Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

Value-Based Insurance Design Model

Hospice Benefit Component

Calendar Year 2021 Monitoring Guidelines

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1. Background and General Information

Through the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model, the Centers for Medicare & Medicaid Services (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 Medicare Advantage (MA) program. For MA Organizations (MAOs) that volunteer to be part of the Hospice Benefit Component, CMS will evaluate the impact on cost and quality of care for enrollees, including how the Model improves quality and timely access to the hospice benefit, and the enabling of innovation through fostering partnerships between participating MAOs and hospice providers. In order to help ensure enrollees' experience at the end-of-life and in hospice reflect high quality care and care coordination and to create transparency for enrollees and their families and caregivers, CMS will monitor enrollee experience and provider quality at the start of the Hospice Benefit Component and over time.

These monitoring guidelines provide MAOs participating in the Hospice Benefit Component in Calendar Year (CY) 2021 ("participating MAOs") with guidance pertaining to Model component reporting activities that support CMS Monitoring and Evaluation activities. Participating MAOs must adhere to this guidance pursuant to the Addendum to Medicare Managed Care Contract for Participation in the MA VBID Model ("Addendum"). In the interest of creating transparency, CMS is making these monitoring guidelines publicly available.

Capitalized terms not otherwise defined in these CY 2021 Hospice Benefit Component Monitoring Guidelines have the meaning provided in the Addendum.

1.1 Hospice Benefit Component Monitoring and Evaluation Strategy

The Model's monitoring strategy is aimed at protecting all beneficiaries, assuring participating MAOs' compliance with the terms of the Model test, and tracking implementation of the Hospice Benefit Component. CMS or its contractor will conduct compliance monitoring on a regular basis to track MAO compliance with the terms of the Model test. Model monitoring and evaluations activities will chiefly rely on existing data sources. However, participating MAOs will be required to report additional data in situations where (1) no existing data are available and (2) this information is necessary for monitoring and/or evaluation of the Hospice Benefit Component. 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.

Robust monitoring and evaluation of the Hospice Benefit Component are critical to CMS' ability to test the Model component. In general, monitoring objectives of the Hospice Benefit Component cover the following areas:

- Ongoing review and tracking of Model participants' efforts and progress and potential issues in implementation of the Hospice Benefit Component;
- MAO compliance with the Hospice Benefit Component terms of the Model Guidance and the Addendum;
- Identification of unintended consequences of operating the Hospice Benefit Component (i.e., beneficiary harm or program integrity issues, and/or spillover effects of operating the Hospice Benefit Component on care, quality, and utilization in other Medicare benefits);
- Ensuring that beneficiaries are not harmed or discriminated against; and

- Making sure that beneficiary choice is protected.

In addition to monitoring activities, all participating MAOs are required to cooperate with evaluation of the Hospice Benefit Component. In general, evaluation objectives of the Hospice Benefit Component include:

- Rigorously assessing the impact of the Hospice Benefit Component on enrollee health outcomes, behavior, service use, quality of care, and cost; and
- Evaluating data submitted to CMS by participating MAOs *as part of their monitoring activities* and administrative data sources already available to CMS.

CMS will collect monitoring data and information to allow for real-time Model monitoring. Delays in reporting will impede CMS' efforts to monitor and evaluate the Hospice Benefit Component. As such, CMS will work with participating MAOs to ensure these data are submitted in a timely fashion to CMS. **MAOs participating in this Model must submit accurate and complete encounter data related to Hospice Benefit Component-specific activities in their usual encounter data submissions so that this Model's monitoring and evaluation have the benefit of those data.**[1] Additionally, for monitoring and learning, CMS will conduct outreach to hospice providers that are providing hospice care in the service areas of participating MAOs (which may include hospice providers who do not directly accept Model beneficiaries) to understand the impact of the Model on these hospice providers. CMS also reserves every right to make changes to the Model as necessary to ensure beneficiary safety and that CMS' aims are achieved.

A guiding principle in CMS's approach toward data collection and reporting is to minimize burden for participating MAOs, consistent with the government's need to monitor and evaluate model tests. Therefore, CMS has developed guidelines around data collection and reporting with consideration of the data needed to support model activities (see section 2) and what data are already available to CMS. CMS may ask for additional information if clarification of submitted data is necessary.

1.2 Overview of Hospice Benefit Component: Transparency and Monitoring Measures

As described in the CY 2021 Request for Applications (RFA) for the Hospice Benefit Component of the VBID Model ("CY 2021 VBID Hospice RFA"), CMS will monitor the impact of the Hospice Benefit Component, based on the following three 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. These quality domains were selected to address key improvement opportunities – relevant to beneficiaries who choose hospice and those who do not, their families and their caregivers.

Within these quality domains, CMS has intentionally selected beneficiary-focused and program integrity-focused measures that support the detection of inappropriate utilization and payment, are clinically meaningful and align with CMS's broader quality measurement strategy.

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[1] For reference, please see the most recent Encounter Data Submission and Processing Guide, which can be found here: https://www.csscoperations.com/internet/csscw3.nsf/DID/C1QB31Y8ZY

CMS is leveraging the following existing CMS data sources for the majority of beneficiary-focused measures, including:

- MA Encounter Data, Medicare Claims, Prescription Drug Event Data (PDE) and Part C and D reporting;
- Beneficiary enrollment, eligibility, and payment data (Medicare Advantage and Prescription Drug system (MARx), CMS Enrollment database);
- Plan data submitted for bids and into the plan benefit package (PBP) software and available in HPMS;
- Quality data (HEDIS, Health Outcome Survey, MA Consumer Assessment of Healthcare Providers and Systems (CAHPS), CAHPS Hospice Survey);
- Medicare Complaint Tracking Module and 1-800 Medicare; and
- Hospice Benefit Component annual application data.

Table 1 provides a list of these measures by domain, source of data and frequency of monitoring review. Each measure is described more fully in Appendix 4. CMS may monitor for additional impacts on quality, beneficiary safety, and potential discrimination beyond those described in these guidelines, using existing CMS data. For example, because hospice providers will continue to submit claims for informational and operational processing and monitoring (sometimes referred to as “shadow billing”), CMS will continue to rely on hospice claims for many of the monitoring measures such as the proportion of enrollees admitted to hospice for less than seven days.

Table 1. Transparency and Monitoring Measures by Domain and Source of Data

Transparency and Monitoring Measures	Source of Data – CMS	Source of Data – Plan Reported	Frequency of Monitoring Review
Palliative Care and Goals of Care Experience			
Development of Advance Care Plans (ACPs) and Wellness and Health Care Planning (WHP)		X	Annually[1]
Access to, and use of, Palliative Care		X	Bi-Annually
Proportion of Enrollees Admitted to Hospice for Less than 7 Days	X		Quarterly, beginning Quarter 2 2021
Enrollee Experience and Care Coordination at End of Life			
Days Spent at Home in Last Six Months of Life	X		Quarterly, beginning Quarter 2 2021
Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life	X		Quarterly, beginning Quarter 2 2021
Hospice Care Quality and Utilization			
Pre-Hospice Consultation Process		X	Bi-Annually
Availability of and Access to Hospice Providers		X	Bi-Annually
Hospice Utilization	X		Quarterly, beginning Quarter 2 2021
Delivery of Transitional Concurrent Care		X	Bi-Annually
Hospice Supplemental Benefits		X	Bi-Annually
Part D Duplicative Drug Utilization	X		Quarterly, beginning Quarter 2 2021
Unrelated Care Utilization	X	X	Quarterly for CMS-sourced data, beginning Quarter 2 2021 & Bi-Annually for Plan Reported
Proportion of Lengths of Stay beyond 180 Days	X		Quarterly, beginning Quarter 2 2021
Visits in the Last Days of Life	X		Quarterly, beginning Quarter 2 2021
Transitions from Hospice Care, Followed by Death or Acute Care	X	X	Quarterly for CMS-sourced data, beginning Quarter 2 2021 & Bi-Annually for Plan Reported
Experience of Care Measures	X		Annually
Appeals and Grievances Processes	X	X	Rolling basis for CMS-sourced data & Bi-Annually for Plan Reported
Provider Complaints and Disputes [2]	X	X	Rolling basis for CMS-sourced data & Bi-Annually for Plan Reported
Timeliness of Claims and Payments		X	Bi-Annually

[1] Reported at summary level as part of VBID Model participation, and not separately for the Hospice Benefit Component; see CY 2021 VBID Model Monitoring Guidelines for more information

[2] Please note that "Provider Complaints and Disputes" includes only those complaints from a provider that do not pertain to a beneficiary's coverage or services provided. Examples of provider complains may include an issue with timely response from the plan to a question about billing, or a complaint about the consultation process. Providers should note that they may also email CMS directly at VBID@cms.hhs.gov with any complaints or issues to aid monitoring efforts.

2. General Reporting Guidance and Requirements

The following sections offer additional detail on the specific reporting required from participating MAOs to support monitoring efforts on the Hospice Benefit Component. This provides guidance on the measures, what should be reported, the data content, file format, and timeline for reporting. More detailed file layouts and background information on measures can be found in Appendices 1-4. CMS may adjust these measures and request additional information as needed to support robust monitoring efforts on the Hospice Benefit Component.

2.1 Applicability of Other Guidance and Requirements

All MA data collection and reporting regulations and guidance issued by CMS, as well as other applicable laws, continue to apply to data collection and reporting activities of participating MAOs.

2.2 Overview of Types of Monitoring Data

Monitoring data collected from participating MAOs will fall into one of two high-level categories: (a) Beneficiary-level Data Reporting; or (b) Summary Reports and Other Reporting. Table 2 provides an overview of these two categories of monitoring data, the frequency for reporting, examples of content included in the reporting, file format, and acceptable methods for transmission to CMS.

Table 2: Attributes of Different Types of Monitoring Data

Type of Monitoring Data	Reporting Frequency	Data Content - Examples	File Format	Transmission Method
Beneficiary-level Data Reporting[1]	Biannually	Benefit Eligible date; Medicare Beneficiary Identification # (MBI), etc.	.txt file	VBID Hospice Web Portal only
Summary Reports and Other Reporting	Biannually/Annually	Summary-level information; qualitative survey questions	Variable format	VBID Mailbox: VBID@cms.hhs.gov
	Three times per year	Network File (adapted Health Service Delivery (HSD) file listing all hospice providers in network (Appendix 3))	.xlsx file	VBID Hospice Web Portal only

[1] This beneficiary-level reporting applies to MAOs offering the Hospice Benefit Component and plan reporting on transparency and monitoring measures is listed in Appendix 1.

2.3 Plan Reported Beneficiary Level Data

Below, CMS provides a list of plan reported transparency and monitoring measures for CY 2021[2] with a description of the beneficiary-level data to be reported. Beneficiary-level data reporting by participating MAOs will be required on a bi-annual basis in CY 2021.

Table 3. Required Plan Reported Beneficiary Level Data

Domain	Transparency and Monitoring Measure	Beneficiary-Level Data Reporting
Palliative Care and Goals of Care Experience		
	Access to, and use of, Palliative Care	• Report on each enrollee receiving palliative care services • Report on spending and beneficiary cost sharing for palliative care
Hospice Care Quality and Utilization		
	Pre-Hospice Consultation Process	• Date of Pre-Hospice Consultation • Selection of In-Network or Out-of-Network Hospice Provider
	Delivery of Transitional Concurrent Care	• Report on Start and End Dates of Transitional Concurrent Care • Report on spending and beneficiary cost sharing for Transitional Concurrent Care
	Hospice Supplemental Benefits	• Report on utilization of each hospice supplemental benefit identified in the Approved Proposal • Report on any hospice supplemental benefits • Report on any beneficiary-level reductions in cost sharing related to the Hospice Benefit Component
	Unrelated Care Utilization	• Report on spending and beneficiary cost sharing for Unrelated Care (not including Part D unrelated drugs)
	Transitions from Hospice Care, Followed by Death or Acute Care	• Report on spending for Post-Live Discharge Care (not including Part D drugs)

Participating MAOs are required to submit the Beneficiary-level Hospice Benefit Component Data File in accordance with the schedule presented in Table 4. The "performance period," as referenced in Table 4, refers to the period where actual services were provided to enrollees. The "reporting period," also referenced in Table 4, refers to the period that a participating MAO has to submit the required Beneficiary-level Hospice Benefit Component Data File to CMS.

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[2] These are described in detail in Appendix 4 of these guidelines; a provisional list was provided in Section 2.5 of the CY 2021 VBID Hospice Benefit Component RFA.

Additionally, beneficiary-level data must be reported to CMMI through the secure hospice portal ("VBID Hospice Web Portal"), unless otherwise instructed by CMS. The VBID Hospice Web Portal will only allow reporting during the applicable reporting period. Therefore, if a participating MAO is unable to report during the applicable reporting period, the MAO must inform CMS in writing before the close of the reporting period and request an extension to meet Hospice Benefit Component reporting requirements.

Table 4: Beneficiary-level Data Reporting Schedule (CY 2021)

Bi-Annual Submission	Cumulative Performance Period	Reporting Period
Bi-Annual Submission Period One, 2021	1/1/21 – 6/30/21	7/1/21– 7/31/21
Bi-Annual Submission Period Two, 2021	1/1/21 – 12/31/21	3/1/22-3/31/22

Appendix 1 provides a sample file layout for bi-annual beneficiary-level reporting associated with the Hospice Benefit Component.

Note: The final file layout and contents may vary marginally from this sample; however, this sample is provided with the intent of representing close approximation of the final file. The final file layout and contents will be provided in Quarter 2 of CY 2021.

Participating MAOs must keep a record of each unique enrollee engaged in Hospice Benefit Component specific activities throughout the year and use the bi-annual update to provide the most current history of enrollees. Each bi-annual submission should serve as a "snapshot" of beneficiary-specific activity to date for the performance year. If, for example, an enrollee's information was delayed or not reported accurately in the CY 2021 Bi-Annual Submission Period One, CMS would expect the information to be updated by the participating MAO in the CY 2021 Bi-Annual Submission Period Two.

Additional instruction and training on beneficiary-level data reporting will be provided to participating MAOs prior to the Bi-Annual Submission Period One. In addition to the reporting requirements for the Hospice Benefit Component referenced above and in the CY 2021 VBID Model Monitoring Guidelines (as applicable, e.g., around the WHP component), MAOs must also comply with the record retention requirements set forth in the Addendum and unwaived regulations.

2.4 Summary Reports and Other Reporting

CMS will collect additional data in several forms and in accordance with the data-reporting schedule in Table 5 below that do not include beneficiary-level data, in order to provide a more holistic approach to monitoring the Hospice Benefit Component. These data are described in Appendix 2 and include summary-level data and survey questions likely to be asked of the participating MAOs in order to provide additional context for other data collected regarding the Hospice Benefit Component. Summary-level items that are described in Appendix 2 include plan-level, summary measures regarding hospice supplemental benefits, appeals and grievances, provider complaints, and claims payment timeliness. Survey questions included in Appendix 2 represent examples of what may be asked of participating MAOs by CMS and/or a CMS contractor. These questions may be edited in advance of discussion with the participating MAO, and specifically may be tailored to the participating MAO's interventions or submitted data. The questions provided in Appendix 2 are included to give a representative example of the type of questions that may be asked, but do not provide a complete list of what may be asked.

Table 5: Summary-level Data Reporting Schedule (CY 2021)

Bi-Annual Submission	Cumulative Performance Period	Reporting Period
Bi-Annual Submission Period One, 2021	1/1/21 – 6/30/21	7/1/21– 7/31/21
Bi-Annual Submission Period Two, 2021	1/1/21 – 12/31/21	3/1/22-3/31/22

CMS will also collect information on participating MAOs' hospice provider networks three times reflecting CY 2021 hospice provider networks at various points in time, as shown in Table 6. The provider network table should include all hospice providers in the participating MAO's network at the time of data submission.

Table 6: Hospice Provider Network Reporting Schedule (CY 2021)

Tri-Annual Submission	Performance Period	Reporting Period
Tri-Annual Submission Period One, 2021	As of January 31, 2021	2/1/21 – 2/28/21
Tri-Annual Submission Period Two, 2021	As of June 30, 2021	7/1/21 – 7/31/21
Tri-Annual Submission Period Three, 2021	As of December 31, 2021	3/1/22-3/31/22

The information required is detailed in Appendix 3, and the file layout represents an adapted version of the Health Service Delivery (HSD) table that MAOs use in other reporting to CMS regarding provider networks.

Table 7: Summary Level or Provider Network Data and Reporting

Data Source	Transparency and Monitoring Measure[1]	Data Description
Summary-level Hospice Benefit Component Information (Appendix 2)	Hospice Supplemental Benefits	Report on number of units (e.g., days, hours, meals as applicable) of hospice supplemental benefits that were provided by type of hospice supplemental benefit
	Beneficiary Appeals and Grievances	Report on all grievances related to services provided to enrollees under the Hospice Benefit Component (palliative care, transitional concurrent care, hospice care, non-hospice care, post-live discharge care) Report on all appeals related to organization determinations regarding services provided to enrollees under the Hospice Benefit Component (palliative care, transitional concurrent care, hospice care, unrelated care provided during a hospice election period and any care provided after a live discharge from hospice care prior to an enrollee's death (this is referred to as post-live discharge care))
	Provider Complaints and Disputes	Report on all complaints and disputes related to care provided to enrollees under the Hospice Benefit Component (palliative care, transitional concurrent care, hospice care, non-hospice care, post-live discharge care) made to the plan from a provider (both in-network and out-of-network). This should not include appeals and grievances included in the above metric.
	Timeliness of Claims and Payments	Report on all hospice claims for services provided to hospice enrollees in the Hospice Benefit Component, from in-network and out-of-network providers, that meet the definition of "clean claims" and those that do not.[2] Report on all hospice claims provided to hospice enrollees in the Hospice Benefit Component subject to prepayment or postpayment review
Hospice Benefit Component qualitative survey questions (Appendix 2)	May be applicable to a variety of measures in Table 1	n/a- See Appendix 2 for example questions
Hospice Provider Network File (Appendix 3)	Availability of and Access to Hospice Providers	Report on all hospice providers with a fully executed contract in the participating MAO's network.

[1] For information regarding the performance and/or reporting period of these transparency and monitoring measures (with the exception of sample survey questions that will be annual), please see Table 5.

[2] See 42 CFR 422.500 for a definition of a clean claim, 42 CFR 422.520 for prompt payment requirements and section 7 of the CY 2021 Hospice Benefit Component Technical Guidance for additional guidance.

Appendix 1: File Layout for Beneficiary-level Hospice Benefit Component Data File Required from MAOs.

This file layout is a .txt file; data variables are separated by a single pipe delimiter with no pipe delimiters needed at the beginning or end of the row (i.e., no pipe delimiter "end"/"cap"). The total number of pipes in each row should be n-1, where n= the number of header variables/data fields. Two pipes indicate the data fields in between and after, respectively, have missing values.

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Beneficiary ID (MBI)	BENEFICIARY_ID		R	1. The 2nd, 5th, 8th, and 9th characters will always be alpha 2. The 1st, 4th, 7th, 10th, and 11th will always be a numeric 3. The 3rd and 6th characters can be numeric or alpha 4. 11 alphanumeric, no spaces or special characters	
Surname	LAST_NAME		R	Alphanumeric	
First Name	FIRST_NAME		R	Alphanumeric	
M. Initial	MIDDLE_NAME		O	Alphanumeric	
Contract Number (H#)	CONTRACT_ID		R	Must be valid VBID approved Contract for Calendar Year	
Plan Benefit Package Number (PBP #)	PLAN_BASED_PLAN_NUMBER		R	Must be valid VBID approved PBP, associated with the VBID approved Contract	

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Segment ID	SEGMENT_ID		R	Must be valid segment for indicated PBP/Contract	For non-segmented plans, enter a single numerical value of "0". For segmented plans, the numeric field is three digits. Must include a valid segment for indicated PBP/Contract, reflected in 3 characters, with leading zeroes as needed. (e.g. "003")
First Date of Enrollment in Palliative Care or Similar Program	FIRST_DATE_OF_ PALLIATIVE_CARE_ ENROLLMENT		Required if the enrollee receives any palliative care	Must be in Date Format [YYYYMMDD], numeric values only	The first date enrollee is enrolled in a non-hospice palliative care or similar program of care or services; leave blank if no palliative care provided.
Total Days in Palliative Care or Similar Program	TOTAL_DAYS_IN_ PALLIATIVE_CARE		Required if the enrollee receives any palliative care	Must be in numeric values only	Total days in a year that the enrollee was enrolled in a non-hospice palliative care or similar program of care or services; leave blank if no palliative care provided.
Beneficiary Cost-Sharing for Palliative Care or Similar Program	BENEFICIARY_COST_S HARING_PALLIATIVE_ CARE		Required if the enrollee receives any palliative care	Must be in Dollar Value [XXXX.XX], numeric values only	Beneficiary payment amount for the cost-sharing of palliative care services that were approved in the application. Enter 0.00 if no beneficiary payment for the Palliative Care services received and leave blank if not applicable.

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Total Cost for Palliative Care or Similar Program	TOTAL_COST_PALLIATIVE_CARE		Required if the enrollee receives any palliative care	Must be in Dollar Value [XXXX.XX], numeric values only	Total cost of providing Palliative Care to an enrollee during the period the enrollee received Palliative Care. Cost is defined as the payment to the providers. Leave blank if no Palliative Care services received.
Date of Pre-Hospice Voluntary Consultation	HOSPICE_CONSULT_DATE		Required if the enrollee receives pre-hospice consultation	Must be in Date Format [YYYYMMDD], numeric values only	Date of pre-hospice consultation. Leave blank if no pre-hospice consultation occurred.
Designated Hospice Provider Elected is In-Network or Out-of-Network	FIRST_HOSPICE_ELECTION_PROVIDER_NETWORK	(A) In-network (B) Out-of-Network	Required if Applicable	Alphanumeric, must be one of two values listed	For enrollees electing hospice, his/her designated hospice provider is in-network or out of network at time of election. Leave blank if enrollee did not elect hospice.
In event of live discharge and re-enrollment or transfer to a new hospice provider, new designated Hospice Provider is In-Network or Out-of-Network, if applicable	SECOND_HOSPICE_ELECTION_PROVIDER_NETWORK	(A) In-network (B) Out-of-Network	Required if Applicable	Alphanumeric, must be one of two values listed	For enrollees who have a live discharge and re-enroll in hospice or transfer to a new hospice provider, new designated hospice provider, provider is in-network or out of network at time of election. Leave blank if enrollee did not elect second hospice provider.

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Start date of receiving transitional concurrent care services, if applicable	TRANSITIONAL_ CONCURRENT_START _DATE		Required if the enrollee received Transitional Concurrent Care	Must be in Date Format [YYYYMMDD], numeric values only	Start date when an enrollee who has elected hospice begins receiving transitional concurrent care services (as provided in the Approved Proposal; this includes clinically-appropriate items, services and drugs related to a hospice enrollee’s terminal illness and related conditions, provided by network providers on a transitional basis outside the hospice benefit. Leave blank if no transitional concurrent care services received.
End date of receiving transitional concurrent care services, if applicable	TRANSITIONAL_ CONCURRENT_END_ DATE		Required if Applicable	Must be in Date Format [YYYYMMDD], numeric values only	End date when an enrollee who has elected hospice begins receiving transitional concurrent care services. Leave blank if no transitional concurrent care services received.

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Up to five most common transitional concurrent services, items or drugs provided for an enrollee receiving Transitional Concurrent Care	FIVE_MOST_COMMON_SERVICES_FOR_TRANSITIONAL_CONCURRENT_CARE	List HCPCS Codes or NDC, as applicable	Required if the enrollee received Transitional Concurrent Care	Alphanumeric for HCPCS code, 11 digit character for NDC code	Up to five most common services, items or drugs provided for an enrollee receiving Transitional Concurrent Care. List HCPCS codes or NDCs as applicable. The codes need to be separated by comma (e.g. CD01, CD02). Leave blank if no transitional concurrent care services received.
Beneficiary Cost-Sharing for Transitional Concurrent Care	BENEFICIARY_COST_SHARING_TRANSITIONAL_CONCURRENT_CARE		Required if the enrollee received Transitional Concurrent Care	Must be in Dollar Value [XXXX.XX], numeric values only	Beneficiary payment amount for the cost-sharing of Transitional Concurrent Care services during the period. Enter 0.00 if no beneficiary payment for the Transitional Concurrent Care services received and leave blank if not applicable.
Total cost of providing Transitional Concurrent Care to an enrollee during the period the enrollee received Transitional Concurrent Care	TOTAL_COST_OF_TRANSITIONAL_CONCURRENT_CARE	Total Cost of Transitional Concurrent Care Utilization During Receipt of Transitional Concurrent Care	Required if the enrollee received Transitional Concurrent Care	Must be in Dollar Value [XXXX.XX], numeric values only	Provide the total cost of providing transitional concurrent care to an enrollee during the period the enrollee received transitional concurrent care. **Cost is defined as the payment to the providers.** Leave blank if no transitional concurrent care received.

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Enrollee Receipt of any Hospice Supplemental Benefits	ENROLLEE_RECEIPT_OF_ANY_HOSPICE_SUPPLEMENTAL_BENEFITS	A. Home and bathroom safety devices/modifications B. Over-the-counter (OTC) benefits C. Support for caregivers D. Meals E. Transportation F. Pest Control G. Room and board H. Others	Required if the enrollee received hospice supplemental benefits	Alphanumeric, must be one or more of seven values listed	Enrollee has received at least one hospice supplemental benefit, **not inclusive of lower cost-sharing**. Leave blank if no hospice supplemental benefit received. List the benefits as a string without any separator if the enrollee received multiple benefits (e.g. ABC). Benefits should be consistent with the approved proposal.

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Enrollee Receipt of Lower Cost Sharing for Hospice Benefit Component Services, Items or Drugs	ENROLLEE_RECEIPT_OF_LOWER_COST_SHARING_FOR_HOSPICE	A. Hospice Drugs and Biologicals B. Hospice Inpatient Respite Care C. Unrelated Services and Items D. Unrelated Drugs and Biologicals E. Transitional Concurrent Care Services and Items F. Transitional Concurrent Care Drugs and Biologicals	Required if the enrollee received lower cost sharing	Alphanumeric, must be one or more of six values listed	Enrollee receipt of lower cost sharing for services, items and/or drugs received in connection with receipt of items and services under the Hospice Benefit Component, consistent with the Approved Proposal. Leave blank if no lower cost sharing received. If multiple lower cost sharing drugs, services and/or items are received, report values as a single string without any separator (e.g., “ABC”).

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Beneficiary Cost-Sharing for Unrelated Care	BENEFICIARY_COST_SHARING_UNRELATED_CARE		Required for hospice enrollees under the Model	Must be in Dollar Value [XXXX.XX], numeric values only	Beneficiary payment amount for the cost-sharing of services unrelated to beneficiary’s terminal illness or related conditions provided during a hospice election period, including Part A inpatient services, Part B outpatient services, professional provider services and durable medical equipment (DME) services. Part D drugs are excluded. Enter 0.00 if no unrelated care services received and leave blank if not applicable.

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Total Cost of Providing Unrelated Care	TOTAL_COST_OF_ UNRELATED CARE	Total Cost of Unrelated Care	Required for hospice enrollees under the Model	Must be in Dollar Value [XXXX.XX], numeric values only	Total cost of care that is unrelated to beneficiary's terminal illness or related conditions provided during a hospice election period, including the same specifiers and exclusions as above. Cost is defined as the payment to the providers. Enter 0.00 if no unrelated care services received for hospice enrollees under the Model and leave blank if not applicable (i.e. enrollee did not elect hospice).

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Total Cost of Providing Post-Hospice Live Discharge Care	TOTAL_COST_OF_POST_LIVE_DISCHARGE_CARE	Total Cost of Post-Discharge Care	Required for hospice enrollees under the Model	Must be in Dollar Value [XXXX.XX], numeric values only	Total cost of care that is provided post-hospice live discharge, including Part A inpatient services, Part B outpatient services, professional provider services and durable medical equipment (DME) services. **Part D drugs are excluded.** Cost is defined as the payment to the providers. Hospice live discharge is when the beneficiary's hospice status terminates due to being discharged alive from the hospice or revoking the election of hospice services. Patient being transferred to another provider is not considered a live discharge.

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Total Cost of Providing Post-Hospice Live Discharge Care (cont.)	TOTAL_COST_OF_POST_LIVE_DISCHARGE_CARE	Total Cost of Post-Discharge Care	Required for hospice enrollees under the Model	Must be in Dollar Value [XXXX.XX], numeric values only	**Post-live discharge period is the time between the live discharge and the end of the calendar month in which the live discharge from hospice occurred.** Enter 0.00 if no post live discharge services received for hospice enrollees under the Model. Leave blank if not applicable (i.e. enrollee did not elect hospice).

Appendix 2: Summary Level Reporting Worksheet

Summary-level Hospice Benefit Component Information Worksheet[3]

Target Reporting Date to CMS: Bi-Annually, between 7/1/21 – 7/31/21 and 3/1/22 – 3/31/22

Plan Year: 2021
Parent Organization: [NAME OF PARTICIPATING PARENT ORGANIZATION]
Model-Participating Contracts: [PLEASE LIST CONTRACT AND PBP IDENTIFICATION INFORMATION]

Summary Statistics[4]

Metric	Metric Description	Unit Description	Participating Contract-PBP "A" [LIST ID]	Participating Contract-PBP "B" [LIST ID]	Participating Contract-PBP "C" [LIST ID]
Hospice Supplemental Benefits, not including reduced cost-sharing	Number of units (must specify unit type, e.g. days, hours, meals, dollars, etc.) of hospice supplemental benefits that were provided by type of supplemental benefit. Populate the row for the supplemental benefits that were provided and specify the unit description. Benefits should be consistent with the approved proposal. For H – Others, insert additional rows as needed to describe the supplemental benefits and the reporting units.				
	A – home and bathroom safety devices				
	B – OTC benefits				
	C – Support for care givers				
	D - Meals				
	E – Transportation				
	F – Pest control				

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[3] Please use the "2021 VBID Hospice Summary_Level_Information_Worksheet_04132021.xlsx" workbook as a template for the submission.

[4] Please refer to 2021 VBID Model Monitoring Guidelines' WHP Monitoring Worksheet for WHP reporting.

Metric	Metric Description	Unit Description	Participating Contract-PBP "A" [LIST ID]	Participating Contract-PBP "B" [LIST ID]	Participating Contract-PBP "C" [LIST ID]
Hospice Supplemental Benefits, not including reduced cost-sharing (cont.)	G – Room and Board				
	H – Others, Describe				
Beneficiary Appeals and Grievances	Number of total Hospice Benefit Component-related grievances (may relate to non-hospice palliative care, transitional concurrent care, hospice care, unrelated care and post-hospice live discharge care)				
	Number of total Hospice Benefit Component-related appeals (may relate to non-hospice palliative care, transitional concurrent care, hospice care, unrelated care and post-hospice live discharge care)				
	Number appeals related only to hospice care[5]				
Hospice Provider Complaints and Disputes[6]	Total number of hospice provider complaints and disputes				
Timeliness of Claims and Payments	Percent of all (in-network and out-of-network) hospice clean claims paid within 30 days				
	Percent of all other (in-network and out-of-network) hospice claims that are not "clean" as defined in 42 CFR 422.500 and paid within 60 days				

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[5] As described in the CY 2021 Hospice Benefit Component Technical Guidance, CMS expects that organization determinations related to hospice care should be rare. Similarly, CMS expects that appeals related to hospice care should be rare as well.

[6] Providers should note that they may also email CMS directly at VBID@cms.hhs.gov with any complaints or issues to aid monitoring efforts.

Metric	Metric Description	Unit Description	Participating Contract-PBP "A" [LIST ID]	Participating Contract-PBP "B" [LIST ID]	Participating Contract-PBP "C" [LIST ID]
Timeliness of Claims and Payments (cont.)	Percent of claims related to the Hospice Benefit Component subject to prepayment and/or postpayment review	▨			

Survey Questions

The following list represents a sample of questions CMS may ask of participating MAOs during implementation check-in calls:

- What quality improvement activities is your organization conducting related to non-hospice palliative care and to hospice care?
- Please provide an overview of how an enrollee and his/her providers (hospice and non-hospice) would interact with your pre-hospice consultation program.
- How does your pre-hospice consultation program ensure timely access to high-quality hospice care?
- How do you define a high-quality hospice provider? A low-quality hospice provider?
- What, if any, changes have you made to the targeting criteria for non-hospice palliative and/or transitional concurrent care that were detailed in your application?
- How does your organization work with enrollees to ensure access to out-of-network hospice where requested?
- What are the primary reasons for enrollees discontinuing transitional concurrent care (after electing hospice)?
- As applicable, what hospice supplemental benefits have been most valued by enrollees and/or their caregivers? If you did not offer hospice supplemental benefits, are there other supplemental benefits that have been most valued by enrollees and/or their caregivers during a hospice stay?
- Are there any differences in timeliness of claims payments between in and out-of-network hospice providers? In receiving Notices of Elections (NOEs) and/or Notices of Termination/Revocation (NOTRs)?

Appendix 3: Hospice Provider Network File

*SSA State/County Code	Facility Name	CCN (CMS Certification Number)	Street Address	City	State	ZIP Code	Date of Network Inclusion	Date of Removal from Network *(if applicable)*

*SSA State/County Code can be found in Health Service Delivery (HSD) files here: https://www.cms.gov/files/document/hsd2020referencefileupdated2020-06-11.xlsx

Appendix 4: Narrative Descriptions of the Transparency and Monitoring Measures

Building on section 2.5 of the CY 2021 VBID Hospice RFA, Appendix 4 is intended to provide additional detail on the transparency and monitoring measures contained in this document, in order to demonstrate how each measure contributes to a robust monitoring approach for the Hospice Benefit Component of the VBID Model. For questions on the measures, contact VBID@cms.hhs.gov.

I. Palliative Care and Goals of Care Experience

Within the domain, “Palliative Care and Goals of Care Experience,” CMS will monitor the impact of the Hospice Benefit Component on how participating MAOs, hospice providers, and other providers focus on the provision of appropriate and timely non-hospice palliative care services for enrollees with serious illness (who are either not eligible for hospice or are hospice-eligible but have chosen not to elect hospice). The Model will monitor performance in the below measures to (1) verify that enrollees’ goals of care are captured over time to reflect changes in the plan of care; (2) verify enrollees have access to and use palliative care services as appropriate and as described in the Approved Proposal; and (3) evaluate whether furnishing non-hospice palliative care and opportunities to discuss and explore enrollees’ care goals affect if and when enrollees elect hospice.

A. Development of Advance Care Plans (ACPs) and WHP

In alignment with the VBID Model’s required WHP component, participating MAOs must develop systems to improve the offer of ACP for enrollees with serious illness. ACP promotes patient choice by providing an opportunity for patients to discuss preferences with their provider 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 2021 VBID Monitoring Guidelines for WHP summary-level reporting.

B. 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 work with participating MAOs to capture 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 cost sharing for palliative care services, total cost for palliative care 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 agnostic regarding hospice election.

C. 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 their 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. 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 their death. Results will be grounded in the context of geographic variations.

II. Enrollee Experience and Care Coordination at End of Life

CMS is testing different service delivery approaches with the goal of improving 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. The Model will monitor the below measures to understand and monitor overall enrollee experience and care coordination at end of life:

A. 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 regulations that provide continuous home care services as needed with the goal of maintaining the patient in the home and the general inpatient (GIP) level of care only for temporary crises that cannot be managed at home.

At the end of life, and consistent across different demographics and regions, most enrollees prioritize spending days at home rather than at health care facilities. Research has used days at home in the last six months of life as a patient-centered measure calculated using administrative data. Thus, when this measure is finalized, CMS expects to 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).

B. 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. Among all enrollees who die (not just those who elect hospice), CMS will monitor the proportion of enrollees admitted to ICUs in the final 30 days of life. 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 a part of coordinated and patient-centered care changes the types and levels of care received by enrollees at the end of life.

III. 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 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, 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:

A. Pre-Hospice Consultation Process

In CY 2021, MAOs are encouraged to implement a voluntary consultation process aimed at engaging enrollees in understanding their care choices and both in-network and out-of-network hospice provider options prior to their accessing an out-of-network hospice. In implementing any type of consultation service, MAOs must ensure the experience takes the form of a high-touch care manager accessible by phone and other means available 24/7 to all enrollees and serviced in a way that is clear, immediately available, culturally competent, and knowledgeable about the hospice benefit and choices.

If this optional process is utilized, MAOs will be required to submit descriptions of the consultation process. CMS will also seek beneficiary level data to compare “Consult to Care” time for those who eventually seek care from both in-network and out-of-network hospices, which could highlight its benefits or identify issues with a participant MAO’s pre-hospice consultation process.

B. Availability of and Access to Hospice Providers

CMS will monitor the availability of and access to in-network hospice providers. MAOs will be required to submit a list of in-network providers three times per year. The format of this list (included in Appendix 3) is an adapted version of the HSD tables the participating MAO submits to CMS for general program network monitoring in order to reduce burden on the participating MAO and align with existing program requirements for network monitoring. While CMS has not established network adequacy requirements for hospice providers for Phase 3 of the Hospice Benefit Component, this monitoring intends to help inform the development of network adequacy requirements and identify any situations in which an enrollee may be unduly limited in in-network hospice provider choices.

C. Proportion of Lengths of Stay beyond 180 Days

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

D. 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.

E. 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).

F. 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.

G. Hospice Supplemental Benefits

Consistent with the overall VBID Model, participating MAOs may offer a broad set of mandatory supplemental benefits to enrollees who elect hospice (called “hospice supplemental benefits” under the Model) in addition to mandatory supplemental benefits offered to all enrollees in the MA plan. 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.

CMS will monitor access and use of hospice supplemental benefits through two methods. One, CMS will request beneficiary-level data on utilization of each hospice supplemental benefit identified by a participating MAO and any information detailing beneficiary-level reductions in cost sharing for necessary care received during a hospice stay. Two, CMS will also request summary level data to understand the number of units of each hospice supplemental benefit provided to hospice enrollees.

H. 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.

I. Unrelated Care Utilization

CMS will monitor participating MAOs' encounter data, as well as beneficiary-level data reported by the plan, 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, this measure is an important payment safeguard as the hospice capitation payment rates paid under this Model reflect a combined payment rate of related and unrelated spending as detailed in the CY 2021 Final Hospice Capitation Payment Rate Actuarial Methodology.[7]

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. CMS intends to compare this utilization against that in-network, out-of-network, and Original Medicare FFS. CMS will also monitor beneficiary payment amount for the cost-sharing of services unrelated to beneficiary's terminal illness or related conditions provided during a hospice election period, including Part A inpatient services, Part B outpatient services, professional provider services and durable medical equipment (DME) services.

As noted in section 1, MAOs participating in this Model must submit as accurate and complete encounter data as possible in their usual encounter data submissions so that this Model's monitoring and evaluation have the benefit of those data. In relation to unrelated care specifically, within encounter data, MAOs must include standard reporting on dates of service, diagnosis codes, procedure codes, and provider NPI.

J. Hospice Utilization

In order to understand the impact of the Model on hospice utilization, CMS will monitor the number of total hospice enrollees, admission by day of month, average and median service days by level of

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[7] View the CY 2021 Final Hospice Capitation Payment Rate Actuarial Methodology at the following link: https://innovation.cms.gov/media/document/cy-2021-final-hospice-capitation-payment-rate-actuarial-methodology-paper-pdf-0

care, length of stay (median and average) by terminal condition, age, race and eligibility-status (aged, disabled, ESRD, dually eligible for Medicaid)), and the amount of Routine Home Care that is delivered in Assisted Living Facilities, Nursing Facilities, and Skilled Nursing Facilities.

K. Appeals and Grievances Processes

The Hospice Benefit Component represents a new coverage arrangement that may result in experiences for the hospice enrollees of participating MAOs that differ from those of prior hospice enrollees. While CMS anticipates that the Hospice Benefit Component will create a seamless care experience for enrollees, CMS will monitor to ensure that enrollees do not experience unintended consequences of this new coverage structure. CMS plans to track beneficiary complaints through CMS data sources, as noted above, as well as through plan-reported summary level data on appeals and grievances that would supplement existing Part C and D reporting data on organization determinations, appeals, and grievances.

L. Provider Complaints and Disputes

CMS believes the Hospice Benefit Component will foster robust communication and coordination between providers and participating MAOs. CMS intends to monitor for any unintended impacts on providers. In addition to the close monitoring of beneficiary complaints noted above, CMS plans to track complaints from hospice providers as well. Appeals and grievances related to beneficiary care or coverage will be distinguished from complaints from hospice providers in the domain of the complaint—all appeals or grievances, whether submitted by a beneficiary or by a provider on behalf of a beneficiary, should be considered beneficiary appeals and grievances if they are relating to the beneficiary's coverage or services received. All other complaints or disputes received by the plan from providers relating to, for example, timeliness of payment, contracting, discrimination, or other concerns should be considered provider complaints or disputes for the purposes of reporting. CMS will quantitatively and qualitatively evaluate complaints and appeals. This information will be collected at a summary level by CMS from participating MAOs.

Providers with concerns relating to the Hospice Benefit Component should submit those complaints or issues to the mailbox at VBID@cms.hhs.gov.

M. Delivery of Transitional Concurrent Care

CMS is allowing MAOs to offer innovative, individualized transitional concurrent care services to help more patients access and receive the full benefits of hospice care. Examples of types of concurrent care include but are not limited to chemotherapy, heart failure treatment, HIV treatment, blood transfusions, radiation therapy, hemodialysis and COPD treatment. 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 evaluate the utilization of transitional concurrent care, CMS will monitor the number of beneficiaries receiving transitional concurrent care and compare against demographics including race, age, gender, terminal diagnoses and eligibility status (i.e. aged, disabled, ESRD, dually eligible for Medicaid). CMS will monitor and review the types of transitional concurrent care delivered, beneficiary cost-sharing for Transitional Concurrent Care services, total cost of Transitional Concurrent Care services and the mean and median duration of transitional concurrent care. This will be collected in beneficiary-level and summary-level plan reporting from participating MAOs.