feedback from hospices and MAOs on their experiences working with each other as well as from enrollees or their representatives and caregivers as set out in sections 3.3 and 3.4. Guidance explaining how existing MA program requirements for grievance, organization/coverage determination, and appeals processing under the MA regulations found at 42 CFR § 422 (and, as applicable § 405) apply in the context of benefits provided only under the Model component will be released in the future. In addition, participating MAOs must make timely and reasonable payment to or on behalf of the plan enrollee for services obtained from a provider or supplier that does not contract with the participating MAO to provide services covered by the participating MA plan, as described in 42 CFR § 422.520.

In turn, CMS expects MAOs to include similar timely data submission requirements as outlined in the Medicare Claims Processing Manual¹⁹ within network participation agreement used with hospice providers. For example, MAOs may require timely-filed Notices of Election (NOEs) to be filed within five calendar days after the hospice admission date. In instances where an NOE is not timely-filed, the MAO may follow processes outlined in the Medicare Claims Processing Manual and not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the MAO. Consistent with current policy, any care provided for these days would be a provider liability and the provider could not bill the enrollee for them.

¹⁸ OIG. U.S. Department of Health and Human Services. Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio. July 2018. Retrieved from <https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf>

¹⁹ Medicare Claims Processing Manual: Chapter 11 - Processing Hospice Claims. Retrieved from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf>

2.7. Model Payments

MAOs participating in this Model component will be paid in accordance with current law for their enrollees who do not elect hospice. For beneficiaries who elect hospice, MAOs participating in this component of the VBI Model will be paid per the following payment structure:

- Consistent with 42 CFR § 422.320(c), the basic benefit capitation rate (also known as the “A/B capitation rate”) will be paid consistent with current law for the month an enrollee elects hospice under 42 CFR § 418.24. The basic benefit capitation rate will not be paid for the month following an enrollee’s hospice election if, as of the first of that month, the enrollee still has elected hospice;
- For all calendar months that a beneficiary elects hospice, including the initial month, the MAO will receive the following:
 - a monthly hospice capitation rate, described below, will be paid to the MAO for all months that a beneficiary elects hospice, including the initial month;
 - consistent with 42 CFR § 422.320(c)(2), the beneficiary rebate amount (as described in 42 CFR § 422.304(a)); and
 - consistent with 42 CFR § 422.320(c), the monthly prescription drug payment described in 42 CFR § 423.315 (if any).

A/B Capitation Rate Payment

A risk-adjusted A/B capitation rate will only be paid in Month 1, where Month 1 reflects the month that an enrollee elects hospice. Total payments from CMS to the participating MAO in Month 1 will be the risk-adjusted A/B capitation rate, an episode-adjusted hospice capitation rate (described below), the beneficiary rebate, and the monthly prescription drug payment, if applicable. The A/B capitation rate will not be paid effective from the first day of the month following the month of election to receive hospice care, until the first day of the month following the month in which the election is terminated.

Hospice Capitation Rate Payment

CMS’s Office of the Actuary is developing a national monthly hospice capitation rate. This rate will reflect FFS paid hospice experience for care both related and unrelated to the terminal condition and related conditions for all Medicare beneficiaries (both enrolled in Original Medicare and MA) who elected hospice, utilizing CMS data from 2016 through 2018 for CY 2021 rate-setting.

This national monthly hospice capitation rate will be adjusted for each Hospice Wage Index area (CBSA) by a hospice-specific average geographic adjustment similar to the Medicare Advantage Average Geographic Adjustment to result in an adjusted monthly hospice capitation rate. Risk adjustment will not be applied to the monthly hospice capitation rate.

For the first month only, the monthly hospice capitation rate that will be paid will have an adjustment applied to better reflect actual beneficiary experience. The hospice capitation rate paid for the first month will vary based on the number of days of hospice benefit occurring in the first calendar month of a hospice episode, whereby for any episode that has fewer than a specified number of days in the first month (e.g., less than 15 days), a participating MAO will receive a lower first month rate, and for any episode that has that number of days or more in the first calendar month (e.g., 15 days or more), a participating MAO will receive the higher first month rate. First month payments will be made in a lump-sum retrospectively to participating MAOs on a quarterly basis for all enrollees who have first calendar month hospice

experience. We are considering whether to provide a further stratification to better reflect first month beneficiary experience in hospice. As noted below, CMS will release additional information about the hospice capitation rate methodology in February, following the release of the Advance Notice of Methodological Changes for CY 2021 for MA Capitation Rates.

For any future month, the MAO will receive a flat hospice capitation rate, the beneficiary rebate amount, and the monthly prescription drug payment, if applicable, for an enrollee that continues hospice.

Revocation: If an enrollee revokes his or her hospice benefit, and that revocation is still in effect as of the first of the following month, the MAO will receive the A/B capitation rate and beneficiary rebate (and the monthly prescription drug payment, if applicable) beginning the month following the revocation.

For operational purposes, if an enrollee who is in hospice as of the first of the month revokes his or her hospice benefit after the first of a month, but re-elects hospice prior to the first of the following month, CMS will only pay one continuing month hospice capitation payment for that month. As such, the MAO will receive the hospice capitation rate, the beneficiary rebate, and the monthly prescription drug payment, if applicable.

If an enrollee elects hospice after the first of a month, revokes, and then re-elects hospice after the first of a new month, CMS will treat both months at a first month rate and pay based on the number of days as described above, in addition to all current payments (the A/B capitation rate, the beneficiary rebate, and the monthly prescription drug payment, if applicable). Of note, CMS will be reviewing revocation and live discharge as part of Model monitoring to examine trends and patterns of hospice utilization in the Model versus outside of the Model.

Hospice Capitation Payment Rate Actuarial Methodology

CMS will release additional information about the hospice capitation rate methodology in February, following the release of the Advance Notice of Methodological Changes for CY 2021 for MA Capitation Rates. In April, CMS will subsequently release Hospice Wage Index Area (CBSA) payment rates following the release of the CY 2021 Medicare Advantage Capitation Rates that reflects updated data, trends, and hospice utilization. Beneficiary-specific risk adjustment will not be applied to the hospice capitation rate payment. While the capitation rates are still in the process of being developed and some of the specifics mentioned above are subject to change, MAOs will be aware of the hospice capitation payment rate actuarial methodology prior to the application due date.

Payment Innovation

Through a focus on palliative care, the introduction of a structure to support transitional concurrent care, and maintaining the A/B capitation rate in full for the month in which the hospice election is made, MAOs and in-network hospice providers are afforded the flexibility to develop innovative payment arrangements for payment to hospice providers, potentially connecting hospice care with upstream palliative care, transitional concurrent care, and other disease-specific care approaches.

Illustrative examples of such alternative payment arrangements with hospice providers are described at a high level below:

- **Palliative Care Services Provided Outside the Hospice Benefit:** Hospice Provider A has a palliative care service offering and has engaged with a participating MAO to be an in-network hospice provider.

The MAO and Hospice Provider A agree to provide palliative care to the MAOs' members, separately from the hospice care that Hospice Provider A is providing to the MAO's enrollees who have elected hospice. As part of the agreement, the MAO and Hospice Provider A agree to a fixed monthly payment for each patient with serious illness on its palliative care program (per member per month, PMPM).

The MAO and Hospice Provider A agree to the types of palliative care services (provided outside the Medicare hospice benefit) that are covered under the PMPM, and include, at a minimum, palliative care consultations, a palliative care focused IDT (including physician, nursing, social work, and access to spiritual services), expert pain and symptom management, meaningful 24/7 clinician availability, shared decision making and education around disease progression and treatment options, advance care planning, family and caregiver support, benefits and entitlements assistance, linkage to community supports, food, transport, safety and housing services as needed, linkage to financial assistance, home environment safety assessment and follow-up, home adaptations or modifications, home-based physical and/or occupational therapy, personal care services, respite services for family caregivers, access to a spiritual professional, and psychological counseling. The participating MAO accounts for medical palliative services as medical costs within its A/B bid and services not covered under Part A, Part B or Part D as supplemental benefits.

- Bundled Payment for a Serious Illness Care Management Program and Hospice Program:** As Hospice Provider A and the MAO gain experience in the care needs of their community, various structures for payment innovation could emerge, including bundling payments for palliative and hospice care, prospective payments, total cost of care structures for specific members, and seamless plans of care that include concurrent care. While CMS will pay MAOs based on hospice eligibility and election consistent with current law and the Model payment parameters, nothing precludes MAOs and hospices from structuring payments differently as long as enrollees who are eligible for and elect hospice continue to receive the integrated and full set of services under the Medicare hospice benefit from the hospice provider. However, the participating MAO must allocate costs to the basic benefit bid and the bid for supplemental benefits consistent with bidding requirements (under 42 CFR Part 422), OACT instructions, and the Model requirements.
- Disease State Bundle Payments:** Over time, MAOs and hospice providers may choose to agree on episodic bundle payments, based on terminal condition and related conditions, where the MAO would pay the contracted hospice provider one total payment for all hospice care services for a specific length of time (e.g., 30, 60, or 90 days). This approach could facilitate appropriate access to hospice care and disease state-specific care solutions across a continuum for patients and their caregivers. For example, an MAO and a hospice provider could agree to palliative and hospice care bundles that allow for care for enrollees with cognitive disorders, cancer, end-organ failure, and other potential disease state bundles.
- Sharing in decreased unrelated care costs:** Plan A creates a benchmark based on data provided by CMS on the spending unrelated to the terminal condition and related conditions by the Medicare program for hospice beneficiaries within a region. If Plan A and its in-network hospice providers are able to change patterns of utilization on unrelated spend, Plan A keeps 50% of realized savings and distributes 50% of realized savings with in-network hospice providers, in proportion to the amount they contribute to the savings. Approaches to innovative payment arrangements between participating MAO and hospice providers must be outlined in the application.

4. Model Requirements

The VBID Model eligibility requirements are outlined below. Participating organizations must comply with the requirements of the Model communication and marketing guidance, and the monitoring, bidding, and other general CMS oversight requirements to ensure beneficiary protections while participating in the Model. CMS reserves the right to impose corrective action plans or take other remedial actions, including termination from the Model test, to rectify or address a failure to adhere to Model requirements. Further, an MAO's failure to adhere to the requirements of the Model test may result in rescission of payment or invalidation of any waiver of the applicable law issued by CMS to that organization in order to participate in this demonstration. The waiver withdrawal would be accompanied by enforcement action by CMS related to the waived requirements. All other regulatory and statutory requirements applicable to the organization's MA plan will remain in effect. Failure by an organization to comply with those requirements could result in enforcement action consistent with the authority of the MA program, including intermediate sanctions or contract termination.

3.1. Eligibility Requirements

Participation in the VBID Model and this component of the VBID Model is voluntary. The Model is open for participation to MAOs at the individual PBP level. MAOs may propose one or multiple MA and MA-PD plans for participation for the VBID Model and for the hospice component. CMS' main goal in listing the below eligibility requirements is to ensure experience in delivering benefits to Medicare beneficiaries. All MAOs applying to participate in the VBID Model in CY 2021, including existing participants, must submit an application to CMS by the application deadline. The application process to offer the Medicare hospice benefit is outlined in Section 5 below.

Eligible MA PBPs must meet the following criteria, which are the same for participation in the hospice benefit component of the Model as for participation in the Model overall:

- **Plan type:**
 - The following MA only and Medicare Advantage-Prescription Drug (MA-PD) plan offerings are eligible to apply:
 - Coordinated Care Plans
 - Health Maintenance Organizations (HMOs), including those with a Point of Service (POS) option
 - Local and Regional Preferred Provider Organizations (PPOs)
 - All Special Needs Plans
 - Chronic Condition Special Needs Plans (C-SNPs)
 - Dual Eligible Special Needs Plans (D-SNPs)
 - Institutional Special Needs Plans (I-SNPs)
 - The following types of Medicare health plan are **not** eligible to participate in the VBID Model:
 - Private Fee-for-Service Plans (PFFS)
 - Employer Group Waiver Plans (EGWP)
 - Medicare-Medicaid Plans or other demonstration plan (MMP)
 - Medicare Advantage Medical Savings Account Plans (MSA)
 - Cost Plans (CP)
 - PACE organizations (PACE)

- **Length of Plan Existence:**
 - At least one of the MAO's MA plans/PBPs included in the Model must have been offered in at least three annual coordinated election (open enrollment) periods prior to the open enrollment period for CY 2021 (i.e., open enrollment for 2018, 2019 and 2020).
- **Plan Performance:**
 - The MA organization is not under sanction by CMS, as described in 42 CFR § 422.750 and 42 CFR § 423.750, under any contract. The MA organization and MA plan must also pass a program integrity screening.
 - The PBP's contract has at least a three-star overall quality rating for the most recently available year. PBPs that are not rated, due to newness or low enrollment, may participate in the Model if other contracts from the same parent organization meet these requirements or the MAO requests, and CMS grants, an exception.
 - The PBP does not have a "consistently low performing" icon on the Medicare Plan Finder.
 - The MA organization that offers the plan is not an outlier in CMS's Past Performance Review; more information about this review is available at the following link:
<http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Complianceand-Audits/PartCandPartDComplianceActions.html>

Outside of a CMS exception, which is outlined below, PBPs that fail to meet these criteria may not participate in the VBID Model in CY 2021, although they may become eligible in subsequent years. Conversely, PBPs that meet these requirements initially, but fail to do so later (i.e., are later sanctioned by CMS or have a drop in overall Star Rating) may be disqualified from participation in later years or terminated by CMS from the Model, upon consideration of the best interests of the plan's enrollees and needs of the Model.

Applicants must disclose any present or past history of sanctions, investigations, probations or corrective action plans for the applicant, affiliates or other relevant persons and entities, including hospice providers contracted with the MAO for this Model. CMS will conduct program integrity (PI) screens during the application process and prior to the beginning of the start of the Model, and may reject an application or terminate a contract addendum on the basis of the results of a PI screening regarding the applicant, its affiliates, and any other relevant individuals or entities. The PI screening may include, without limitation, the following:

- Confirmation of current Medicare enrollment status and history of adverse enrollment actions
- Identification of delinquent debt if applicable;
- Review of performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;
- Review of compliance with Medicare program requirements;
- Review of any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse; and
- Review of any civil or criminal actions related to participation in a federal health care program.

CMS will consider exception requests in limited circumstances and will reserve the right, in its sole judgment, to admit an MAO or a MA plan/PBP that does not strictly meet the criteria. For example, CMS might admit a plan offered for fewer than three years, where that plan is a successor to a previously

offered plan, such that sufficient baseline data is available for evaluation. However, CMS will only exercise that discretion when that admission is consistent with the administration and goals of the VBID Model. In circumstances where a plan fails to meet quality-related criteria, CMS will apply a high degree of scrutiny to the request, and is unlikely to approve such an exception without consideration of additional monitoring or other conditions to be imposed upon the excepted PBP. In addition, CMS will consider applications for plans that do not meet the criteria at the time of application but are anticipated to meet these criteria by January 1, 2021.

Applicants seeking an exception should do so in writing by submitting a request to VBID@cms.hhs.gov, specifying the specific contract and plan numbers for which an exception is sought, and the grounds for the exception. Applicants are strongly encouraged to make requests well in advance of the due date for responses to this RFA.

The participant selection requirements are in addition to any participation requirements generally applicable to the MA program. A condition of continuing participation in the VBID Model is that the participating PBP continues to be offered in the MA program.

3.2. Marketing and Enrollee Communications

All MA communications and marketing regulations and guidance, including but not limited to the Medicare Communications and Marketing Guidelines, remain applicable to materials and activities of the participating organization and other MA and MA-PD plans (See, e.g., 42 CFR §§ 422 and 423, subparts V) and should serve as the main reference for plans. (See, e.g., 42 CFR §§ 422 and 423, subparts V and <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>)

Because the Medicare hospice benefit is a Part A benefit, participants offering the Medicare hospice benefit must use the language within the Evidence of Coverage (EOC) for the VBID Model hospice benefit component made available by CMS that indicates that the benefit is covered by the MAO, not Original Medicare.

MAOs participating in the Model and offering the Medicare hospice benefit must provide beneficiaries with a list of in-network hospice providers through their plan website as well as information and instructions for how to access network providers in the EOC. As part of this communication for CY 2021, MAOs must state that enrollees may seek hospice services at out-of-network providers, with currently allowable cost sharing in FFS, and may include the limitations of choosing to utilize an out-of-network provider.

MAOs participating in the Model must create communication and marketing strategies that ensure enrollees are engaged and informed. CMS will provide guidance on Model communications and marketing; all communications and marketing materials must comply with the prevailing requirements for MA and MA-PD plans (See e.g., 42 CFR §§ 422 and 423, subparts V).

In addition to communications with enrollees, participating organizations must communicate their Model participation to network providers that may be providing services to enrollees as part of the Model. Additionally, MAOs may communicate the eligibility status of enrollees for benefits under the VBID Model once established.

3.3. Model Monitoring and Data Collection

CMS will monitor hospice and palliative care utilization, patterns of dates of hospice election and revocation, and all other aspects of this Model component. Participating organizations will be required to provide the necessary data to CMS to allow for real-time monitoring of the Model's implementation and for Model evaluation. CMS will provide participating organizations with the Model Monitoring Guidelines that set out the timeliness, format, and necessary data to be submitted. At a minimum, participating MAOs should expect to provide a mix of beneficiary-level information and summary data, including:

- summary of total number of enrollees engaged in receiving palliative care services;
- hospice election date(s);
- principal diagnosis(es);
- accounting of the total number of enrollees that received concurrent care services;
- the types and length of concurrent care services received;
- level of care by hospice days;
- types of unrelated care provided (if any);
- unrelated spending for beneficiaries;
- date of death (or date of hospice revocation date(s) and reason(s) as applicable);
- percentage of enrollees that elect hospice; and
- additional data as necessary to fully support the implementation and monitoring of the Model.

Additional data guidelines will be provided, such as file layouts and transfer procedures, draft form in 2020 in order to assist participating plans with setting up systems for data collection and submission. As part of implementing the Model and the required evaluation, CMS will extract and analyze relevant utilization data, including all hospice data, as well as all beneficiary complaints for either hospice providers or MAOs.

Multi-pronged data collection efforts, including qualitative approaches, will be used to collect the information necessary to understand the perspectives of different stakeholders. Interviews and/or surveys encompassing a variety of sources, including beneficiary and family experiences and the perceptions of palliative care and hospice staff and MAOs are envisioned in order to identify and assess both the intervention plans and the reality of what specifically was implemented and achieved.

CMS will work with participating MAOs and may conduct on-site visits to allow for the direct observation of the model's implementation. CMS will also work with hospice providers to understand Model implementation and any material differences that hospice providers are experiencing in working with different MAOs. Overall, CMS expects to learn from the Model implementation and reserves every right to make changes to the Model as necessary to ensure beneficiary safety and that CMS' aims are achieved.

MAOs should submit to CMS any member complaints of steering of beneficiaries away from an MAO by any hospice provider or others as well as any other actions perceived to discriminate against, intimidate, or negatively impact a beneficiary, the care a beneficiary chooses, or where the beneficiary chooses their care. CMS will also monitor beneficiary, family, and caregiver satisfaction with hospice care and monitor impact on existing and future Star ratings.

The Model's monitoring plan is designed to protect all beneficiaries and assure organizations' compliance with the terms of the Model test. CMS or its contractor will conduct compliance monitoring on a regular basis to track MA organization compliance with the terms of the Model test. As with evaluation, while CMS or its contractor will monitor chiefly through existing data sources, participating plans will be

required to provide additional data collected specifically for the Model test where no existing data are available. CMS or its contractor may also conduct specific audits in identified risk areas, and may initiate audit activity that requires additional data or site visits, particularly in response to high levels of complaints or other indicators of poor performance.

3.4. General Model Oversight

CMS reserves the right to terminate an organization's participation in the Model or exercise other available remedies at any time if the organization has failed to comply with the terms of the Model, is subject to investigation or sanctions for program integrity issues, or if CMS determines that the organization's participation in the Model, or its performance of Model activities, may compromise the integrity of the Model, including by resulting in lower quality care or adverse outcomes for enrollees or the Model.

CMS will use a contractor to conduct regular monitoring to review compliance with the terms of the Model test. The contractor will monitor for compliance using existing data sources to the extent practicable, but may seek plan-provided data or conduct site visits, particularly in response to high levels of complaints or other indicators of poor performance. CMS will closely monitor Model implementation, to ensure that plan performance is consistent with Model rules and approved applications and that the Model is not leading to any adverse beneficiary outcomes. This will include, but not necessarily be limited to, observing existing measures of beneficiary access, outcomes, and satisfaction, and monitoring of increased beneficiary questions or complaints through 1-800-MEDICARE or the <https://www.medicare.gov> website. CMS will also monitor the impact the Model has on other CMS initiatives, such as the Part C and D Star Ratings.

CMS reserves the right to investigate an organization and downstream entities if there is evidence that indicates that the organization's participation in the Model is adversely impacting enrollee quality of care, and exercise all available remedies in appropriate instances, including potential termination of a Model participant or downstream entity from the Model test.

CMS retains the right to change any Model policy on an annual basis or more frequently, in accordance with procedures and parameters that will be established in the Model's contractual addendum to the MA organization's agreement with CMS for participation in the MA program.

CMS may consider more broad-reaching policy changes, including changes to the permissible interventions and Model components, setting additional financial requirements for participants, as well as adding or eliminating requirements for participation.

An organization may withdraw a PBP from the Model test, or cease participating entirely, by providing advance notice to CMS in accordance with the timeframes stated in the contractual addendum for participation in the VBID Model. In each case of withdrawal from the Model, organizations are required to provide CMS, by the bid deadline each year that precedes the start of the upcoming Plan Year, with a Model termination plan that includes how, what, and when the MAO will provide adequate notice to participating enrollees that are impacted by the change. If an MAO chooses not to participate in a future year, the MAO will propose to CMS a way to ensure beneficiaries eligible for VBID Benefits are made aware of any changes to their benefits. With respect to the MAO's implementing the Hospice benefit

component of the model, the MAO will make updates to the evidence of coverage for model PBPs to reflect the change as well as propose to CMS a way to ensure beneficiaries and their families or caregivers are made aware of any changes. Such notices must be in writing and must inform the beneficiaries of any changes to their benefits for the next Plan Year.

MAOs must continue to cover, through discharge, hospice services of a non-plan enrollee if the individual was an enrollee at the beginning of the hospice election stay. Similarly, if an MAO chooses not to participate in a future year, MAOs must continue to cover, through discharge, hospice services of an enrollee who has elected hospice in the prior year in which the MAO is participating through the future year an MAO is not participating, if applicable.

4. Evaluation

In addition to timely submission of required data and reports, all model participants will be required to cooperate with efforts to conduct an independent, federally funded evaluation of the model, which may include participation in surveys, interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation. The evaluation will assess the impact of the Model in meeting intended goals in order to inform future policy directions. To do so, the evaluation will seek to understand the behaviors of plans, providers, suppliers, and enrollees in response to the Model's alignment of financial accountability and incentives, the effects of various payment arrangements between plans and hospice providers on market dynamics, the impact of the model's care delivery approach on beneficiary engagement and experience, and other factors associated with patterns of results. Key outcomes of interest in the evaluation are the impact of the Model on Medicare expenditures and quality of care. The evaluation will also assess specific related outcomes such as improving appropriate rates of access to hospice (e.g., reducing length of stay "tails"), and demonstrating the ability to provide concurrent care cost effectively.

CMS anticipates including in the evaluation administrative data submitted to CMS by the model participants, and publicly available data sources. In situations where the evaluation uses non-publicly available data, CMS will publicly report the results of such evaluation at an aggregate-level or in a blinded manner (as appropriate) to avoid the disclosure of private and sensitive information.

CMS' independent evaluation will utilize qualitative and quantitative methods to both quantify the impact on health outcomes and expenditures, and document the experiences of enrollees, hospices, and MAOs. CMS will conduct quantitative analysis of both quality performance and monitoring measures in order to answer a number of evaluation questions, outlined below. The evaluation will also include qualitative analyses in order to capture and compare characteristics and experiences of model participants, as well as assess patient, family, provider, and plan perceptions, facilitators and barriers to change, areas of particular enthusiasm and practice culture. As part of the qualitative assessment, the evaluation will capture the implementation processes and describe the networks and concurrent care arrangements pursued by Model participants. Beneficiary utilization measures will provide preliminary insight into how plans are administering the Medicare Hospice Benefit, and how concurrent care is received.

Specific research questions that will be part of the evaluation will include, but are not limited to:

1. Which palliative care or transitional concurrent care do enrollees receive in the Model and how does that impact hospice utilization, revocation, length of stay, and enrollee, family, and/or care giver perceptions of hospice care?
2. What hospice supplemental benefits do MAOs offer as part of the hospice benefit component, and how are they used by enrollees?
3. How has the Model affected the way hospice care is introduced to enrollees deemed potentially eligible, including the timing of the initial discussion of hospice and the approach to introducing the topic and options?
4. How did MAOs participating in the Model identify and select in-network hospices? How do the MAOs monitor quality, and what payment arrangements are used? What policies, procedures, or other

mechanisms are used to coordinate services for enrollees and to collaborate with physicians and other healthcare providers?

5. In what ways do hospices designated as in-network by participating plans deliver hospice care differently to enrollees in the Model, relative to the hospice program's standard care delivery approach?
6. How does the Model impact the decision to elect hospice, and the timing of hospice election, by Medicare Advantage enrollees and dually eligible Medicaid beneficiaries?
7. What is the effect of the Model on Medicare expenditures, unrelated care expenditures, and beneficiary out of pocket costs?
8. Does the Model lead to changes in utilization of services (e.g., fewer ED visits and ICU admissions, decreased hospitalization, shorter hospital stay) relevant to the hospice population?
9. How does the Model affect beneficiary hospice experience, as measured by visits in the last week of life, likelihood of live discharge/transfer/revocation, among others?
10. What are the elements of each participating MAO's approach to care delivery? Which elements do enrollees, family/caregivers, and providers identify as the most important to improving quality of life?
11. How does the Model affect which hospice(s) enrollees choose for their care?
12. How are hospices administering the hospice benefit to at least one participating MAO's enrollees affected by the Model? How does the Model affect their census level and composition? What are the significant implementation and operational adaptations needed to participate in the Model? What do hospices perceive as the benefits and drawbacks of engaging with MAOs as part of the Model, both anticipated and unanticipated?

- **Application Process and Selection** MAOs interested in applying to participate in the VBID Model should submit their application by no later than **March 16, 2020**. The application portal will be accessible on the VBID Model website at: <https://innovation.cms.gov/initiatives/vbid/> in January 2020.

Questions regarding the Model or application process may be sent by email to VBID@cms.hhs.gov. While CMS will not share the source of the question, CMS may publicly share questions and responses or compile them into a Frequently Asked Questions compendium to ensure that all applicants have access to information regarding the VBID Model and the application process.

To participate in the model, applicants must follow the following process:

Step 1: CMS Technical Assistance (December 2019 through March 16, 2020)

In an effort to provide MAO support for the VBID Model, CMS will provide feedback and technical assistance on a rolling basis between the release of this RFA through March 16, 2020. CMS expects to engage with MAOs and/or hospice providers to ensure the success of the Model and to offer technical assistance where possible in regards to model participation, model requirements, and beneficiary protections. CMS cannot interfere in MAO contracting with any provider and will not offer any guidance beyond offered in this RFA.

Because the Model relies on high-quality network formation, it entails a higher level of awareness of hospices in MAO markets than under the status quo. There are a number of publicly available data sources that may be useful in understanding the hospice delivery landscape within a plan's service area, and assessing the organizational structure and profile of potential in-network hospices. In Appendix A of this document, CMS provides a description of these publicly available data sources that capture both structural and delivery characteristics of Medicare-certified hospice providers.

Step 2: Application (March 16, 2020)

Using the Application portal provided by CMS through the VBID Model website, MAOs may apply with one or multiple model-eligible PBPs under one or multiple MA contracts to include the hospice component of the Model. MAOs must indicate to CMS the contract(s), PBP(s), and segment(s), if eligible, that they are proposing to include in the model.

CMS will use the application process to capture concise, complete applications from MAOs on all of their proposed VBID intervention(s) and Model components, including the optional hospice benefit component. Plans are encouraged to provide specific, clear answers in their application that directly state what the plan proposes to do, for whom, how, and when. Where applicable, a supplemental document or presentation that better defines the overall narrative and specifics of the program may be uploaded.

Specific to the hospice component of the VBID Model, CMS will ask MAOs to outline its approach to palliative care services, transitional concurrent care, network development and administration of the Medicare hospice benefit, hospice supplemental benefits, if any, and in-network hospice provider cost-sharing. MAOs participating in the hospice component will also be requested to share their approach to wellness and health care planning, which is a required Model component.

After the application has been submitted, CMS will review applications and reach out to applicants for clarity, additional information, or to request changes. CMS will also provide additional technical assistance

and share data with MAOs who have submitted an Application to allow interested MAOs to understand current patterns of hospice utilization, current care patterns, current hospice revocation trends, aggregate utilization and types of utilization, and unrelated utilization and care.

MAOs will have through May 1, 2020 to work with CMS and finalize which contracts and PBPs will be included to participate in the Model. After review and technical assistance, CMS will aim to provide each applicant with a provisional approval (issuing such provisional approvals on a rolling basis) if the MAO submits a completed application earlier than the due date. For applicants that apply by the due date, CMS expects to provide provisional approvals and any required technical changes by April 2020 for model participation. MAOs that choose not to participate after provisional approval may do that by informing CMS and not including in its bid. Of note, model participant selection is not competitive. CMS does not intend to set a maximum number of qualified organizations participating in the Model test. CMS also reserves the right to reject any organization, PBP, or application to preserve the integrity of the Medicare program, the welfare of beneficiaries, or the efficient and advantageous administration of the Model.

In accordance with authorities granted in Section 1115A(d)(2) of the Social Security Act, CMS is exempt from administrative or judicial review of its selection of organizations, sites, or participants to test models. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFA; all costs associated with responding to this RFA will be solely at the interested party's expense. There is no requirement to respond to this RFA, as participation in the VBID Model is voluntary.

Step 3: Bid Submission (June 1, 2020)

A provisionally approved MAO will include participation in the VBID Model, and all VBID Model components it is participating in, as part of submitting its plan benefit package(s) to CMS by June 1, 2020. MAOs must follow all bid guidance as provided by CMS.

In addition, provisionally approved MAOs will be required to confirm their participation in the Model by the bid submission date of June 1, 2020 concurrent with and as part of their plan bid submission. In addition to the bid submission requirements, MAOs that were provisionally approved must notify CMS in writing by June 1, 2020 of any changes from their provisionally approved application, including changes to participating PBPs. MAOs should submit one application per contract that includes all PBPs and segments to be included as model PBPs.

5.1. Timeline

Below outlines the timeline for the application period for the VBID Model:

Date	Milestone
December 19, 2019	VBID Model – Hospice Component-Request for Application and Application released
December 19, 2019 – March 16, 2020	CMS provides feedback and technical assistance to MAOs applying for the hospice component
Mid-February 2020	CMS, in conjunction with the Office of the Actuary releases additional information about the hospice capitation rate methodology
March 16, 2020	Completed Application due to CMS by 11:59pm EST
April 2020	Office of the Actuary releases Hospice Wage Index Area (CBSA) payment rates and CMS completes review of applications and provides feedback to MAOs for inclusion in their CY 2021 plan benefit package
June 1, 2020	CY 2021 MA and Part D Bid submission deadline
September 2020	Contract addenda for model participation executed
October 2020	Initial hospice provider directory available, including in-network providers, as well as communication of benefits under the Evidence of Coverage.
January 1, 2021	CMS begins test of incorporation of the Medicare Hospice Benefit into Medicare Advantage; CY 2021 performance period of the VBID Model begins

5.2. Withdrawal or Modification of Application

Applicant organizations seeking to withdraw an entire application or requesting to modify a pending or preliminarily approved application should submit a written request on the organization's letterhead that is signed by the primary point of contact named in the application submission. To submit a withdrawal request, applicants must send the request in a PDF format by email to VBID@cms.hhs.gov.

Prior to bid submission, CMS will allow incremental changes to provisionally approved interventions or Model components so applicants may incorporate feedback from CMS or to otherwise improve the application to meet their goals for the Model. After application and bid submission on June 1, 2020, CMS will only allow changes of a type typically allowed for MA and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings, or permitted during rebate reallocation. Allowance of changes to preliminarily approved interventions is a matter of CMS discretion, and CMS may require resubmission of actuarial documentation to account for proposed changes.

5.3. Amendment of RFA

CMS may change the terms of the Model or cancel it entirely in response to stakeholder comments or other factors. The terms set forth in this RFA may differ from the terms set forth in the final addendum for participation in the Model test.

Appendix A: Publicly Available Data Sources for Hospice Organizations and Utilization

The data sources described below are publicly available and may be of interest for participating MAOs in identifying and characterizing hospices in their service areas.

[Hospice Utilization and Payment Public Use File:](#) This annual data set (available for 2014-2017) provides descriptive information on hospices providing services to Medicare beneficiaries, and also offers summary data at the state and national levels. Many of these variables are claims-based, and thus capture aspects of the beneficiary experience. Information include location and contact info, amount of care provided (e.g., number of beneficiaries served, number of days of care provided), characteristics of care delivery (e.g., number of live discharges, skilled nursing visit hours per day, number with stays shorter than seven days), and beneficiary characteristics (e.g., demographics, primary diagnosis, number enrolled in MA). Of note, hospices serving 10 or fewer Medicare beneficiaries are not included in this file, and cells based on 10 or fewer Medicare beneficiaries (or derived from such values) are set to missing. Sample variables of interest include:

- Percent of Days in Hospice RHC: This variable indicates the percentage of a hospice's Medicare-paid hospice days that were billed as routine home care. Routine home care is one of the four levels of care that hospices are mandated to provide. In 2016, the average hospice billed 98.6% of Medicare-provided days as routine home care, and the median level was 100%. This variable may be meaningful as reflecting a number of factors, including beneficiary case mix, hospice delivery style, and composition of local hospital markets.
- Percent of Hospice Beneficiaries with Seven or Fewer Hospice Care Days: This variable reflects the number of Medicare beneficiaries a hospice served with seven or fewer days of care, not including beneficiaries with stays that extend across calendar years. Given that the Medicare Hospice Benefit is designed for the last six months of life, this variable is often regarded as a measure of those who are unable to take full advantage of the array of services that the benefit offers. This variable is influenced by factors such as case mix, since beneficiaries tend to have different lengths of stay based on primary diagnosis.

[Provider of Services File:](#) This quarterly data set provides organizational information on hospices serving Medicare beneficiaries. Information in this file includes location data, ownership, facility type, and the number of employees serving in various positions. Sample variables of interest include:

- Ownership type code: This measure indicates the hospice ownership type, and allows for differentiation among non-profits, for-profits, and government-owned hospices. This variable may be relevant because MedPAC, OIG and CMS have shown that non-profit and for-profit hospices differ on characteristics such as size, case mix, and length of stay.²⁰
- Facility type code: This variable identifies whether a hospice is freestanding or is affiliated with another type of facility (hospital, home health, etc.). MedPAC, OIG and CMS have shown differences in length of stay based on facility type, and this variable highly correlated with ownership type.²¹

²⁰ (1) MedPAC. Hospice Services. March 2019. Retrieved from http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch12_sec.pdf (2) OIG. Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm. July 2019. Retrieved from <https://innovation.cms.gov/initiatives/vbid/> (3) OIG. Hospice Deficiencies Pose Risks to Medicare Beneficiaries. July 2019. Retrieved from https://oig.hhs.gov/oei/reports/oei-02-17-00020.pdf?utm_source=summary-page&utm_medium=web&utm_campaign=OEI-02-17-00020-PDF (4) CMS. Medicare Hospice Payment Reform: Analyses to Support Payment Reform. May 2014. Retrieved from <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/May-2014-AnalysesToSupportPaymentReform.pdf>

²¹ Ibid

Other Resources

The following links are to CMS and other documents that are helpful in understanding the Medicare hospice benefit in general and provide data and information on details that may be of interest to MAOs.

The 'Hospice Center' CMS [webpage](#) has important links to hospice research and analyses, regulations and related transmittals, billing and payment information, coordination of benefits, wage index files, Medicare hospice data, CMS manuals and transmittals, quality initiatives and other educational resources.

The below chapters of the Medicare Managed Care Manual, Medicare Benefit Policy Manual and the Medicare Claims Processing Manual provide details on CMS policies around current special payment rules when MA enrollees elect hospice, the Medicare Hospice Benefit, and billing for the hospice benefit, respectively.

- [Chapter 8 of the Medicare Managed Care Manual, “Payments to Medicare Advantage Organizations”](#)
- [Chapter 9 of the Medicare Benefit Policy Manual, “Coverage of Hospice Services Under Hospital Insurance”](#)
- [Chapter 11 of the Medicare Claims Processing Manual, “Processing Hospice Claims”](#)

Annual Hospice Wage Index Final Rules

- <https://www.govinfo.gov/content/pkg/FR-2019-08-06/pdf/2019-16583.pdf>
- <https://www.gpo.gov/fdsys/pkg/FR-2018-08-06/pdf/2018-16539.pdf>
- <https://www.gpo.gov/fdsys/pkg/FR-2016-08-05/pdf/2016-18221.pdf>
- <http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18506.pdf>

Medicare Payment Advisory Committee

- <http://www.medpac.gov/-documents/-reports> (Chapter 12 of the Annual Report to Congress which is issued in March each year)
- http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_hospice_final_sec.pdf?sfvrsn=0 (Payment Basics Hospice Services Payment System overview, 2019)

For More Detailed Data

The following data sets provide more detailed information:

- Standard Analytical Files (Medicare Claims) – LDS <https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/StandardAnalyticalFiles>
- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/Downloads/SAFidsHospiceDec2010.pdf>

Appendix B: MAO Application Questions for the Hospice Benefit Component

CMS will accept applications from MAOs that meet model eligibility requirements for the hospice benefit component within the VBID Model. MAOs interested in applying to the hospice benefit component should review the RFA in detail to learn about the design and requirements of the Model. In order to assist potential model applicants in drafting their responses to the application, CMS is providing the core set of questions that MAOs must answer. The application portal will be accessible on the VBID Model website

at: <https://innovation.cms.gov/initiatives/vbid/> in January 2020.

CMS is available for technical assistance by emailing VBID@cms.hhs.gov at any time during the application process. Please answer each application question as carefully and accurately as possible to avoid a delay in CMS review. CMS will review submitted applications and reach out to applicants with clarifying questions, requests for additional information, or to request necessary changes. CMS will also provide additional technical assistance and share data with MAOs who have submitted an application to allow interested MAOs to understand current patterns of hospice utilization, current care patterns, current hospice revocation trends, aggregate utilization and types of utilization, and unrelated utilization and care.

Approach to and Delivery of Palliative Care

The following questions are about your MAO's approach to providing access to timely, appropriate, and palliative care services for enrollees who can benefit from these services.

1. Which of the following does, or will, your palliative care program include? Select all that apply.
 - ☐ Palliative care consult
 - ☐ Comprehensive care assessments for targeted enrollees
 - ☐ Comprehensive services available from an interdisciplinary palliative care team
 - ☐ Care planning and goals of care discussions
 - ☐ Advance care planning
 - ☐ Access to social services and community resources
 - ☐ 24/7 access and support by the interdisciplinary care team
 - ☐ Psychosocial and spiritual support
 - ☐ Pain and symptom management
 - ☐ Medication reconciliation
 - ☐ Caregiver support
 - ☐ Other (Please describe)
2. Please use this section to provide any additional narrative on the above identified palliative care program and the role of an interdisciplinary team in providing palliative care services. Please include both clinical/medical and social support aspects (e.g., community-based model, telephonic case management, case management, inpatient, outpatient, etc.).
3. Approximately how many patients do you anticipate serving in your palliative care program(s) in CY 2021? Please include definition(s) of eligibility for your palliative care program(s).
4. What is your patient identification process (e.g., based on clinical interaction, claims data algorithm, etc.) and what are the patient population characteristics associated with that process (e.g., identified by diagnoses and utilization of specific services)?
5. Describe your approach to align or introduce different care options, including hospice for those beneficiaries that elect the hospice benefit, through offering upstream palliative care services in CY 2021.
6. Describe the providers you expect to engage with to provide palliative care (e.g., in-network hospice providers, primary care providers, or other specialists).

7. How are you accounting for palliative care in the bid (e.g., administrative, medical and/or supplemental benefits)? What are the projected costs for palliative care? Please include cost buildup of the projection (e.g., types of services, volumes and costs for each)? If costs are not budget neutral had hospice not been carved in, please explain.

Transitional Concurrent Care

The following questions are about your MAO's approach to transitional concurrent care.

1. Please describe the approach to working with in-network hospice providers to identify the services that will be offered, based on a beneficiary's plan of care, on a transitional concurrent basis.
2. Please describe the expected items or services that, based on the beneficiary's plan of care, would be offered on a transitional basis in addition to the items or services offered as part of the hospice benefit.
3. What are the projected costs for concurrent care? Please include cost buildup of the projection (e.g., types of services, volumes and costs for each).
4. Please verify the following:
 - ☐ Concurrent care will be appropriate, reflective of patients' and caregivers' needs as identified in the plan and goals of care;
 - ☐ Concurrent care is transitional and will not duplicate the services covered in the Medicare hospice benefit; and
 - ☐ Concurrent care will be coordinated among in-network hospices, MAOs and other treating providers, as applicable;
 - ☐ Concurrent care guidelines or policies will be maintained by the MAO to ensure appropriate enrollee access to concurrent care.

Hospice Supplemental Benefits (for applicants offering supplemental hospice benefits)

Please fill out the Plan Benefit Package and answer each of the following questions regarding hospice supplemental benefits.

1. Are you offering any mandatory supplemental benefits for enrollees that elect hospice? If so, what is the maximum plan benefit amount?
2. Please indicate the types of supplemental benefits that will be offered:
 - ☐ Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization, including:
 - ☐ Home and bathroom safety devices/modifications
 - ☐ Over-the-counter (OTC) benefits
 - ☐ Support for caregivers of enrollees
 - ☐ Meals
 - ☐ Transportation
 - ☐ Other _____ (Please describe)
 - ☐ Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to which to discharge

- ☐ Reduced cost sharing for unrelated medical care services received during hospice election
- ☐ Other mandatory supplemental benefits _____ (Please describe) _____

3. Please detail any use of care managers or other approaches that allow for the provision of hospice supplemental benefits for enrollees that have elected hospice.
4. Please identify any hospice supplemental benefits that are limited to enrollees who choose in-network providers.

Beneficiary Access to Hospice Care and Network Requirements

The following questions are about your enrollees' access to hospice care, including questions about the hospice provider network structure.

1. Describe the identification and selection criteria and processes (including credentialing) supporting the creation of your organization's hospice provider network.
2. Describe how you will monitor and evaluate quality of care provided by in-network providers. Include the types of data or processes you expect to use in monitoring and evaluating quality for the purposes of network selection and on an ongoing basis and any training or quality improvement initiatives you plan to offer.
3. Describe any planned innovative programs or payment arrangements.
4. Please identify any hospice providers your organization proposes to exclude as well as any justification. Network exclusion criteria may include one or more of the following: (1) the hospice provider was found through publicly available data or sources to pose a risk for beneficiary harm in the past three years; (2) the hospice provider consistently has not offered all four levels of hospice care, infrequently provided physician services, or rarely provided care on weekends in the past three years; or (3) the hospice provider did not respond to your organization's credentialing attempts.
5. Please describe any voluntary consultation process aimed at engaging enrollees prior to their accessing an out-of-network hospice.