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

Calendar Year 2023 Request for Applications

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Table of Contents

1. 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) ("Hospice Benefit Component") of the Value-Based Insurance Design (VBID) Model ("Model") for Calendar Year (CY) 2023. 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 apply and are approved 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.

The CMS Innovation Center will issue a separate CY 2023 VBID Model Request for Applications (RFA) for MAOs interested in offering the other components of the VBID Model;[1] this RFA is only for the Hospice Benefit Component of the Model. Although there are separate RFAs, **there is only one application for participating in the Model in 2023**. CMS encourages interested MAOs to review the CY 2023 VBID Model RFA for general instructions on filing an application and general rules for participation in the Model. MAOs who intend to participate in the Hospice Benefit Component are required to comply with all the Model requirements outlined in the CY 2023 VBID RFA.[2]

1.1. Summary of the 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 2023. Sections three, four, and five set out Model requirements, a high-level description of the Model component evaluation, and the application process for this Model component.

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[1] CMS encourages MAOs to note that there have been certain changes made in the CY 2023 VBID Model RFA, including the termination of the Cash or Monetary Benefits component of the VBID Model, and the resulting inapplicability of the waivers related to that Model component.

[2] 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 2023 VBID Model RFA: https://innovation.cms.gov/initiatives/vbid/.

In participating in this Model component, MAOs will incorporate the current Medicare hospice benefit into MA covered benefits in combination with offering additional 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. Participating MAOs will be paid a hospice capitation payment amount as set out at section 2.7, and will provide services consistent with the quality improvement goals set out at section 2.5 and the network adequacy requirements set out at section 2.6.

The six main elements of this Model component are as follows:

1. Participating MAOs must provide the full scope of hospice care, as defined in the Social Security Act (Act) at section 1861(dd), that is covered by Medicare Part A. Participating MAOs' enrollees receiving hospice benefits must meet the statutory standard of "terminally ill," as set out in the Act at section 1861(dd)(3)(A). Through contracting hospices, MAOs must work with an interdisciplinary care team (IDT), described at section 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 the hospice benefit will remain exclusively with the enrollee (or his or her representative), as set out in the Act at section 1812(d) and in CMS regulations at 42 CFR 418.24 and 42 CFR 418.28.

2. In addition to hospice services, CMS will require participating MAOs to have a comprehensive strategy around equitable access and delivery of palliative care services for enrollees with serious illness who are either not yet eligible for or who have not yet chosen to receive hospice services. While MAOs may set the criteria (which must also be provided in their application) 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 section 1852 in a way that is neutral to the total Parts A and B bid (the bid for basic benefits) and expenditures.

3. 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 transitional concurrent care services necessary to address continuing care needs, as clinically appropriate, for the treatment of hospice enrollees' terminal illness and related 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. To increase understanding of transitional concurrent care for beneficiaries and healthcare providers, CMS encourages participating MAOs to work with their in-network hospice providers on the inclusion of an addendum to the hospice election statement by the enrollee and for that hospice election addendum to specifically

address the provision of transitional concurrent care items, services and drugs that will be covered by the Model-participating MAO.[3]

4. To provide transparency and improved beneficiary, family, and caregiver experience with end-of-life care, CMS will monitor the performance of participating 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 measure areas that present improvement opportunities relevant to health equity and enrollees' care and quality of life, are clinically meaningful, and are aligned with CMS's broader quality measurement strategy.[4]

5. In order to ensure access by hospice enrollees to hospice providers, for CY 2023, all participating MAOs and their corresponding PBPs in the Model must cover hospice services furnished by both in-network and out-of-network hospice providers that have participation agreements with Original Medicare. Consistent with sections 1852(a)(2) and (k)(1) and 1866(a)(1)(O) of the Act and 42 CFR 422.100(b)(2) and 422.214, participating MAOs must pay non-contracted hospice providers (and non-contracted providers must accept payment) at a rate equal to the Original Medicare Fee-For-Service (FFS) payment for hospice services. Furthermore, participating MAOs and their corresponding PBPs that will enter into their second or third year of participation in CY 2023 will be required to form and maintain provider networks in line with a more traditional MA network adequacy approach centered around a minimum number of providers requirement along with a comprehensive network formation strategy. Regardless of year of participation, cost sharing for all hospice services (in-network and out-of-network) may be no higher than the cost sharing in Original Medicare for hospice benefits.

6. Participating MAOs will be paid a monthly hospice capitation payment amount 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 length of stay during the first month in hospice (see section 2.7 for additional details).

In sum, CMS believes this Model test represents an opportunity for Medicare beneficiaries who choose MA and elect hospice, as well as their families and caregivers, to experience a more

[3] For more information on this matter, please refer to pages 14 through 16 of the Technical and Operational Guidance: https://innovation.cms.gov/media/document/vbid-hospice-technical-guidance-cy2021

[4] For more information on the CMS Quality Strategy, visit: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy

seamless transition to hospice care, if elected, with improved coordination of care throughout their elections.

1.2. Hospice Benefit Component for CY 2023

CMS is exercising its authority under section 1115A of the Social Security Act (the "Act") to grant limited program waivers to participating MAOs that apply and are approved 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 testing the Hospice Benefit Component of the Model will also help determine whether this service delivery model improves access to and provision of high-quality hospice care for Medicare beneficiaries who elect the hospice benefit.

Participating MAOs that apply and are approved 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 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, high-quality, and standardized hospice care.

CMS is testing the impact on hospice utilization patterns, costs of care related and unrelated to the terminal illness, and on enrollee experience of care, 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 in the Model Plan Benefit Packages (PBPs), 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 the CMS Innovation Center's 2021 Strategy Refresh[5] to increase utilization of high-value care through regulatory, beneficiary, and plan flexibilities and bolsters the CMS Innovation Center's portfolio of models that take steps to expand appropriate access to palliative and hospice care.

Hospice care furnished under the Model must meet all statutory and regulatory requirements of the Medicare hospice benefit as outlined at section 1861(dd) of 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

[5] CMS Innovation Center Strategy Refresh. October 2021. Retrieved from https://innovation.cms.gov/strategic-direction-whitepaper

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 facilitating 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 six 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 include, at the request of the patient or their representative, an addendum that contains information aimed at increasing coverage transparency for patients under a hospice election, as required under 42 CFR 418.24(c). In addition, the election statement must conform to any subsequent changes to the regulation made during the course of the Model period.

- **Hospice Election Period:** Hospice election period refers to the period in which an individual may elect to receive hospice care. The hospice election period includes one or more of the following election periods: (i) the initial 90–day period; (ii) the subsequent 90–day period; and (iii) an 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).

- **Hospice Care:** Hospice care means a comprehensive set of services (described at section 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 exclusively 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; 42 CFR 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 and related conditions as required at section 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 a ten-year period 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 98.3 percent of total hospice days; GIP accounting for 1.2 percent of total hospice days; CHC accounting for 0.2 percent of total hospice days; and, IRC accounting for 0.3 percent of total hospice days.[6] 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 beneficiaries can return to their home and continue to receive RHC. GIP may also cover medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring. 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. CHC may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in

[6] Proposed Rule, "Medicare Program; FY 2022 Hospice Wage Index and Payment Rate, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements (86 FR 19700, April 14, 2021).

accordance with CMS regulations at 42 CFR 418.204. For any given patient, the type of care can vary throughout the hospice stay as the patient's needs change.

- **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 418.28(c)(2)).

Model Geography

Eligible MA plan types in all states and territories may apply to participate in this component of the VBID Model for CY 2023 (See section 3.1: Eligibility Requirements).

Model Performance Period

CMS is only announcing an application period for CY 2023 at this time for the Hospice Benefit Component. CMS currently anticipates that the Hospice Benefit Component of the Model will be tested through the end of CY 2024.

1.3. Advancing Health Equity[7]

Executive Order 13985 *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government* directs the pursuit of a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Executive Order 13988 *Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation* builds upon this commitment by making it the policy of the Biden-Harris Administration "to prevent and combat discrimination on the basis of gender identity or sexual orientation" and "to address overlapping forms of discrimination." Stemming from this mandate, CMS's vision for the next decade's innovation prioritizes achieving the goal of attaining the highest level of health for all people and eliminating health disparities.[8] CMS recognizes that this requires that equity be embedded in all stages of model design, operation, and evaluation, and that these concepts align with other CMS programs.

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[7] Health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

[8] Innovation at The Centers for Medicare And Medicaid Services: A Vision for The Next 10 Years. August 12, 2021. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20210812.211558/full/

Recently published studies evaluating inequities in hospice and palliative care point to a series of concerning findings. These include, but not limited to, the presence of gender-based and race-based bias in pain assessment and treatment recommendations,[9,10] disparate use of hospice along racial lines,[11] gender-based disparities in caregiver burden and their resulting negative impact on the wellbeing of women,[12] and disparities in the use of palliative and hospice care among the LGBTQ+ population.[13] Systematic reviews of research regarding disparities in this field also point to a significant number of research questions that require further study, indicating a broad range of opportunities to advance the field's understanding of these issues and the care and experience of historically underserved populations.[14]

Within the context of the Medicare hospice benefit, CMS recently solicited stakeholder feedback through the FY 2022 Proposed Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements (86 FR 19700)[15] on "recommendations for quality measures, or measurement domains that address health equity, for use in the [Hospice Quality Reporting Program] HQRP," "ways CMS can promote health equity in outcomes among hospice patients," "methods that commenters or their organizations use in employing data to reduce disparities and improve patient outcomes," and other topics regarding health equity. CMS is continuing to review the comments as CMS considers policies to address health equity.

CMMI is committed to incorporating into the Hospice Benefit Component of the VBID Model, and the Model as a whole, strategies for improving health equity, especially among populations

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[9] Hoffman, Kelly M., et al. "Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites." Proceedings of the National Academy of Sciences, vol. 113, no. 16, 2016, pp. 4296–4301, https://doi.org/10.1073/pnas.1516047113.

[10] Gott, M., Morgan, T., & Williams, L. (2020). Gender and Palliative Care: A Call To Arms. Palliative Care and Social Practice, 14, 263235242095799. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7576896/

[11] Ornstein, Katherine A., et al. "Evaluation of Racial Disparities in Hospice Use and End-of-Life Treatment Intensity in the Regards Cohort." JAMA Network Open, vol. 3, no. 8, 2020, https://doi.org/10.1001/jamanetworkopen.2020.14639.

[12] Washington, K. T., Pike, K. C., Demiris, G., Parker Oliver, D., Albright, D. L., & Lewis, A. M. (2015). Gender differences in caregiving at end of life: Implications for hospice teams. Journal of Palliative Medicine, 18(12), 1048–1053. https://doi.org/10.1089/jpm.2015.0214

[13] Cloyes, Kristin G., et al. "Palliative and End-of-Life Care for Lesbian, Gay, Bisexual, and Transgender (LGBT) Cancer Patients and Their Caregivers." Seminars in Oncology Nursing, vol. 34, no. 1, 2018, pp. 60–71., https://doi.org/10.1016/j.soncn.2017.12.003.

[14] Bazargan, Mohsen, and Shahrzad Bazargan-Hejazi. "Disparities in Palliative and Hospice Care and Completion of Advance Care Planning and Directives among Non-Hispanic Blacks: A Scoping Review of Recent Literature." American Journal of Hospice and Palliative Medicine®, vol. 38, no. 6, 2020, pp. 688–718., https://pubmed.ncbi.nlm.nih.gov/33287561/.

[15] Proposed Rule CMS-1754-P. FY 2022 Proposed Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements. Retrieved from https://www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf

with serious illness. Accordingly, this round of applications for participation in CY 2023 requires each applicant for the Hospice Benefit Component to describe a detailed strategy for advancing health equity as part of its approach to the Hospice Benefit Component. This strategy must include, but is not limited to, applying the principles of health equity to their palliative care strategies and to their coverage and coordination of the Medicare Hospice Benefit. Please see *Appendix B: MAO Application Questions for the Hospice Benefit Component* for more information. In the future, CMS anticipates expanding upon these efforts to address health equity issues and is exploring initiatives such as providing Model participants with additional data and/or information to facilitate use of interventions that can advance health equity. **We welcome Model participant and other stakeholder feedback on the role of the Hospice Benefit Component in advancing health equity.**

1.4. 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.[16] 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 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.[17]

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 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.[18] 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

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

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

[18] 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

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.[19,20] Further, in the 1983 Hospice final rule (48 FR 56010), 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."[21]

Despite this clear policy objective, in the FY 2016 Hospice Final Rule, CMS cited 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.[22] 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 2019, CMS found that Medicare paid over $1 billion for non-hospice items and services under Parts A, B, and D for beneficiaries during their hospice elections.[23] Additionally, on the basis of its 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. Additionally, although hospices told OIG that 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.[24] These two patterns result in CMS

[19] 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
[20] 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
[21] 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
[22] 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
[23] Proposed Rule CMS-1754-P. CMS FY 2022 FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements. Retrieved from https://www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf
[24] 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

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). In a subsequent CMS analysis, beneficiary cost sharing in FY 2019 increased overall with amounts of $170 million for Parts A and B and $59 million under Part D.[25] Overall, some hospice providers' patterns of care impose 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 would have been subject to the protections of 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.
- Also beginning in January 1, 2016, Medicare makes additional payments, referred to as Service Intensity Add-on (SIA), 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.
- Additionally, the FY 2022 Hospice Final Rule (86 FR 42528, August 4, 2021) rebased and revised the labor shares for all four levels of care based on the compensation cost weights for each level of care from the 2018 Medicare cost report data for freestanding hospices.

Further, while hospice care is a covered Medicare Part A benefit, the MA program – formerly known as Medicare+Choice program – does not include coverage, risk or financial accountability for providing the Medicare hospice benefit as part of MA plan obligations.[26] Specifically, the Act

[25] Proposed Rule CMS-1754-P. CMS FY2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements. Retrieved from https://www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf

[26] 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

provides that if an individual enrolled in an MA plan elects to receive hospice care, payment for that hospice care is made to the hospice program through the Medicare FFS program, 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 (now Medicare Advantage Organization, or MAO) or the provider or supplier of the service, provided the individual who elected hospice also elected to remain in the MA plan.[27] Per 42 CFR 422.320(c)(2) and (3), during the time the hospice election is in effect, CMS's 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 42 CFR 422.304(a)(3) or to zero for plans with no beneficiary rebate, described at 42 CFR 422.304(a)(2); and (ii) the amount of the monthly prescription drug payment described in 42 CFR 423.315 (if any).

CMS pays through the Original Medicare FFS program (subject to the usual rules of payment in the FFS program) (i) the hospice program for hospice care furnished to the Medicare enrollee; and (ii) the MAO, 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.[28]

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, that are at risk for hospice spending, and MAOs, that 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.

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

[28] MedPAC. The Medicare Advantage program: Status report. Chapter 13. Retrieved from https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar14_ch13.pdf

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.

1.5. Statutory Authority

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

1.6. 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.

For this Model and consistent with the authority under section 1115A(d)(1), the Secretary issued waivers of the fraud and abuse provisions in section 1128A(a)(5) (relating to the civil monetary penalties for beneficiary inducements) and sections 1128B(b)(1) and (2) of the Act (relating to the federal anti-kickback statute) for the following remunerations, provided that conditions of the relevant waiver are satisfied: (i) certain rewards and incentives offered by the MAO to Targeted Enrollees; and (ii) certain supplemental benefits provided by the MAO to all enrollees in a VBID PBP that has been approved by CMS to provide Cash or Monetary Rebates. CMS has terminated the Cash or Monetary Rebates Component of the VBID Model for Plan Year 2023. Accordingly, the fraud and abuse waiver for the provision of Cash or Monetary Rebates will be inapplicable for CY 2023.

Further, no new fraud and abuse waivers are being issued in this document; any new or revised fraud and abuse waiver would be set forth in separately issued documentation. Any such waiver would apply solely to this Model and could differ in scope or design from waivers granted for other programs or models, or those described below. 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 this Model.

1.7. Medicare Program and Payment Waivers

No waivers of program requirements or payment provisions are provided in this document. This RFA merely describes the waivers contemplated at this time for the Model; program or payment waivers, if any, would be set forth in Model documentation (such as an appendix to the contractual addendum for participation in the Model). In support of the Model, the Secretary intends to waive certain Title XVIII provisions and their implementing rules, to the extent described below and only as necessary to conduct the tests described in this RFA. 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 and 42 CFR 422.100(a) and 422.101, 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 the Medicare hospice benefit consistent with the scope of coverage under Part A and consistent with the terms of this Model;
- Section 1851(i) of the Act, to the extent necessary, to permit payment to the MAO by CMS for hospice coverage consistent with the terms of the Model and payment by the MAO to Hospice Providers for Hospice Care covered under Part A;
- 42 CFR 422.320 with respect to payment to the extent necessary to permit payment to participating MAOs as provided under the Hospice Benefit Component of the VBID Model; [29]
- 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 transitional concurrent care by MAOs participating in this component of the VBID Model as a Part A and B benefit that is covered by the participating MAO only when furnished through in-network providers to enrollees who have elected hospice;
- Sections 1812(d)(2)(A)(ii)(I) and 1852(a)(1) of the Act, and implementing regulations, 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, as described in section 2.3 and required as part of the Model, transitional concurrent care may be treated as a Part A and B benefit that is covered by the participating MAO only when furnished through in-network providers to enrollees who have elected hospice;
- Uniformity and Accessibility of Benefits: To be waived to the extent necessary to permit MAOs 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 must be identified based on hospice election, which may be further targeted to those hospice enrollees who choose an in-network hospice provider AND/OR have (i) one or more chronic health conditions, or (ii) low income status (LIS) eligibility, or (iii) a combination of both these health conditions and socioeconomic statuses. These are called "hospice supplemental benefits."

[29] Section 1853 of the Act and the regulations at 42 CFR part 422, subparts F and G regarding development of the benchmark, bidding, and payment to MA organizations for basic benefits do not apply to payments for the hospice services covered and furnished under this Model.

- Sections 1852(d)(1)(A) and 1854(c) of the Act;
- 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 CFR 423.104(b)(2) and 42 CFR 423.265(c).

- Uniform Cost-Sharing Requirements for MA Plans: To be waived to the extent necessary to offer certain 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 must be identified based on hospice election, which may be further targeted to those hospice enrollees who choose an in-network hospice provider AND/OR have (i) one or more chronic health 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 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 CFR 423.104(b)(2) and 42 CFR 423.265(c).
- Requirements for Supplemental Benefits to Permit Coverage by a Participating MA Plan of Non-Primarily Health Related Supplemental Benefits:[30] To be waived to the extent necessary to allow the MAO to offer to the targeted enrollee population, but not to all enrollees, in the VBID PBPs participating in the Hospice Benefit Component certain additional non-primarily health related supplemental benefits, subject to the conditions and limitations 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 health condition or socioeconomic status of the targeted enrollee population during hospice election. The targeted enrollee population must be identified based on hospice election, which may be further targeted to those enrollees who choose an in-network hospice provider AND/OR have (i) one or more chronic health conditions, or (ii) LIS eligibility, or (iii) a combination of both these health condition and socioeconomic statuses. In using one or more chronic health 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 and any implementing regulations.
  - Provisions of 42 CFR §§ 422.100(c)(2)(ii)(A) and 422.102(f)(2)(i), (ii), and (iii) that limit eligibility for non-primarily or primarily health related supplemental benefits to certain enrollees.

[30] These benefits that are not primarily health related are of the same type and scope as special supplemental benefits for the chronically ill (SSBCI), which are authorized under section 1853(a)(3)(D) of the Act and 42 CFR 422.102(f) but are permitted under this Model, pursuant to the necessary waivers, to be furnished to a different population of MA enrollees based on different eligibility criteria than required for SSBCI. SSBCI are limited to only being provided to "chronically ill enrollees," as that term is defined in section 1853(a)3)(D) of the Act and 42 CFR 422.102(f). We do not use the term "SSBCI" or "special supplemental benefits for the chronically ill" in this Model in order to avoid potential confusion about the eligibility criteria that may be used in the Model.

- Application of the Hospice Inpatient Cap and Hospice Aggregate Cap: Section 1814(i)(2) of the Act and 42 CFR §§ 418.302(f) and 418.309, to exclude from the calculation of a hospice's inpatient cap and the hospice aggregate cap those enrollees in an MAO's VBID PBP(s) providing the Hospice Benefit Component.
- QIO Review of Terminations of Hospice Services: All obligations, standards, requirements and duties imposed on and rights of beneficiaries, including the timeframe on which and the manner and form by which a beneficiary may request review by a QIO, are not waived and shall continue to apply to a Hospice Enrollee. Unless explicitly waived, obligations on hospice providers in 42 CFR §§ 405.1200 through 405.1204 remain in effect. The regulations at 42 CFR §§ 405.1200 through 422.1204 are waived only to the extent necessary to permit the MAOs and applicable QIOs to comply with the appeals process detailed in Appendix 3, Section B(8) for reviews of termination of hospice services under the Hospice Benefit Component of the Model.
    - The provision of 42 CFR 405.1202(b)(4) regarding QIO review when a beneficiary does not file a timely request for review by a QIO of a termination of hospice services is waived.
    - The provision of 42 CFR 405.1202(e)(7) that makes the provider liable for the cost of the hospice services being continued when the provider fails to furnish information to the QIO to support the termination of services, is waived.
    - The provision of 42 CFR 405.1202(c) that relates to provider liability for the cost of hospice services in certain situations, is waived.
    - 42 CFR 405.1204(b) through (f), regarding expedited reconsiderations by a Qualified Independent Contractor of a QIO's review of a termination of hospice services, is waived. The right of a Hospice Enrollee to seek review of a QIO's determination regarding the termination of hospice services in 405.1204(a) is not waived but that review is as described in Appendix 3, Section B(8).
- Stars Ratings for MAOs Participating in the VBID Model: The following may be waived to the extent necessary to permit CMS to adjust the rules for calculating the Star Ratings for MAOs participating in the VBID Model and protect against a statistically significant negative impact to the Part C or Part D Star Ratings for MAOs that are not participating in the Model when the impact is directly attributable to participation in the Model:
    - 42 CFR 422.162 through 422.166, Part C Star Ratings for participating MAOs; and
    - 42 CFR 423.182 through 423.186, Part D Star Ratings for participating MA-PDs.

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 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 (that is, PBPs) for which CMS has approved an application for participation in the

Hospice Benefit Component; and (4) are granted only for the term of participation in the Model set out in the addendum to the underlying MA contract. 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 422) regarding basic benefits will apply to hospice benefits under the terms of this Model component.

2. Incorporating the Medicare Hospice Benefit into Medicare Advantage

In CY 2021, the VBID Model began testing the incorporation of the Medicare hospice benefit into MA to evaluate a more seamless care continuum, in addition to the other components of the VBID Model.[31] 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 VBID Model participating MAOs must meet the Wellness and Health Care Planning (WHP) requirements of the VBID Model for CY 2023, including MAOs participating in only the Hospice Benefit 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 2023; that RFA will be available soon on the VBID Model Website here: https://innovation.cms.gov/initiatives/vbid/.

2.1. Maintaining the Medicare Hospice Benefit

[31] Please see the VBID Model Website for the CY 2023 VBID Model RFA: https://innovation.cms.gov/initiatives/vbid/

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 42 CFR 422.503), and MAOs must have written agreements with hospice providers. In addition, participating MAOs may only contract with hospice providers that have participation agreements with Medicare (See 42 CFR 422.204(b)(3); hospice providers are "providers of services" as defined in section 1861(u) of the Act.)

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' decisions that specific items or services were "unrelated" were reasonable (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, prior to or upon 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 care 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. Please note that CMS expects MAOs to be mindful of the requirements found within the Advancing Health Equity section of this RFA and tailor their palliative care proposals to be responsive to those requirements. Subject to the terms of the Model and the Model addendum, approved applications detail the specific performance required from participating MAOs. Specifically, applicant MAOs must include in their proposals:

- how palliative care (or other serious illness care services that are not hospice services and are not transitional concurrent care) will be offered to enrollees with certain conditions or other indicators of serious illness, as identified in the MAO's application;
- how care will be coordinated for enrollees, including how providers will develop an individualized plan of care inclusive of all relevant services and meet enrollees' evolving needs as their illness advances, as based on the participating MAO's 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. CMS strongly encourages MAOs' palliative care programs to include the following services when medically necessary and reasonable for the palliation or management of serious illness and related conditions: palliative care assessment and consultation services; care coordination by an interdisciplinary care team; care planning and goals of care discussions; advance care planning; access to social services and community resources; access to mental health and medical social services; 24/7 telephonic palliative care support; psychosocial and spiritual support; pain and symptom management; medication reconciliation and caregiver support. In implementation of palliative care services as

required by the Model, MAOs may consider a variety of provider types (palliative care providers, hospice providers, home health agencies, primary care providers, etc.) assuming they possess all relevant certifications, interdisciplinary team configurations (e.g., physician, nurse practitioner, physician assistant, registered nurse, social worker, pharmacist, chaplain and/or community health workers, etc.), and settings of care (e.g., inpatient, outpatient, home- and community-based settings, etc.) to meet the individual needs of each patient based on his or her preferences and goals of care.

CMS encourages participating MAOs to consider disease-specific palliative care programs to help tailor services and supports to the specific needs of enrollees with a particular condition. For example, palliative care programs designed to address the needs of enrollees with a neurodegenerative disease (e.g., dementia, Alzheimer's, etc.) or specific forms of cancer may help to address the impact of an increasingly frequent disease state among the Medicare population. These programs may also be prime candidates for innovative payment arrangements between the MAO and health care providers, as further discussed below under *Payment Innovation* in section 2.7.

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.[32]

In April 2018, CMS provided guidance that home-based palliative care services not covered under Original Medicare may be covered as a supplemental benefit.[33] 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 illustrative purposes to supplement and clarify other CMS bid guidance. Participating MAOs must follow all CMS bid instructions in submitting their CY 2023 bids.

[32] Note: There may be palliative care-related expansions without offsetting cost reduction if these expansions would have occurred outside the scope of the VBID Model. These costs must be captured in the bid and reflected in any relevant responses to the application.

[33] 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

2.3. Transitional Concurrent Care

As set out in the Act at section 1812(d)(2) and reflected at 42 CFR 418.24(b)(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 his or her designated hospice or the individual's attending physician (if the attending physician is not an employee of his or her 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.

To ease care transitions between curative and palliative care, participating MAOs must work with their network of hospice and non-hospice providers, to define and provide a set of concurrent care services related to a hospice enrollee's terminal illness 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 Hospice Benefit Component 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 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.

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.

As part of providing transitional concurrent care, MAOs must establish transparent guidelines and processes for enrollees to access transitional 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 network of hospice and non-hospice providers to have policies and procedures for coverage of transitional 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 transitional concurrent care, MAOs must limit the availability of transitional 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 the plan of care and required by CMS regulations at 42 CFR 418.56(c), at Original Medicare rates). As such, we note nothing in this Model component 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 care-focused services at the same levels as they provided before participating in the Model component. Overall, MAOs interested in participating in the Hospice Benefit Component must describe their approach to transitional concurrent care and their associated processes within their application, which will be reviewed and approved by CMS.

Participating MAOs will be paid the A/B services capitation payment for the month in which a hospice election occurs (except if hospice election occurs on the first day of the month; see more detailed discussion in section 2.7: Model Payments) in addition to a hospice capitation payment rate 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 costs of care that would have been utilized but was not due to an enrollee's decision to elect hospice in thinking about 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, we expect that MA enrollees who elect to utilize their hospice benefit will experience a smoother transition into hospice. CMS believes that transparent discussions regarding hospice care 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.[34]

2.4. Hospice Supplemental Benefits in the VBID Model

Participating MAOs may offer a broad set of mandatory supplemental benefits for enrollees who elect hospice (hereafter "hospice supplemental benefits") in addition to any mandatory supplemental benefits offered to all or other targeted enrollees in the plan (see VBID RFA regarding the ability to limit other supplemental benefits besides hospice supplemental benefits to targeted enrollees). Such hospice 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 and set a specific dollar amount for the aggregate coverage of said set of items and services that may be provided to enrollees receiving hospice care. In offering these hospice supplemental benefits, MAOs must clearly identify the items and services restricted to hospice enrollees (i.e., offered as hospice supplemental benefits), as well as any use of care managers or other approaches based on objective standards that allow for the provision of these hospice supplemental benefits for enrollees who 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, as well as the theory of action, estimated number of targeted enrollees, and the 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 hospice supplemental benefits limited to hospice enrollees that may be offered in addition to supplemental benefits offered to other enrollees and/or in aggregate as a "package" of hospice supplemental benefits or alone may include:

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[34] For more detail on transitional concurrent care and transitions to hospice more broadly, see the CY 2021 VBID Hospice Benefit Component Technical and Operational Guidance here: https://innovation.cms.gov/media/document/vbid-hospice-technical-guidance-cy2021

- Coverage of primarily health-related services and items that have a reasonable expectation of improving or maintaining the health or overall function of the hospice enrollee (for example, benefits that ameliorate the functional/psychological impact of hospice enrollees' health conditions and 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, meals, transportation, and other items. MAOs should refer to additional guidance within the Medicare Managed Care Manual, Chapter 4;[35]
- 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 the enrollee, with eligibility for these benefits targeted to those with low income status. These could include, but are not limited to, meals (beyond the current allowable limits), utilities, room and board, legal aid (e.g., to obtain or maintain shelter), personal care items, linens, clothing, pest control, service animal expenses, and other items;
- Reductions in coinsurance, as applicable, for hospice drugs and biologicals and/or inpatient respite care received by an enrollee during hospice election; and
- Reductions in cost sharing for specific transitional concurrent care drugs that an enrollee receives during hospice election.

CMS may, as part of the waiver of uniformity, permit participating MAOs to limit these hospice supplemental benefits to enrollees who have elected hospice ***and use in-network hospice providers***. Participating MAOs must clearly indicate in their proposals that such hospice supplemental benefits are limited to enrollees who choose in-network providers. 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, limiting benefits and waiving uniformity this way is a critical component to test having MAOs cover the Part A Hospice Benefit within the MA benefits package. This further ensures participating MAOs can appropriately manage and timely offer hospice supplemental benefits, allowing participating MAOs to fully test the integration of the hospice benefit into the MA program.

Of note, other supplemental benefits for which the enrollee is already eligible prior to hospice election will continue to be provided to that enrollee.

[35] See Medicare Managed Care Manual, Chapter 4 here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

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. This section provides an overview of some key metrics within these domains. For a full list of quality and monitoring measures, please see the Appendix 4 of the CY 2022 VBID Hospice Monitoring Guidelines,[36] which may be adjusted in the CY 2023 VBID Hospice Monitoring Guidelines.

CMS has intentionally selected topics and areas for measurement 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.

Palliative Care and Goals of Care Experience

CMS will monitor the impact of the Model on how participating MAOs, hospices, and others focus on the provision of appropriate, equitable and timely palliative care services for all 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 quality areas listed below to (1) verify that all MA enrollees' goals of care are captured over time to reflect that plans of care change and care needs may increase; (2) verify all MA enrollees receive access to and use palliative care services (as appropriate); and (3) evaluate whether a coordinated continuum of care improves the timeliness of appropriate hospice election. Of note, CMS is committed to achieving equity in health care outcomes for all beneficiaries, including those enrolled in plans participating in the Hospice Benefit Component, by supporting MAOs and providers in quality improvement activities to reduce health inequities, enabling beneficiaries to make more informed decisions, and promoting provider accountability for health care disparities. The following metrics will be

[36] For reference, please see the CY 2022 VBID Hospice Monitoring Guidelines, which can be found on: https://innovation.cms.gov/media/document/vbid-hospice-cy22-monitoring-gl

monitored across terminal condition, age, race, ethnicity, and eligibility-status (aged, disabled, ESRD, dually eligible for Medicaid).

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

In compliance with the VBID Model's required WHP component, participating MAOs must develop systems to improve the offering of ACPs. ACP promotes patient choice by providing an opportunity for patients to discuss preferences with their provider(s) that impact the kind of care they would like to receive, should they not have the capacity to do so at some time in the future. It can also be a time to prepare documents, including Advance Directives, explaining their wishes. Further requirements related to the WHP component can be found here: https://innovation.cms.gov/initiatives/vbid/. Participating MAOs should review the CY 2023 VBID Monitoring Guidelines for WHP summary-level reporting.

2. *Access to, and use of, Palliative Care*

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. This type of care throughout the course of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitates patient autonomy, access to information, and choice. To assess access to and use of palliative care, CMS will assess enrollee experience with respect to palliative care during the Model period. CMS will also review the duration of palliative care received, the reason(s) and timeliness of the election to receive non-hospice palliative care, beneficiary payment amount for the cost-sharing of palliative care services and the election rate of hospice care for those who received non-hospice palliative care. To ensure optimal care for beneficiaries who do not elect or are not eligible for hospice but may benefit from palliative care, MAOs will be required to submit beneficiary level data on palliative care provided to those eligible enrollees who do not elect hospice, as well as summary level data on palliative care that is regardless of hospice election.

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 beneficiaries are enrolled in hospice for less than seven days before death, which limits the benefit they may gain from these services. The existing evidence-base demonstrates that beneficiaries enrolled in hospice experience better quality of life – benefits that increase the longer beneficiaries are enrolled in hospice.[37] To evaluate whether integration of WHP and non-hospice palliative care services and access to Transitional Concurrent Care improves the timeliness of optimal hospice election, CMS will use FFS data to assess the percentage of enrollees who elect hospice less than seven days prior to death. Results will be grounded in the context of geographic variations.

[37] 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.

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.

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.[38] Research has used days at home in the last six months of life as a patient-centered measure calculated using administrative data.[39] 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

An important goal through testing the Hospice Benefit Component is to improve access to high-quality hospice care for MA enrollees who elect the hospice benefit. Through monitoring of the Hospice Benefit Component, CMS aims to ensure that testing this component does not raise concerns about decreases in quality that may harm beneficiaries or create unintended

[38] Barnato AE, Herndon MB, Anthony DL, et al. Are Regional Variations in End-of-Life Care Intensity Explained by Patient Preferences?: A Study of the US Medicare Population. Med Care. 2007;45:386–393.

[39] Gill TM, Gahbauer EA, Leo-Summers L, Murphy TE, Han L. Days Spent at Home in the Last Six Months of Life Among Community-Living Older Persons. Am J Med. 2019 Feb;132(2):234-239. doi: 10.1016/j.amjmed.2018.10.029. Epub 2018 Nov 14. PMID: 30447203; PMCID: PMC6349467.

consequences. In addition to the total number of hospice beneficiaries electing hospice for each MAO, CMS will monitor hospice elections by terminal conditions, age, race, ethnicity, and Medicare eligibility status (e.g., aged, disabled, ESRD, dually eligible for Medicaid). CMS will also monitor election by day of the month and evaluate average and median number of hospice service days. Also, CMS will monitor 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, under the Hospice Benefit Component, CMS will monitor lengths of stay for hospice enrollees in participating plans that are beyond 180 days, differences in lengths of stay between in-network and out-of-network hospice 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*

Avoiding unnecessary hospital and Emergency Department (ED) admissions and re-admissions was identified by the National Quality Forum (NQF) as a high priority measurement opportunity for hospice. In addition, MedPAC suggests that while there are many reasons for live discharges from hospice care, 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 stay within seven days. Additionally, CMS will monitor total number of live discharges, live discharges by day of the month, live discharges for enrollees who are determined to no longer be terminally ill, average cost of post-live discharge care, and the number of days between live discharges and reelection, when applicable.

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 will conduct outreach calls to participating MAOs to understand quality improvement activities regarding access to hospice care visits and will also review and monitor FFS claims. Specifics of this measure can be found in the CMS Measures Inventory Tool: (https://cmit.cms.gov/CMIT_public/ListMeasures).

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 and the MAO may only use hospice programs that have a Medicare participation agreement to furnish the Medicare hospice benefit (42 CFR 422.204(b)(3)).

Recognizing the lag time associated with the CAHPS Hospice survey, CMS will also closely monitor any patient complaints that are submitted to CMS through the Complaint Tracking Module (CTM) and react swiftly to remedy any concerns in real-time. Total number of complaints from beneficiaries will be compared to data submitted by MAOs that detail complaints to the plan, the level of severity, and how each patient concern was addressed. Similarly, to ensure enrollees who seek hospice care have access to care and their choice of providers, CMS will monitor for enrollment and disenrollment trends in participating plans.

10. *Part D Duplicative Drug Utilization*

CMS will quantify and monitor Part D covered drug utilization patterns and PDE data for enrollees who elect hospice. OIG found that duplication and fragmentation of Part D coverage 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. CMS will assess PDE data for enrollees of participating plans relative to those of non-participating plans 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.

11. *Unrelated Care Utilization*

CMS will monitor 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. Over time, CMS expects that this measure will be 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 illness and related conditions.

Beyond these measures, and those included in the Hospice Monitoring Guidelines, CMS reserves the right under the Model to develop additional performance, monitoring 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 is a new type of care for MAO networks, CMS has adopted a phase-in approach for MAOs to develop and meet network adequacy standards for hospice providers. This approach allows MAOs and hospice providers to develop networks for delivery of hospice care while still ensuring enrollees maintain adequate access to safe hospice care choices as networks form. The updated two-phase structure, rather than the three phases described in prior RFAs is outlined below. This two-phase structure is designed to foster the development of meaningful networks over time by MAOs and hospice providers that further **access** to hospice and its comprehensive scope of services, including hospice care's focus on the community and volunteerism that is central to many hospice providers today.

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 relationships and agreements for the provision of hospice care within a service area. Over both the short- and long-term, CMS believes participating MAOs developing high-quality hospice provider networks is critical for care coordination and management across the care continuum.

The individual PBPs of the participating MAOs will be at different phases of the network phase-in approach based on the length of their participation in the Model component. The groupings will be:

- Phase 1: PBPs in their first year of participation ("first-year PBPs") in a service area the MAO has not participated in under the Model component; and
- Phase 2: PBPs that will enter their second or third year of participation ("mature-year PBPs") in a service area the MAO has participated in under the Model component.

An MAO may request an exception to this length of participation requirement for individual PBPs operating in a particular service area if the MAO can demonstrate they otherwise have experience operationalizing and contracting with hospice providers under the Hospice Benefit Component for the same amount of time in the same service area.

The provider network requirements and flexibilities associated with each phase are described below, after a description of current MA program networks.

Current MA Program Networks: CMS regulations at 42 CFR 422.112(a)(1)(i) require that MAOs maintain and 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, an MAO may specify the network of providers from 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 plan consistent with MA regulations. 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, including hospices, must have a participation agreement with Medicare in order to be in the MAO's network.

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 services are provided in a culturally competent manner to enrollees, including those with limited English proficiency, limited reading skills, or those with diverse cultural and ethnic backgrounds, in compliance with 42 CFR 422.112(a)(8),in addition to obligations under 45 CFR Part 92. 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: A participating MAO offering a PBP in the Hospice Benefit Component for the first time in a service area the MAO has not participated in under the Model Component will be in Phase 1 for that PBP. To meet network adequacy requirements for hospice providers, first-year PBPs must offer access to in-network hospice providers as well as out-of-network Medicare-certified hospice providers. 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 in first-year PBPs 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 provider.

In implementing any type of consultation process, MAOs must ensure the experience takes the form of a high-touch care manager accessible by phone and other means available 365/24/7 to all enrollees and serviced in a way that is clear, immediately available, culturally competent, personalized to the enrollee and their values, and knowledgeable about the hospice benefit and choices. MAOs choosing to implement a voluntary consultation service must specifically ensure that this service provides enrollees with information on transitional concurrent care services and hospice supplemental benefits, as well as a clear description of out-of-network options. This consultation process should be clearly voluntary to the enrollee, and not coercive.

As part of implementing such a consultation process, participating MAOs will be required to inform any enrollee who requests to access out-of-network hospice providers 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 the limits imposed on coverage of hospice supplemental benefits or transitional concurrent care services furnished by out-of-network hospice providers.

The application submitted by the MAO in response to this RFA should detail its proposal to use a voluntary consultation process.

Phase 2: For CY 2023, CMS will require participating MAOs with mature-year PBPs to create and maintain networks of hospice providers at the participating MAO level (i.e., across all mature-year PBPs in the same participating MAO within a county) in a manner similar to the current MA program's approach to provider networks. However, participating MAOs must continue to provide coverage for in-network and out-of-network hospice services. With this requirement to create and maintain a network of hospice providers, participating MAOs and their mature-year PBPs must, in addition to abiding by current MA network adequacy standards referenced above, meet Model-specific requirements to ensure their enrollees have access to timely, high-quality services.

Participating MAOs with mature-year PBPs must meet two Model-specific requirements for those PBPs to receive approval from CMS as having an adequate network: (1) contract with hospice providers such that there are a minimum number of providers (MNP) serving each county in the MAO's service area(s); and (2) describe and attest to a comprehensive strategy for providing adequate access to necessary, appropriate, equitable, and high-quality hospice services in all service areas. CMS will also consider past performance in the Model component when determining approval.

Minimum Number of Providers (MNP)

CMMI will impose a requirement for MAOs to maintain a minimum number of hospice providers for mature-year PBPs within their service area(s) but will not require PBPs participating in the Hospice Benefit Component to meet specific time and distance requirements for their hospice networks. The regulation at 42 CFR 422.116 currently imposes a minimum number of providers requirement in conjunction with time and distance standards for specified healthcare provider specialty and facility types.

Current regulations (42 CFR 422.116) and procedures apply a multi-step formula to calculate an MNP numerical value for every county in an MAO's service area. The formula considers historical utilization patterns, MA market penetration rates, and the number of enrollees a typical MAO serves.[40] Subsequently, the numerical value represents *at least* how many in-network providers an MAO must make available to deliver care to enrollees in a particular county.

CMS has derived and will apply a Model-specific MNP requirement largely in line with current regulations and procedures for MA network adequacy, with certain key exceptions. These MNP

[40] For additional information, please reference the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance at the following link: https://www.cms.gov/files/document/medicareadvantageandsection1876costplannetworkadequacyguidance6-17-2020.pdf

values will be calculated and set for each county in a mature-year PBP's service area; the MNP requirement will then be applied and evaluated at the participating MAO level by totaling the MNP values across all mature-years PBPs in a county for each county in the service area(s) of the mature-year PBPs. This would apply in cases when multiple mature-year PBPs offer coverage in overlapping service areas. Please see below for an example of how this might apply. CMS will use a formula similar to the one used in setting the specific network evaluation criteria under 42 CFR 422.116 to calculate an MNP value for each county in the United States.[41] However, CMMI will not apply a time and distance standard for hospice providers given that the vast majority of hospice care is provided in a patient's home or community-based setting. In addition, the minimum number of providers calculation will be tailored to each individual mature-year PBP across each county within its service area, rather than using broad county type designations (i.e., large metro, metro, micro, rural, and counties with extreme access considerations). CMS is tailoring the calculation at this level to reflect the specific provider and enrollee utilization patterns found within the service area(s) of each mature-year PBP. Participating MAOs will be required to form and maintain a network of Medicare-certified hospice providers to ensure that there are *at least* the applicable number of hospice providers (i.e., the MNP) at the participating MAO level serving every county in the MAO's service area(s).

For example, the service areas of two hypothetical mature-year PBPs (H1234-001 and H1234-002) of a participating MAO include County A, County B, and County C for H1234-001 and County A and County B for H1234-002. CMMI has determined the MNP for H1234-001 for hospice providers in County A is four providers, County B is five providers, and County C is three providers. CMMI has also determined the MNP for H1234-002 for hospice providers in County A is three providers and County B is five providers. The participating MAO must then form a network of hospice providers such that *at least* seven providers can deliver services to the Participating MAO's enrollees in County A, *at least* ten providers can deliver services to enrollees in County B, and *at least* three providers can deliver services to enrollees in County C.

CMS will not apply any credits to the calculations of the MNP for CY 2023 for mature-year PBPs. However, consistent with the process in 42 CFR 422.116(f) regarding network evaluations for specified health care provider specialty and facility types, CMS will accept and evaluate requests for exceptions to the hospice MNP requirement for mature-year PBPs in the Hospice Component of the Model. CMS will provide participating MAOs with additional instructions in the future on the process for preparing and submitting any potential exception requests.

In Spring 2022, CMS will release a data book and technical methodology paper that provides participating MAOs with the MNP for each mature-year PBP and at the participating MAO level

[41] For further information on the application of 42 CFR 422.116, please reference Final Rule Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program: https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf

across their service area(s), along with background on the process by which CMS derived the MNP (see section 6.1 for timeline). The data book will initially only be made available to applicants in Spring 2022, and CMS intends to later publish a public version on or shortly after Model participant announcements in late September 2022. As part of the Model's requirement for participating MAOs to provide the full Medicare hospice benefit as specified in current law and regulation, participating MAOs must ensure that each provider within their network is able to provide the full scope of the Medicare Hospice Benefit and has a participation agreement with Medicare. See 42 CFR §§ 422.200 through 422.224 for CMS rules regarding MA plan relationships with contracted providers. Applicants must detail the process and strategy they intend to use to form their networks (described further below) in the application but CMS will not require applicants to meet the Model hospice MNP requirements by the time of Model's application deadline. CMS will instead perform a review of an applicant's hospice provider network in Summer 2022. CMS will provide MAOs with further submission instructions in the future.

The requirements under 42 CFR 422.112(a)(1)(i) to maintain and monitor a network of appropriate providers will continue to apply to participating MAOs in Phase 2. With regards to Phase 2 obligations, participating MAOs must inform CMS of any provider termination considered to be "significant" 90 days prior to the termination. CMS considers significant changes to provider networks to be those that go beyond individual or limited provider terminations that occur during the routine course of plan operations; affect, or have the potential to affect, a large number of the MAO's hospice enrollees; or would affect the participating MAO's ability to meet MNP requirements for their service area(s). Participating MAOs must also continue to follow requirements at 42 CFR 422.111(e) and make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

Comprehensive Network Development Strategy

To supplement the hospice MNP requirement described above along with existing provider network maintenance and monitoring requirements described in CFR 422.112, CMS will also require participating MAOs with mature-year PBPs to describe their comprehensive strategy for forming a network of Medicare hospice providers to ensure that enrollees receive a set of timely, comprehensive, and high-quality services aligned with enrollee preferences in a culturally-sensitive and equitable fashion. CMS will review applications to assess:

- MAOs' criteria and processes supporting hospice provider network selection, including those related to monitoring and oversight of quality of care provided by in-network providers;
- MAOs' processes to ensure that each in-network hospice is able to deliver care in a timely manner across all four levels of hospice care;

- MAOs' processes to ensure their hospice provider networks have adequate capacity (e.g., average daily census, staffing, access to facilities, etc.) to meet the needs of projected demand for hospice across service area(s);
- MAOs' efforts to engage hospice providers who have a history of serving underserved populations, provide additional value-added services to patients and families, have strong relationships with their local communities, and/or actively collaborate with organizations that may help meet the social needs of enrollees; and
- MAOs' efforts to ensure cultural competency throughout the hospice network.

Please reference *Appendix B: MAO Application Questions for the Hospice Benefit Component* regarding the specific information CMS requires participating MAOs to provide as part of their application process.

General Requirement for Networks: Given the role hospice care plays in both an enrollee's life, but also in his or her family's and caregiver's life, networks focused on minimizing cost over time are fundamentally not aligned with the spirit and or stated aims of the Model component or of the Medicare hospice benefit.

Transition Policy: CMS will apply a transition policy between Phases, in line with its current approach to hospice elections, that begin in a particular calendar year and continue into the next calendar year.[42] Generally, MAOs must uniformly apply policies associated with specific Phases across all enrollees within a PBP. However, for hospice elections that span across calendar years, flexibilities and policies associated with a particular Phase are applied based on the calendar year in which the hospice election began and continue through the end of the hospice election. For example, an enrollee elects hospice on December 15, 2022, and revokes hospice on January 15, 2023, with coverage from a participating PBP under Phase 1 in 2022 and Phase 2 in 2023. The PBP must apply policies or flexibilities associated with Phase 1 for this enrollee's hospice election throughout the entirety of the hospice stay between December 15, 2022 and January 15, 2023. If the same enrollee were to subsequently re-elect hospice on April 15, 2023, then the MAO must apply any Phase 2 policies or flexibilities. Other than this exception for hospice benefit periods that straddle the two different years, participating PBPs must use the same phase for all PBP enrollees in the PBP uniformly.

Out-of-Network Provider Payments: For enrollees who utilize an out-of-network hospice provider for hospice care within the scope of the Medicare hospice benefit, a participating MAO is required to cover these services. Additionally, participating MAOs must 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. This is regardless of the

[42] See section 3 of the CY 2021 VBID Hospice Benefit Component Technical and Operational Guidance, available at: https://innovation.cms.gov/media/document/vbid-hospice-technical-guidance-cy2021.

phase any PBP might be in and consistent with sections 1852(a)(2) and (k)(1) and 1866(a)(1)(O) of the Act and 42 CFR 422.100(b)(2) and 422.214.

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 422.214; 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 enrollees 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 his or her behalf to allowable out-of-network hospice providers that have participation agreements with Medicare.

In-Network and Out-of-Network Cost Sharing: Under all phases, 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 with the usual MA program rules, participating MAOs may use different cost-sharing at in-network hospice providers versus out-of-network hospice providers.

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:

1. Coinsurance on hospice drugs and biologicals:[43] 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 by the hospice while a hospice enrollee is receiving routine home care or continuous home care. A hospice enrollee 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 drugs, items, and services furnished to enrollees during the period of a hospice election, regardless of the setting of the

[43] CMS makes a per diem payment to a hospice provider for each day that a beneficiary is in hospice care, regardless of the number of services provided. All drugs and biologicals for the palliation and management of pain and symptoms of a patient's terminal illness and related conditions are covered under the Medicare hospice benefit, and the cost of providing these drugs is included in the per diem rate.

services. MAOs must count toward its MA maximum out-of-pocket (MOOP) limit (for Part A and Part B benefits) the cost sharing amounts for Part A (and Part B) benefits furnished to a hospice enrollee.

As required at 42 CFR 422.111, Model-participating MAOs must identify any differences in cost-sharing at in-network versus out-of-network hospice providers. For example, MAOs must appropriately update their Evidence of Coverage (EOC), Annual Notice of Change (ANOC), and any other enrollee-facing materials. Also, CMS encourages participating MAOs to develop provider engagement strategies, including with providers who may serve as referral sources to hospice providers to ensure awareness of cost-sharing differences at in-network versus out-of-network hospice providers.

Under the Model component, when MA enrollees receive services unrelated to their terminal illness and related conditions from Medicare FFS providers, they are subject to plan rules. The provision of unrelated care is still subject to regulations and expectations surrounding plan-directed care. In other words, out-of-network unrelated care furnished as a result of a referral from an in-network hospice provider (who has not consulted with the MAO about its policy for in-network unrelated care) must be treated as in-network unrelated care for the purposes of determining any applicable cost sharing responsibilities for the enrollee. As outlined in the CY 2021 Technical and Operational Guidance, CMS recommends that Model-participating MAOs conduct outreach to hospice providers in their service areas regarding plan rules so that the hospice providers do not inappropriately refer an enrollee for unrelated services that do not align with the plan's rules.

The current regulations (e.g., 42 CFR 422.105(a)) and expectations around instances in which an in-network provider refers an enrollee to an out-of-network provider will continue to apply. Namely, as stated in CMS-4069-F,[44] "if a network physician furnishes a service or directs an MA beneficiary to another provider to receive plan-covered care without following the plan's internal procedures then the beneficiary should not be penalized to the extent the physician did not follow plan rules." This enrollee protection is commonly referred to as "plan-directed care." In other words, participating MAOs must treat any referral by an in-network hospice provider (even one who has not consulted with the MAO about its policy for in-network hospice referrals) to an out-of-network provider as an in-network referral for the purposes of determining enrollee cost sharing amounts.[45]

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[44] See the January 2005 Final Rule *Medicare Program; Establishment of the Medicare Advantage Program*: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads/CMS4069F.PDF

[45] Please refer to Section 160 "Beneficiary Protections from Improper Referrals and Insolvency" of Chapter 4 of the Medicare Managed Care Manual for more information on plan-directed care: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R115MCM.pdf

Network Provider Limitations to Ensure Beneficiary Safety: Participating MAOs must apply the usual limitations on providers as described at 42 CFR 422.222 and 422.224 that prohibit payment to providers on CMS's preclusion list and OIG's exclusion list. To the extent that a provider presents a risk of enrollee harm or a program integrity concern, the MAO should report that provider to CMS, OIG, and the local authorities for legal action and/or consideration for inclusion on one of the aforementioned lists as needed.

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. Participating MAOs may implement appropriate program integrity safeguards in line with the MAO's policies and procedures. Any policies and procedures should ensure appropriate Medicare spending and protection of enrollees. These should not be used to create unnecessary burden for hospice providers or impose a barrier to or discourage access to care. Aligned with guidance set forth in the Medicare Program Integrity Manual (MPIM), Chapter (Ch.) 3, participating MAOs have the discretion to initiate prepayment and/or postpayment review processes in certain circumstances. Participating MAOs are encouraged to build policies aligned with MPIM, Ch. 3, section 3.2.1, which outlines how Medicare Administrative Contractors (MACs) are to set priorities for prepayment and postpayment review.

For example, participating MAOs could implement the following prepayment or postpayment review policies:[46]

- A prepayment or postpayment 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 or postpayment review strategy to address long lengths of stay (for example, greater than 180 days) to assess whether recertification was appropriate.

If not aligned with MPIM, Ch. 3, section 3.2.1, participating MAOs must submit to CMS for approval their prepayment or postpayment review strategy. Additional guidance on implementing these types of program safeguards can be found in the CY 2021 Technical and Operational Guidance document.[47] 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

[46] For additional guidance, please see the CY 2021 VBID Hospice Benefit Component Technical and Operational Guidance at the following link: https://innovation.cms.gov/media/document/vbid-hospice-technical-guidance-cy2021

[47] The CY 2021 VBID Hospice Benefit Component Technical and Operational Guidance can be found at the following link: https://innovation.cms.gov/media/document/vbid-hospice-technical-guidance-cy2021

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 Part 422 (and, as applicable, 42 CFR Part 405) apply in the context of benefits provided only under the Model component can be found in the CY 2021 VBID Hospice Benefit Component Technical and Operational Guidance.[48] In addition, participating MAOs must make timely 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 required by 42 CFR 422.520. Model-participating MAOs must follow the prompt payment provisions established in their contracts with providers and pay providers under the terms of those contracts (see 42 CFR 422.520(b)(1) and (2)).

CMS encourages MAOs to include similar timely data submission requirements as outlined in the Medicare Claims Processing Manual (MCPM)[49] in network participation agreements used with hospice providers and to seek timely data submission from out-of-network providers to ensure eligibility for payment. For example, MAOs may require timely-filed Notices of Election (NOEs) from all hospice providers furnishing services to their enrollees to be filed within five calendar days after the hospice admission date, and may include timely submission requirements for the Notice of Termination/Revocation, in alignment with guidance set forth in the MCPM, Chapter 11, and regulation at 42 CFR 418.24(a)(2). In instances where an NOE is not timely-filed, the MAO may follow processes outlined in the MCPM and the CY 2022 VBID Hospice Benefit Component Technical and Operational Guidance 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, in alignment with 42 CFR 418.24(a)(3). Consistent with current policy, any care provided for these days would be a provider liability, and the provider cannot bill the enrollee for this care.

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 their enrollees who elect hospice under 42 CFR 418.24, MAOs participating in this component of the VBID Model will be paid per the following payment structure:

(1) For all calendar months in which an enrollee elects hospice care, **including the first month of hospice election ("Month 1"),** ***and subject to the note in (2) below,*** a Model-participating MAO will receive from CMS the following:

[48] Id.

[49] MCPM, Chapter 11 - Processing Hospice Claims. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf

- A **monthly hospice capitation rate** for all months that an enrollee is in a hospice stay. The national monthly hospice capitation rate will be adjusted by two rating factors: (1) an area factor, which is a hospice-specific average geographic adjustment similar to the Average Geographic Adjustment (AGA) used in the MA ratebook development; and (2) for Month 1 only, a monthly rating factor. The Month 1 rating factor is intended to better reflect the first month beneficiary experience in hospice. The hospice capitation rate paid for Month 1 will vary based on the number of days of the hospice stay that occurs in the first calendar month using a three-tiered structure (days 1-6, 7-15, 16+). The national hospice capitation rate for subsequent calendar months of a hospice stay ("Months 2+") will be a monthly rate, adjusted only by the area factor. In the event an enrollee has live discharge from hospice and re-enrolls in hospice in Month 1, for the calculation of the number of days in Month 1, for purposes of pricing, the sum of days in Month 1 during which the enrollee began a hospice election will be used to calculate the tier of the Month 1 hospice capitation rate.
- 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).

(2) For the first month of hospice election ("Month 1"), the basic benefit capitation rate (also known as the "A/B capitation rate") will only be paid if an enrollee is not under hospice election status as of the first day of the month, consistent with 42 CFR 422.320(c).

For example, if an enrollee elects hospice on the second day of a calendar month (or any subsequent day of that month), the basic benefit capitation rate will be paid. The Medicare Advantage Prescription Drug System (MARx) will perform the payment calculation of these beneficiary-level payments prospectively to plan-level payments, under the Model, as applicable.

However, if, and only if, an enrollee elects hospice on the first day of a calendar month (e.g., March one), the basic benefit capitation rate will not be paid for that month (e.g., for March). Instead, only the monthly hospice capitation rate, the beneficiary rebate amount and the monthly prescription drug payment (if any) will be paid. Operationally, MARx will prospectively pay a Month 2+ hospice capitation rate for Month 1 along with the beneficiary rebate amount and the monthly prescription drug payment (if any); this payment may be more (or potentially less) than the cost to the Model-participating MAO of furnishing hospice services during that period. However, an adjustment to reconcile the Month 2+ hospice capitation payment amount against the appropriate Month 1 hospice capitation rate will be reflected in a retrospective payment for Month 1 hospice capitation payment amounts.

Operationally, Month 1 hospice capitation payments will be made quarterly, on a retrospective and lump sum basis, for all enrollees with a Month 1 hospice experience. This will be reflected at the contract level within the Plan Payment Report (PPR). Consistent with current law, as applicable, the A/B capitation rate, beneficiary rebate amount, and monthly prescription drug payment will be paid prospectively for Month 1 (subject to the special case mentioned in (2) above). These payments will be seen within the Monthly Membership Report (MMR) at the enrollee level.

For any calendar month hospice enrollee experience after Month 1, a Model-participating MAO will receive through MARx the Month 2+ hospice capitation rate, the beneficiary rebate amount, and the monthly prescription drug payment, if applicable, for an enrollee who continues hospice. This will be paid prospective to the extent that hospice status information is up-to-date in MARx. If hospice status information is delayed in MARx, MARx will calculate retroactive adjustments. These payments and any adjustments will be seen within the MMR at the enrollee level.

Hospice Capitation Payment Rate Actuarial Methodology

For additional background on the hospice capitation rate actuarial methodology, please see the CY 2022 Final Hospice Capitation Payment Rate Actuarial Methodology document.[50] CMS intends to release the CY 2023 Preliminary Hospice Capitation Payment Rate Actuarial Methodology in early March 2022, prior to releasing the CY 2023 Final Hospice Capitation Payment Rate Actuarial Methodology and Hospice Capitation Ratebook for the Model in mid-to-late April 2022. Other resources, including the data books and the Model Hospice Capitation Ratebooks for CY 2021 and CY 2022 can be found on the VBID Model website here: https://innovation.cms.gov/innovation-models/vbid.

While the capitation rates for CY 2023 are still in the process of being developed and few of the specifics mentioned above are subject to change, MAOs will be aware of the hospice capitation payment rates and corresponding actuarial methodology for CY 2023 prior to bid submission.

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.

[50] See the CY 2022 Final Hospice Capitation Payment Rate Actuarial Methodology: https://innovation.cms.gov/media/document/vbid-hospice-final-actuarial-2022-meth

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 non-hospice, 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 non-hospice, palliative care to the MAOs' enrollees with serious illness (who have not chosen hospice), separate from the hospice care that Hospice Provider A is providing to the MAO's hospice enrollees. 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 non-hospice, palliative care program (per member per month, PMPM).

  The MAO and Hospice Provider A agree to the types of non-hospice palliative care services (provided outside the Medicare hospice benefit to enrollees who have not elected hospice) that are covered under the PMPM. Non-hospice palliative care services that the MAO might include in this kind of arrangement include 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 from the MAO to the hospice provider differently as long as enrollees who are eligible for and elect hospice continue to receive the integrated and full set of hospice care 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 section 1854 of the Act and 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. An MAO and a hospice provider could agree to palliative and hospice care bundles that allow for care for enrollees with cognitive disorders (e.g., dementia), cancer, end-stage organ failure, and other potential disease state bundles. For example, a care bundle focused on patients with dementia could begin by providing supportive palliative care to an enrollee with mild to moderate dementia followed by a transition to hospice at the patient and family's choosing if the dementia progresses to a severe stage and the enrollee meets the conditions necessary to qualify for the Medicare Hospice Benefit.
- **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 spending, 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.

3. 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 Model component. 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 overall 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 PBPs for participation in the VBID Model and for the Hospice Benefit Component. All segments of a PBP participating in the Hospice Benefit Component must offer the Hospice Benefit Component.

CMS's main goal in listing the below eligibility requirements is to ensure participating MAOs have experience in delivering benefits to Medicare beneficiaries. All MAOs applying to participate in the VBID Model in CY 2023, including existing participants, must apply 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 *(unless an exception is requested and granted)*, 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 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)[51]
        - Medicare-Medicaid Plans or other demonstration plan (MMP)
        - Medicare Advantage Medical Savings Account Plans (MSA)
        - Cost Plans (CP)
        - PACE organizations (PACE)

[51] This exclusion applies to EGWPs that are offered exclusively to employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations and that exclusively enroll members of group health plans. An MA plan that is open to all beneficiaries in the service area and enrolls members of an employer (or union, labor organization, or fund) group health plan as well may be eligible to participate if the other eligibility criteria are met.

- **Length of Plan Existence:**
    - At least one of the MAO's MA plans/PBPs listed in the application for the Model must have been offered in at least three annual coordinated election (open enrollment) periods prior to the open enrollment period for CY 2023 (i.e., offered in open enrollment for 2020, 2021 and 2022).

- **Plan Performance and Compliance:**
    - In the last 12 months from the date of application submission, the MAO's contract offering the PBP is not and has not been under sanction by CMS, as described in 42 CFR 422.750 and 42 CFR 423.750.
    - CMS may deny an application on the basis of information obtained from a program integrity screening or patterns of consistent low performance.

In regards to plan type, although an individual market MA plan that is one of the eligible types outlined above may participate in the Model while contracting with an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations for the enrollment of members of a group health plan *into the individual MA plan*, benefit design waivers are prohibited in connection with Model Benefits (e.g., actuarial swapping or actuarial equivalence of Model Benefits). See Medicare Managed Care Manual, Chapter 9 sections 10 - 10.2[52] and Appendix 2 for discussion of the differences between an individual MA plan that enrolls members of these group health plans and EGWPs. EGWPs that enroll only members of plans sponsored by an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations may not participate in the Model.

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 2023, 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) 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.

In their applications, MAOs must disclose any present or past history of sanctions, investigations, probations or corrective action plans for the MAO, affiliates or other relevant persons and entities, including hospice providers contracted with the MAO for this Model. Before execution of the VBID Contract Addenda, MAOs must also disclose any sanctions, investigations,

[52] Please find Chapter 9 of the Medicare Managed Care Manual here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c09.pdf

probations, or corrective action plans for the MAO, affiliates, or other relevant persons and entities. CMS will conduct appropriate 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:

- 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, contract or PBP that does not strictly meet the criteria. For example, CMS may consider approving an exception request for an MAO's contract offering a PBP that *is or has been* under sanction in the past 12 months based on considerations that demonstrate improvement by the MAO and that the sanction and the conduct underlying the sanction are not related to the Model's purposes and Model performance requirements. In addition, CMS might admit an MAO with plans offered for fewer than three years, where that MAO is a successor to a previously offered MAO, 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, 2023.

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

The participant selection requirements listed in this section 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 42 CFR 423, subparts V) and should serve as the main reference for plans (See, e.g., 42 CFR 422 and 42 CFR 423, subparts V and https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html). In addition to compliance with those existing requirements, participating MAOs must comply with marketing and communication standards in the Model. For reference, please see the CY 2022 VBID Model Communications and Marketing Guidelines, which will be updated for CY 2023: https://innovation.cms.gov/media/document/cy2022-vbid-communications-and-marketing-guidelines.

Because the Medicare hospice benefit is a Part A benefit, participants offering the Medicare hospice benefit must use the standardized 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 enrollees with a list of in-network hospice providers through their plan website and provider directory as well as information and instructions for how to access network providers in the EOC. Participating MAOs in Phases 1 or 2 must state, as part of this communication for CY 2023, that enrollees may seek hospice services at out-of-network Medicare-certified providers, with currently allowable cost sharing in Original Medicare. Participating MAOs under Phase 2 of the network design phase-in (see section 2.6 above) must also include information about the formal consultation program implemented by the MAO. Participating MAOs under Phase 2 must make clear to their enrollees the financial implications of using an out-of-network hospice provider compared to an in-network hospice provider if there is any associated increase in cost-sharing. All MAOs must continue to follow the disclosure requirements described at 42 CFR 422.111, including 422.111(b) to accurately and completely describe all benefits offered, including the hospice benefit.

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 42 CFR 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, and out-of-network providers in the plan's service area who may provide care

to the participating MAO's enrollees. 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 as well as plan-reported data related to the quality measures used in this Model (see section 2.5). CMS will provide participating organizations with updated Model Monitoring Guidelines that set out the timeliness, format, and necessary data to be submitted.[53] 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;
- accounting of the total number of enrollees who received transitional concurrent care services;
- the types and length of transitional concurrent care services received;
- transitional concurrent care and unrelated spending for beneficiaries; and
- additional data as necessary to fully support the implementation and monitoring of the Model. [54]

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 both hospice providers and MAOs, as applicable.

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 or virtual 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 may make changes to the Model as necessary to ensure beneficiary safety and that CMS's aims are achieved.

[53] For reference, please see the CY 2022 Monitoring Guidelines for the Hospice Benefit Component.
[54] A sample file layout is provided in the CY 2022 Monitoring Guidelines for the Hospice Benefit Component. Please note that this file format and the data requested may change for CY 2023.

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 MAO 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 for a number of reasons, including but not limited to the following: 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 uses a contractor to conduct regular monitoring to review compliance with the terms of the Model test. The contractor monitors 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 MAO and its downstream entities if there is evidence that indicates that the MAO'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 have been established in the Model's contractual addendum to the MAO'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 MA Program bid deadline, which is the first Monday in June of each year, prior to the upcoming Plan Year, with a Model termination plan that includes how, what, and when the MAO will provide adequate notice to participating enrollees who 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, such as the ANOC. With respect to the MAOs implementing the Hospice Benefit Component of the Model, the MAO will make updates to the EOC and the ANOC 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. If an MAO chooses not to participate in a future year, it 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.[55]

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

[55] More guidance relating to enrollment scenarios and participating MAOs' responsibility for hospice coverage can be found in the CY 2021 VBID Hospice Benefit Component Technical and Operational Guidance here: https://innovation.cms.gov/media/document/vbid-hospice-technical-guidance-cy2021

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 items 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 transitional 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's 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. There will be an equity element to the evaluation, with outcomes of interest examined both overall and by relevant sociodemographic characteristics. Where sample size and resources permit, subgroup analyses will be conducted.

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

1. Which palliative care (outside of the context of hospice) 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 caregiver 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. What payment and delivery innovations emerged as the result of the Hospice Benefit Component?
7. How does the Model impact the decision to elect hospice, and the timing of hospice election, by Medicare Advantage enrollees?
8. What is the effect of the Model on Medicare expenditures, unrelated care expenditures, and beneficiary out of pocket costs?
9. 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?
10. 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?
11. What are the elements of each participating MAO's approach to serious illness and end-of-life care delivery? Which elements do enrollees, family/caregivers, and providers identify as the most important to improving quality of life?
12. How does the Model affect which hospice(s) enrollees choose for their care?
13. How are hospices furnishing 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?

5. Learning System Strategy

In the Hospice Benefit Component, CMS will continue to provide access to a voluntary learning system for participating MAOs and interested hospice providers, including:

1. **Technical Assistance:** Information-sharing about how the Model works and what is required for success through onboarding for participating MAOs and support resources for participating MAOs, hospice providers and other interested stakeholders, such as a technical

and operational implementation guide, newsletters, Frequently Asked Questions (FAQs), and webinars/office hours.

2. **Use of Data for Improvement:** Use of data sharing and analytics with participating MAOs to guide the operational and care delivery changes necessary for success.
3. **Assessment and Feedback:** Ongoing and timely assessment of participating MAO capabilities.
4. **Learning Communities:** Management of participating MAO connections for peer-to-peer sharing e.g., beneficiary stories, and diffusion of promising strategies, e.g., via monthly learning workgroup sessions on topics ranging from ways to achieve health equity in serious illness care, develop community-based palliative care strategies, and structure meaningful hospice supplemental benefit designs. Offering of optional, local engagement and learning opportunities for hospice providers.

6. Application Process and Selection

MAOs interested in applying to participate in the VBID Model should submit their application by no later than **April 15, 2022.** The application portal will be accessible on the VBID Model website at: https://innovation.cms.gov/initiatives/vbid/ by March 2022. 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 (Early March 2022 through April 2022)

In an effort to provide MAO support for the VBID Model, CMS will provide feedback and technical assistance on a rolling basis through April 15, 2022. 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 regard to model participation, model requirements, and beneficiary protections. Per section 1854(a)(6)(B) of the Act, CMS is prohibited from requiring an MAO to contract with a specific provider and from requiring a particular price structure for payment under such a contract, except for limited statutory exceptions (e.g., payments to federally qualified health centers); therefore, CMS will not offer any guidance beyond that offered in this RFA and existing technical guidance documents.

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 (April 15, 2022)

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 Benefit 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. MAOs 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 Benefit Component of the VBID Model, CMS will ask MAOs to outline their 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. Participating MAOs are also required to submit to CMS projected costs and projected net savings to Medicare over the course of their participation in the Model component; as part of this requirement, participating MAOs must submit a supplemental document (the "CY 2023 VBID Financial Application Template" on the Model webpage). Applications must also include the MAO's approach to WHP, which is a required Model component. For additional information on the financial application and WHP, please see the CY 2023 VBID Model RFA.

CMS will review submitted applications and reach out to applicants for clarity, additional information, or to request changes if needed. CMS will also provide additional technical assistance.

MAOs will have through early May 2022 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 mid-May 2022 for Model participation. See withdrawal section below for guidance for MAOs that decide not to participate after applying.

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 6, 2022)

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 6, 2022 (11:59 pm PT). 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 6, 2022 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 6, 2022 (11:59 pm PT) 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.

Step 4: Network Adequacy Review (Summer 2022) [Applicants Subject to Phase 2 Network Adequacy Policy ONLY]

A provisionally approved MAO with mature-year PBPs will submit to CMS its network of hospice providers to establish that it will meet the MNP requirements for each county in its service areas(s) at the participating MAO level. CMS will provide MAOs with further submission instructions in the future.

6.1. Timeline

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

Date	Milestone
Early March 2022	VBID Model's Hospice Benefit Component Request for Application released
Early March 2022 – April 15, 2022	CMS provides feedback and technical assistance to MAOs applying for the Hospice Benefit Component
Early March 2022	CMS, in conjunction with the Office of the Actuary, releases additional information about the CY 2023 Preliminary Hospice Capitation Payment Rate Actuarial Methodology
Early March 2022	VBID Model Application Portal opens (inclusive of Hospice Benefit Component)
Spring 2022	CMS releases additional information on Phase 2 network adequacy requirements, including the Minimum Number of Provider (MNP) Technical Methodology and Operational Guidance
Mid-to-Late April 2022	Office of the Actuary releases the CY 2023 Final Hospice Capitation Payment Rate Actuarial Methodology and Hospice Capitation Ratebook
April 15, 2022	Completed Application due to CMS by 11:59pm PT
Early May 2022	CMS releases Data Book for MNP calculations at the participating MAO level
Mid-May 2022	CMS completes review of applications and provides feedback to MAOs for inclusion in their CY 2023 plan benefit package
June 6, 2022	CY 2023 MA and Part D Bid submission deadline by 11:59 pm PT
Summer 2022	Participating MAOs with mature-year PBPs submit provider networks for CMS review
Mid-to-Late September 2022	Contract addenda for Model participation executed CY 2023 Model Participants announced
October 2022	MNP Data Book made available to all stakeholders Initial hospice provider directory available, including in-network providers, as well as communication of benefits under the Evidence of Coverage
January 1, 2023	CY 2023 performance period of the Hospice Benefit Component of the VBID Model begins

6.2. 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 .

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 6, 2022 (11:59 pm PT), 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.

6.3. 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 2013-2019) 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 FY 2019, the average hospice billed 98.3% of Medicare-provided days as routine home care. 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.

Link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/PAC_Hospice

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.[56]

- 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.[57]

Link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services

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 (available at https://www.cms.gov/Center/Provider-Type/Hospice-Center) has important links to hospice regulations, 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 MCPM 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" available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c08.pdf
- Chapter 9 of the Medicare Benefit Policy Manual, "Coverage of Hospice Services Under Hospital Insurance" available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c09.pdf
- Chapter 11 of the MCPM, "Processing Hospice Claims" available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c11.pdf

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[56] (1) MedPAC. Hospice Services. March 2020. Retrieved from https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_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

[57] Ibid

Fiscal Year Hospice Wage Index and Hospice Regulations and Notices

- Proposed and Final Hospice Wage Index and Payment Rate Updates, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices
- Hospice Wage Index Files, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index

Medicare Payment Advisory Committee

- Chapter 11 of the March 2021 Annual Report to Congress, available at https://www.medpac.gov/document/chapter-11-hospice-services-march-2021-report/
- Payment Basics: Hospice Services Payment System, available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospice_final_sec.pdf

For More Detailed Data

The following data sets provide more detailed information:

- Standard Analytical Files (Medicare Claims) – LDS, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/StandardAnalyticalFiles
- Research Data Distribution Center LDS Hospice Claim Record Data Dictionary, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/StandardAnalyticalFiles

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 both this RFA and the VBID 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 here 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/ by March 2022.

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.

Advancing Health Equity

The following questions ask about the efforts you plan to undertake to address potential inequities and disparities in access, outcomes, and/or enrollee experience of care as it relates to your participation in the Hospice Benefit Component as a whole. For illustrative examples of inequities in palliative and/or hospice care that may be applicable to your enrollee populations (e.g., across race, ethnicity, cultural or religious beliefs, disability, sexual orientation, gender, etc.), please see section 1.3 of the CY 2023 RFA for the Hospice Benefit Component.

As a resource to aid in completing this section of the application, please see the Office of Minority Health (OMH) Disparities Impact Statement, a planning tool that can be used to learn how to identify, prioritize, and take action on disparities that impact health outcomes for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf. Additional technical assistance will be provided by CMS upon request.

Please note: Except as otherwise permitted by applicable law, a health equity plan may not propose actions that selectively target or discriminate against Beneficiaries based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, geographic location, or income.

1. Describe how you will identify, address and monitor any potential inequities in access, outcomes, and/or enrollee experience of care as it relates to palliative care, transitional concurrent care, and hospice. This can include, but is not limited to, the use of internal or external data sources, patient or caregiver feedback, provider feedback, and patient/caregiver/community needs assessments. Similarly, what are some potential metrics

of success you may use to track your efforts?

2. Describe how you will engage enrollees, caregivers, and providers in your strategy to address any potential inequities.

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. Please confirm that your palliative care or other serious illness care program does or will include the following: palliative care assessment and consultation services; care coordination by an interdisciplinary care team; care planning and goals of care discussions; advance care planning; access to social services and community resources; access to mental health and medical social services; 24/7 telephonic palliative care support; psychosocial and spiritual support; pain and symptom management; medication reconciliation and caregiver support.

2. Please use this section to provide any additional narrative on the above identified palliative care program and the role of an interdisciplinary care team in providing palliative care services. Please include both clinical/medical and social support aspects.

3. Approximately how many enrollees do you anticipate serving in your palliative care program(s) in CY 2023? Please include definition(s) of eligibility for your palliative care program(s).

4. What is your enrollee identification process (e.g., based on clinical interaction, claims data algorithm, etc.) and what are the enrollee 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 enrollees that elect the hospice benefit, through offering upstream palliative care services in CY 2023.

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.

8. [For CY 2022 participants] Please describe any changes to your palliative care program from

CY 2022 to CY 2023, if applicable. Include description of how CY 2021 and/or CY 2022 experience (including the Public Health Emergency) informed these changes.

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 an enrollee's plan of care, on a transitional concurrent basis.

2. Please describe the expected items or services that, based on the enrollee'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. [For CY 2022 participants] Please describe any changes to your transitional concurrent care program from CY 2022 to CY 2023, if applicable. Include description of how CY 2021 and/or CY 2022 experience informed these changes.

5. 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;
   - ☐ Concurrent care will be coordinated among in-network hospices, MAOs and other treating providers, as applicable; and
   - ☐ 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 hospice supplemental benefits that are targeted to or for which eligibility is limited to enrollees who have elected hospice? If so, what is the maximum plan benefit amount?

2. Please indicate the types of hospice supplemental benefits that will be offered:
   - ☐ Home and bathroom safety devices/modifications
   - ☐ Over-the-counter (OTC) benefits

- ☐ Support for caregivers of enrollees
- ☐ Meals
- ☐ Transportation
- ☐ Other (Please describe)
- ☐ Temporary coverage (as a not primarily health related benefit) 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
- ☐ Reduced cost-sharing for services under the hospice benefit, including hospice drugs and biologicals or inpatient respite care

3. Please detail any use of care managers or other approaches that allow for the provision of hospice supplemental benefits for enrollees who have elected hospice.

4. Please identify any hospice supplemental benefits that are limited to enrollees who choose in-network providers. For MAOs offering PPO plans, please include an explanation for why the coverage of hospice supplemental benefits need to be limited to in-network providers only.

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. These questions are posed with the understanding that your network may still be under development and encourage you to provide additional information as it becomes available.

1. Describe the identification and selection criteria and processes (including credentialing for in-network providers) supporting the creation of your organization's hospice provider network and how that process complies with MA regulations on provider networks (see 42 CFR §§ 422.200 through 422.224). Please identify specific standards and sources of public or non-public information you may use in this process.

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. Describe how you plan to work with out-of-network hospice providers to ensure access for your enrollees and coordination of care throughout the Hospice Benefit Component.

5. Will you be using a voluntary consultation process?

- ☐ Voluntary Consultation Process
- ☐ No Consultation Process

6. If you use a voluntary consultation process, please list which PBPs will use one or the other.

7. Please describe any voluntary consultation process aimed at engaging enrollees prior to their accessing an out-of-network hospice.

Additional Network Requirements for Participating MAOs with Mature-Year PBPs ONLY

8. Do you attest that all counties in your service area(s) will meet the hospice MNP requirements set forth by CMS prior to January 1, 2023, **and** that you will maintain compliance with the hospice MNP requirements all throughout 2023?

9. Please describe how you will ensure that each in-network hospice is able to deliver care in a timely manner across all four levels of hospice care. Please include separate considerations for in-home or in-community care (i.e., routine home care and continuous home care) and for inpatient care (i.e., general inpatient care and respite care).

10. Please describe, beyond meeting the MNP requirement, how you will ensure that your network of hospice providers have adequate capacity (e.g., average daily census, staffing, access to facilities, etc.) to meet the needs of projected demand for hospice across your service area(s) and how your organization intends to ensure compliance with 42 CFR 422.112 for hospice benefits.

11. Please describe any efforts to engage and incorporate hospice providers into your network who have a history of serving underserved populations, provide additional value-add services to patients and families, have strong relationships with their local communities, and/or actively collaborate with organizations that may help meet the social needs of patients.

12. Please describe how you will ensure cultural competency throughout your hospice network. This may include a description of cultural competency programs and/or trainings; if/how you engage local organizations to develop and inform relevant trainings, and which organizations you will engage; etc.