Frequently Asked Questions

Hospice Benefit Component of the Value-Based Insurance Design Model

Updated March 30, 2021

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Key Acronyms

Acronym	Meaning
ANOC	Annual Notice of Change
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARC	Claims Adjustment Reason Code
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DDE	Direct Data Entry
DTRR	Daily Transaction Reply Report
EOC	Evidence of Coverage
EMR	Electronic Medical Record
IRE	Independent Review Entity
HIS	Hospice Item Set
HIPAA	Health Insurance Portability and Accountability Act
HETS	HIPAA Eligibility Transaction System
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MAO	Medicare Advantage Organization
NOE	Notice of Election
PBP	Plan Benefit Package
RARC	Remittance Advice Remark Code
RFA	Request for Applications
SIA	Service Intensity Add-on
VBID	Value-Based Insurance Design

Background

This document provides answers to frequently asked questions (FAQs) regarding the implementation of the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model's Hospice Benefit Component ("Model"), which started in Calendar Year (CY) 2021. Information in this FAQ document serves to help provide further transparency and clarity on requirements and flexibilities of the Model, based on questions raised by MA Organizations (MAOs) participating in the Model, hospice providers, and other stakeholders. Further guidance on the Model can be found in the following documents:

- CY2021 VBID Hospice Benefit Component Technical and Operational Guidance, subsequently referred to as "CY2021 Technical and Operational Guidance," here: https://innovation.cms.gov/media/document/vbid-hospice-technical-guidance-cy2021,
- CY2021 VBID Hospice Benefit Component Request for Applications (RFA), here: https://innovation.cms.gov/files/x/vbid-hospice-rfa2021.pdf;
- CY2021 VBID Hospice Benefit Component Monitoring Guidelines, here: https://innovation.cms.gov/media/document/cy21-vbid-hospice-benefit-component-monitoring-guidelines; and
- VBID Hospice Benefit Component Overview webpages, here: https://innovation.cms.gov/innovation-models/vbid-hospice-benefit-overview.

MAOs, hospice providers, and others are encouraged to email VBID@cms.hhs.gov directly with any additional questions on the Model.

Billing and Claims Processing Questions for Providers

1. **How does a hospice provider bill for hospice services under the Model?**
   Under the Model, how a hospice provider bills depends on whether the hospice provider has a contract with the MA plan participating in the Model ("participating MA plan"). If a hospice provider has a contract, that hospice provider must follow the requirements for billing and payment agreed to in its contract with the participating MA plan. If a hospice provider does not have a contract (otherwise known as an "out-of-network" hospice provider), then the hospice provider can bill the participating MA plan in the same way that it bills its Medicare Administrative Contractor (MAC) for hospice care. Regardless of contractual status with the MA plan, hospice providers must send all claims and notices for enrollees in a participating MA plan to its MAC. There is more information on billing and payment for hospice services in the Medicare Claims Processing Manual, Chapter 11. Participating MA plans may have similar requirements for timely submission of notices and claims. CMS encourages hospice providers to reach out to the MA plans that are participating in the Model.

2. **What are the Notice of Election (NOE) timely submission requirements to the MAC and to the participating MA plan?**
   The hospice provider must submit the NOE within five days of hospice election to its MAC and should submit the NOE within five days of hospice election to the hospice enrollee's MA plan, unless the MA plan has communicated a longer timeframe for NOE timely submission requirements (42 CFR 418.24(a)(2)).

3. **What method will participating MA plans use to accept NOEs?**
   Participating MA plans will establish their policies and procedures for accepting NOEs. CMS has posted MA plan-provided information on the VBID-Hospice Benefit Component webpages (linked above; online here: https://innovation.cms.gov/innovation-models/vbid-hospice-benefit-participating-plans) and will continue to provide updates to this webpage as a resource.

4. **Some hospices use CMS Direct Data Entry (DDE) for NOEs. Will participating MA plans get NOE data from DDE?**
   Hospice providers should plan to send their NOEs to participating MA plans directly and should contact the participating MA plan to confirm how this information should be submitted. In order to effectively coordinate care, participating MA plans need to have this information from hospice providers.

5. **Are plans required to collect copies of the NOE and the Certification of Terminal Illness from hospice providers? Is the Certification of Terminal Illness part of the NOE?**
   The NOE must be submitted by the hospice to their MAC within 5 days of an enrollee's hospice election (42 CFR 418.24(a)(2)). The participating MA plan has the option to require submission of the NOE within 5 days as well; this will allow the participating MA plan to coordinate care, as the enrollee's hospice election may not show up on the Daily Transaction Reply Report (DTRR) until 22-23 days after their election. Neither the Election Statement nor the Certification of Terminal Illness is required to be submitted to the participating MA plan (or CMS). Only the hospice provider keeps the Election Statement and Certification of Terminal Illness on file, but as part of a participating MA plan's prepayment or postpayment review strategies, a participating MA plan may request to see/review the Election Statement and/or Certification of Terminal Illness. The Certification of Terminal Illness is not part of the NOE.

6. **Does a participating MA plan begin paying for hospice services on the effective date of the hospice election by the member? Is this the date that the NOE is filed?**
   As long as the hospice submits claims and notices in alignment with Chapter 11 of the Medicare Claims Processing Manual or their contract with the participating MA plan (if applicable), payment for hospice services for an enrollee is made based on the effective date of the hospice election (42 CFR 418.302(d)(1)). Hospice care may begin prior to the filing of an NOE. Participating MA plans may include similar timely filing requirements for hospice providers stated in 42 CFR 418.24 and described in further guidance within the Medicare Claims Processing Manual, Ch. 11.

7. **If a hospice provider fails to file the NOE within five calendar days after the effective date of hospice election, will the participating MA plan be allowed to deny payment from the effective date of election to the date of filing of the NOE?**
   Consistent with the CY2021 Technical and Operational Guidance, participating MA plans may include timely filing requirements that track those in Chapter 11 of the Medicare Claims Processing Manual, including requirement of a timely NOE filing. Pursuant to 42 CFR 418.24(a)(3), when a hospice does not file the required NOE for its Medicare enrollees within 5 calendar days after the effective date of election, Medicare will not cover and pay for days of hospice care from the effective date of election to the date of filing of the NOE. These days are a provider liability, and the provider may not bill the beneficiary for them.

8. **Can notices and claims be submitted to the participating MA plan and MAC at the same time, or do hospice providers need to wait for the MAC denial before submitting to the participating MA plan?**
   Notices and claims can be submitted to the participating MA plan and the MAC at the same time, pending organizational billing capabilities. CMS encourages hospice providers to submit timely notices and claims to participating MA plans and their MAC.

9. **Do the hospice sequential billing rules apply for participating MA plans? For example, must the NOE be clear and settled with the participating MA plan before regular service claims can be submitted?**
   Sequential billing rules still apply for hospice notices and claims submitted to MACs. With regard to claims from and payments to contract hospice providers, the participating MA plan and the hospice provider may agree to other terms so long as the MA plan complies with 42 CFR 422.520 regarding prompt payments. For non-contracted hospice providers, the participating MA plan must ensure that total payments for Medicare-covered hospice services are what the hospice provider would receive from the Medicare FFS program, consistent with section 1852(a)(2) of the Act and 42 CFR 422.100(b) (See also § 422.214). The participating MA plan may elect to adopt less strict rules than used in the Medicare FFS program for non-contracted providers regarding sequential billing.

10. **What will CMS do if payments from participating MA plans are delayed?**
    As included in section 7 of the CY2021 Technical and Operational Guidance, participating MA plans are required to meet all timely payment requirements outlined in MA regulations and guidance. MA regulations at 42 CFR 422.520 define the following four specific prompt payment requirements:

    1. MA plans must pay 95 percent of the clean claims submitted by an out-of-network provider within 30 days of receipt;
    2. MA plans have a statutory requirement to pay interest on clean claims that are not paid within 30 days;
    3. Claims from a non-contracted provider that are not clean must either be paid or denied within 60 calendar days from the date of the request; and
    4. Although the timelines for payment by MA plans to contracted providers are as determined by the contract between the MA plan and the provider, that contract must contain a prompt payment provision which specifies in detail how the MA plan will pay its contracted providers.

    Violations of these requirements as well as other input and feedback should be submitted to CMS at VBID@cms.hhs.gov.

11. **If a hospice is paid by a participating MA plan independently of their claims to the MAC, what will prevent hospices from only billing to the participating MA plan?**
    CMS and the participating MA plans will be reconciling hospice data on a quarterly basis. If a hospice provider sends claims to a participating MA plan for payment, but does not bill their MAC, CMS systems will not appropriately pay the participating MA plan for services provided on behalf of its hospice enrollees. Given this concern, CMS has included in the CY2021 Technical and Operational Guidance the option for participating MA plans to implement a prepayment strategy under which hospice providers that routinely do not submit notices or claims to Medicare must submit their remittance codes from their respective MACs to the participating MA plan *prior to receiving payment from the MA plan*. This would result in delays in payment to the hospice provider. For purposes of this Model, hospice claims that are submitted only to the participating

MA plan and not to the MAC as well are not clean claims subject to the prompt payment provision in § 422.520.

12. **How will the participating MA plans handle Service Intensity Add-On (SIA) payments for the month prior to an enrollee's death? Currently MACs automatically adjust those claims.**
All participating MA plans are aware of the requirement to make payments to out-of-network hospice providers as Original Medicare would make them, including the SIA payments. If a hospice provider is an in-network provider, this (along with any other payment arrangements) should be outlined in its contractual agreement with a participating MA plan.

13. **Do payments involved with participating in this program count towards hospices' inpatient or aggregate caps?**
Payments made to hospice providers by participating MA plans for care provided to the plan's enrollees do not count towards the Original Medicare inpatient or aggregate cap calculations for hospice providers. CMS will closely monitor the length of stay in hospice overall and the extent to which hospice providers are furnishing hospice inpatient care (general inpatient care (GIP) and inpatient respite care (IRC)) as part of a robust monitoring strategy.

14. **If an enrollee of a participating MA plan revokes or is discharged alive after electing hospice before 1/1/2021, and then he/she is readmitted after 1/1/2021, do hospice providers bill both the participating MA plan and MAC for hospice services furnished after 1/1/2021 or just the MAC as during the first election?**
In order to be covered under the Model, a hospice enrollee in a participating MA plan must elect to receive hospice care on or after 1/1/2021. If the enrollee of a participating MA plan revokes the election of hospice care and then re-elects to receive hospice care on or after 1/1/2021, the new hospice election is covered under the Model. The hospice provider should bill both the participating MA plan and the MAC for any services provided under the new hospice election. The hospice election that began in 2020 (prior to 1/1/2021) is not covered under the Model and the hospice provider should bill only the MAC for this hospice election.

15. **Will enrollees of a participating MA plan who elected hospice prior to the start of the Model (before 1/1/2021) continue to receive their Hospice benefit through Original Medicare?**
If an enrollee in a participating MA plan elects hospice prior to 1/1/2021, that enrollee's hospice care continues to be covered by Original Medicare even after the start of the Model. If an enrollee of a participating MA plan elects hospice on or after 1/1/2021, he/she is covered under the Model, and their care will be paid for by their plan, rather than Original Medicare.

16. **Whom should a hospice provider contact with questions about an enrollee's MA plan eligibility and billing under the Model?**
If a hospice provider has questions about an enrollee's MA plan eligibility and billing for hospice services furnished to an MA enrollee in a participating MA plan, contact the participating MA plan to confirm an enrollee's coverage with that plan and the process for billing.

Hospice Benefit

17. What benefits are offered under the Model? Does the Model require plans to cover the full Medicare Part A hospice benefit?

Participating MA plans must offer the full Medicare Part A hospice benefit, as set out under Original Medicare and listed at section 1861(dd)(1) of the Social Security Act, and may not "unbundle" any of the services that are part of the Medicare hospice benefit. In addition to covering Medicare Part A hospice services, participating MA plans must also have and implement a strategy for furnishing and covering non-hospice comprehensive palliative care services and transitional concurrent care services, which are intended to provide broader access to non-hospice palliative care as well as ease the transition to hospice for enrollees. Participating MA plans may also offer hospice supplemental benefits that are part of a CMS-approved bid, including additional coverage for room and board, transportation, home modifications, and more. MA plans may also offer cost-sharing below Original Medicare for drugs and biologicals or inpatient respite care that are part of a CMS-approved bid.

18. Do participating MA plans include the same Medicare benefits (other than hospice care) as other MA plans?

Participating MA plans must cover all Original Medicare Part A and Part B benefits (subject to limited exclusions such as for the cost of kidney acquisitions) the same way that other MA plans must cover those benefits. Participating MA plans, like other MA plans, may have slightly different supplemental benefits and cost sharing, so it is important to read all benefit information carefully to understand what supplemental benefits each plan includes. This information can be found in the plan's Evidence of Coverage (EOC).

19. What is transitional concurrent care?

The term "Transitional Concurrent Care" means clinically appropriate continuing care needs related to the treatment of Hospice Enrollees' terminal conditions. To ease care transitions and ensure that hospice-eligible enrollees face a less stark transition and choice between foregoing either curative or hospice care, as part of the Model, participating MA plans must work with their in-network hospice providers, as well as in-network 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. This is referred to as transitional concurrent care; transitional concurrent care strategies must be approved by CMS. More details on transitional concurrent care can be found in the CY2022 VBID Hospice Benefit Component RFA, section 2.3

20. Are in-network hospice providers' comprehensive assessments supposed to include transitional concurrent care services?

To clarify, the waiver of § 1812(d)(2) of the Act and § 418.24(d)(2) to permit the provision of concurrent curative care to an enrollee who has elected hospice is limited to transitional concurrent care services furnished by in-network providers for enrollees of a participating MA plan. So, if a hospice provider is not in-network with a participating MA plan, the hospice provider's process for completing comprehensive assessments and establishing plans of care should not change (see 42 CFR 418.54). If a hospice provider is in-network with a participating MA plan and providing transitional concurrent care, this should be considered as part of the initial assessment for a hospice enrollee, included as part of the enrollee's plan of care, and updated throughout the enrollee's care as needed.

21. Will enrollees' cost sharing be different under the Model compared to Original FFS Medicare?
Participating MA plans may not charge higher cost sharing for hospice services provided in- or out-of-network than those levels permitted under Original Medicare during Phase 1 and Phase 2 of the Model.[1] Participating MA plans are permitted to offer lower cost sharing than is found in Original Medicare for services, items, and/or medications received in connection with the hospice benefit and may offer additional supplemental benefits, provided the structure and supplemental benefits have been approved by CMS in a properly submitted plan bid in June of the year preceding the contract year in which benefits are provided. Note that generally there are relatively small cost sharing amounts for hospice care under Original Medicare pursuant to section 1813 of the Act.

22. Under Original Medicare, the enrollee's Medicare Part D plan provides payment for some drugs. Is this the same under the Model?
Coverage of Part D drugs and furnishing the Part D benefit will not change for an enrollee in a participating MA plan. When a Part D enrollee enters hospice, their Part D plan will provide coverage for drugs unrelated to the enrollee's terminal illness or related conditions during a hospice election, while the hospice provider covers drugs related to the enrollee's terminal illness and related conditions, in alignment with requirements to cover these drugs as part of the hospice benefit at 42 CFR 418.202(f).

23. Currently, the Medicare hospice benefit includes coverage for some physician services. Is this the same under the Model?
Consistent with the scope of Part A coverage of hospice services, participating MA plans must provide payment for services provided by the hospice enrollee's designated attending physician, in addition to the daily hospice payment rates. Beneficiaries may receive direct patient care services that are reasonable and necessary for the palliation and management of the terminal illness and related conditions from an independent designated attending physician (not employed by the hospice). Payment may not be made for volunteer services. More details can be found in section 7 of the CY2021 Technical and Operational Guidance.

24. What is a pre-hospice consultation process?
For CY2021, some participating MA plans may offer their enrollees with serious illness a CMS-approved voluntary pre-hospice consultation process aimed at engaging enrollees in understanding their care choices. This pre-hospice consultation process may be with a case manager or other member of a hospice or palliative care team to help an enrollee learn more about their hospice options and benefits. CMS pre-hospice consultation process guidelines can be found in section 4 of the CY2021 Technical and Operational Guidance.

25. Do all aspects of the Explanation of Benefits, Addendums, and hospice Conditions of Participation remain the same?
The hospice Conditions of Participation for Medicare remain the same under the Model. The content requirements for the hospice election statement and hospice election statement addendum for hospice care in regulations at section 42 CFR 418.24(c) are not changed by the Model. However, as explained in the CY2021 Technical and Operational Guidance, CMS permits participating MA plans to work with their in-network hospice providers to consider adding a

[1] During Phase 1 and Phase 2 of the Model, participating MA plans must cover hospice services furnished to their enrollees by out-of-network hospice providers, and provide payment for these services at Original Medicare rates. More detail on the network phases of the Model can be found in the CY2022 VBID Hospice Benefit Component RFA, section 2.6.

separate addendum to the hospice election statement detailing services, items, and drugs that the enrollee may receive as part of transitional concurrent care benefits offered under the Model.

Under the Model, as with other benefits provided by the plan, the participating MA plan should only provide enrollees with an Explanation of Benefits if there is claims activity to report, and enrollees have financial liability for those claims in alignment with existing CMS guidance.

26. If a Medicare covered service is not related to treatment of the terminal illness and related conditions, and is furnished during a hospice election period, how should such a service be billed by the rendering provider under the Model?

Any covered Medicare services not related to the treatment of the enrollee's terminal illness and related conditions, and which are furnished during a hospice election period, ("unrelated care") may be billed to the participating MA plan by the rendering provider using professional or institutional claims for non-hospice Medicare payment.

In a situation where an enrollee receives unrelated care without complying with the plan rules, an enrollee may be financially responsible for the unrelated care received consistent with MA regulations (e.g., participating MA plans are still financially responsible for emergency services and urgently needed services regardless of whether services are obtained within or outside the plan's authorized service area and/or network (if applicable) and/or there is prior authorization for the services). Consequently, given the potential impact on enrollees, it is important that hospice providers and participating MA plans communicate with each other and enrollees and their caregivers. Due to the difference between coverage of unrelated care provided outside the Model, as outlined in the Medicare Managed Care Manual, Chapter 4, section 10.4, and coverage of unrelated care under the Model, participating MA plans must inform enrollees of their coverage rules for unrelated care. CMS also recommends that participating MA plans 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.

27. Will hospice room and board charges be submitted to participating MA plans?

Hospice room and board charges for beneficiaries are not paid by Original Medicare, except for general inpatient care and up to five days of inpatient respite care, as applicable (see 42 CFR 418.302). Outside these circumstances, room and board charges while a beneficiary is in hospice are the responsibility of the enrollee or, if the member qualifies for Medicaid, the State Medicaid Agency. This is still the case under the Model.

Participating MA plans have the option to voluntarily cover additional services or items for their enrollees as hospice supplemental benefits if approved as part of their proposal for the Model, which could, for example, include room and board for hospice enrollees. A hospice provider should contact the participating MA plan to understand any supplemental benefits that may be covered for their enrollees.

MA Plan Enrollment Changes

28. Do enrollees choose MA over Original Medicare, or are they automatically enrolled in MA instead of Original Medicare?

The MA program gives Medicare beneficiaries the option of receiving benefits from private MA plans rather than from the Original FFS Medicare program. Medicare beneficiaries can choose to

enroll in an MA plan, and enrollment is limited to certain times, such as the Annual Enrollment Period. Beneficiaries who do not elect to enroll in an MA plan are generally default enrolled into the Original FFS Medicare program. More information is available in the annual Medicare & You booklet about enrollment and coverage options for Medicare beneficiaries and at Medicare.gov. In the MA program outside of the Model, an enrollee who elects hospice will have Part A and Part B benefits, including hospice, covered by the Original Medicare FFS program but will remain enrolled in the MA plan with coverage of supplemental benefits.

Participating MA plans are required to follow all MA rules that aren't waived under the Model, which means that any beneficiary in a participating MA plan must choose to enroll in that MA plan, and only in those cases can the participating MA plan cover hospice services for that enrollee.

29. **Can Medicare beneficiaries enrolled in participating MA plans opt out of the Model?**
Medicare beneficiaries enrolled in a participating MA plan cannot 'opt out' of the Model and may not choose to receive their hospice services through Original Medicare while remaining in their MA plan. However, enrollees may choose to switch from a participating MA plan to an MA plan that is not participating if the beneficiary qualifies for a special enrollment period. Please note that all current Medicare enrollment rules apply.

30. **Can enrollees choose to join the Model?**
The Model is designed so that MA plans apply for and participate in the Model. Enrollees who are not enrolled in a participating MA plan cannot choose to join the Model without enrolling in a participating MA plan. Enrollees interested in the Model may be able to enroll in a participating MA plan in order to receive Model benefits during the annual coordinated election period or during a special enrollment period; all current Medicare enrollment rules for MA plans apply.

31. **What happens if an enrollee switches to another MA plan that is also participating in the Model during a hospice election? Is a new NOE needed?**
If an enrollee switches plans during a hospice election, coverage for that enrollee's care depends on his/her current enrollment. If an enrollee in a participating MA plan switched to a another participating MA plan, the enrollee's hospice coverage would be provided by the first participating MA plan until the expiration of the enrollee's coverage with that plan, and then would be covered by the second participating MA plan after the new coverage started. A new NOE is only needed if the enrollee is discharged from hospice or revokes the election of hospice services and then re-elects hospice care (see 42 CFR 418.24(f)). Read more details in the CY2021 Technical and Operational Guidance, section 3.

32. **If a hospice enrollee is enrolled in a participating MA plan, and then chooses to switch to an MA plan that does not participate in the Model, who would the hospice provider bill after the enrollee has switched plans?**
If an enrollee switches out of a participating MA plan to an MA plan that does not participate in the Model, either during open enrollment or during a special election period, his/her hospice coverage aligns with the plan with which they are actively enrolled. For example, if a hospice enrollee in a participating MA plan makes an enrollment request for a non-participating MA plan on 12/5/2021 for a start date of 1/1/2021 that enrollee's hospice care would continue to be covered by the participating MA plan until 1/1/2021. On and after 1/1/2021, existing MA rules (i.e., outside the Model) would apply, and the enrollee's hospice care would be paid by the Original Medicare

program in alignment with existing, non-Model rules and regulations. Read more details in the CY2021 Technical and Operational Guidance, section 3.

Contracting, Networks, and Appeals

33. Can a participating MA plan require prior authorization for hospice services?

No, participating MA plans cannot require prior authorization for hospice election, a change hospice level of care, or hospice services. This prohibition applies to hospice services furnished by an in-network provider and by an out-of-network provider. Participating MA plans may implement pre- or postpayment review strategies in alignment with current MAC policies and procedures, in order to reduce risk of beneficiary harm or program integrity concerns. More detail on organization determinations in the Model can be found in section 8 of the CY2021 Technical and Operational Guidance.

34. Can a participating MA plan require prior authorization for non-hospice services (e.g., non-hospice palliative care)?

Participating MA plans can require prior authorization, medical review, or apply other plan rules (e.g. network rules) to non-hospice services, even for an enrollee who is currently in hospice care. However, PPO plans and PFFS plans may not require prior authorization for plan services obtained from non-contracted providers (other plan rules apply). For questions on a participating MA plan's rules, a hospice provider should contact that plan.

35. Who handles the appeals process for hospice care under the Model?

Appeals and grievances regarding hospice care will be addressed using the existing appeals and grievances processes for the MA program, with the exception of immediate reviews of a termination of hospice service which are addressed in the next Q&As.

Appeals are generally about denials of coverage or payment. For complaints or concerns about other things associated with the MA plan, an enrollee can file a grievance with the MA plan. The MA appeals process is handled in multiple stages. The first level of appeal is an appeal to (or request for reconsideration by) the participating MA plan; if the MA plan makes a decision that is adverse (in whole or in part) to the enrollee, the case is automatically reviewed by an Independent Review Entity (IRE) that can support or reverse the decision of the MA plan. If an enrollee is dissatisfied with the IRE's decision and the amount in controversy exceeds a threshold set under the Medicare statute, the enrollee can request additional appeals to an Administrative Law Judge, the Medicare Appeals Council or review by a federal court.

More information on the appeals and grievances processes for MA plans can be found at 42 CFR 422, Medicare.gov, and https://www.cms.gov/medicare/appeals-and-grievances/mmcag.

Compliance by MA plans with coverage and appeal requirements are periodically audited by CMS.

36. Does a hospice enrollee in a participating MA plan have the right to review a hospice discharge decision by a Quality Improvement Organization (QIO)?

Yes, hospice enrollees in a participating MA plan have the right to immediate review (also called a "fast appeal" or "fast review") of a hospice discharge decision by a QIO. The hospice provider must deliver a Notice of Medicare Non-Coverage (NOMNC) to hospice enrollees prior to termination of hospice services, which provides details on how to request review by a QIO.

37. Can a hospice provider provide an Advance Beneficiary Notice of Noncoverage (ABN) under the Model?

The ABN used in the Original Medicare program is not applicable to the MA program and is not appropriate for use by a participating MA plan with respect to its enrollees. Participating MA plans must follow the process for issuing a notice of a denial of coverage in accordance with 42 CFR 422.568 and 422.572. For additional guidance, including a copy of the denial notice and its accompanying instructions, see the MA Denial Notices webpage: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.

38. Does an MA plan have to contract with Medicare-certified hospice providers under the Model?

Under 42 CFR 422.204(b), a participating MA plan may contract only with Medicare-certified hospice providers to furnish the Medicare Part A hospice benefit but is not required to contract with all Medicare-certified hospice providers in the MA plan's service area. CMS does not assume the role of arbitrating or judging the bona fides of contract negotiations between an MA plan and available providers. Participating MA plans must provide access to a network of hospice providers that meet all Medicare requirements for furnishing hospice care and have participation agreements with Medicare, pursuant to 42 CFR 422.204(b)(3). Participating MA plans must comply with the requirements for all MA plans to have written policies and procedures for the selection and evaluation of providers that furnish covered services under § 422.204 and the requirements for participation procedures for health care providers under § 422.202. Additionally, consistent with MA program requirements in 42 CFR 422, subpart E regarding MA plan relationships with providers, participating MA plans must be responsive to hospice providers' outreach to them with requests to participate in a participating MA plan's hospice network or to enter into a contracting process with the participating MA plan.

Participating MA plans are permitted to decline to include a hospice provider or group of hospice providers in its networks, but must furnish written notice to the affected provider(s) of the reason for the decision.

39. Participating MA plans are required to work with out-of-network providers during Phases 1 & 2. What about Phase 3? And when might Phase 3 happen?

The earliest that Phase 3 would be implemented is CY2023. CMS is seeking comment on network design and the definition of network adequacy standards for Phase 3. CMS wants to hear any feedback regarding (1) whether a minimum hospice provider ratio is the appropriate metric or if there is a more appropriate access metric; (2) how to develop the minimum hospice provider ratios in each county or service area; (3) how the quality and types of care a hospice provider traditionally has provided should apply in setting a network adequacy requirements; and (4) considerations for continuing to allow for broad access. CMS also will be soliciting comments via a variety of different channels. Comments can be submitted to CMS at VBID@cms.hhs.gov.

40. Will hospice providers be required to complete the participating MA plan's credentialing requirements? Will this be a condition for payment?

A hospice provider does not need to be credentialed with an MAO or any of its participating MA plans to receive payment as an out-of-network provider from that MAO. A hospice provider only needs to submit a valid NOE and clean claims in alignment with Original Medicare billing methodology.

41. Is there any guidance on rates of reimbursement for in-network hospice providers?
The reimbursement rate for an in-network hospice provider is determined based on the agreed upon contract between that provider and the participating MA plan. The rate paid to an in-network provider may or may not be aligned with Original Medicare rates. CMS is prohibited by section 1854(a)(6) of the Act and 42 CFR 422.256(a)(2) from requiring MA plans to use a particular price structure for payment under a contract between the MA plan and health care provider, with the exception of payments to Federally Qualified Health Centers as set forth at § 422.316.

42. Will there be any risk-sharing for in-network providers based on quality or other metrics?
This depends on a hospice provider's contract and relationship with the participating MA plan. The Model provides opportunity for hospice providers to build these kinds of relationships with participating MA plans.

Communication between Hospice Providers and Participating MA Plans

43. Will hospices within the service area of participating MA plans receive information from CMS?
In late November 2020, CMS sent a letter and provider checklist to all hospices with a service area that overlapped with the service area(s) of one or more participating MA plans for CY2021. This mailing provided information on the plans in the area, billing processes, and how to check for enrollment under the Model. CMS Regional Offices additionally reached out to state hospice, palliative care and other medical societies and groups to ensure broader reach of this information. In addition, CMS has held national and state-based webinars to disseminate information further and published provider friendly webpages on its VBID Model website, including contact information for participating MA plans, links to other resources, and answers to common questions about billing, coverage, and participation under the Model.

44. Are participating MA plans required to communicate with or conduct outreach to hospice providers in their service area(s)?
The CY2021 Technical and Operational Guidance requires participating MA plans to communicate their participation in the Model to hospice providers in their service area(s). This requirement is intended to help inform hospice providers in the impacted areas. While CMS has provided online resources and mailed letters, CMS recognizes that participating MA plans know their service areas and their own operations best, and this communication to both in- and out-of-network providers can help establish working relationships and raise awareness about the Model and the MA plans' participation.

45. If hospice providers have reached out to the points of contact identified for participating MA plans at the organizational level on the VBID Hospice Benefit Component Participating Plan webpage but have not heard back, what should they do?
Each participating MAO has several points of contact listed on the VBID Hospice Benefit Component Participating Plan webpage and the directory so a hospice provider may want to check to confirm that it is reaching out to the right point of contact for the question that it has—for example, claims and billing questions should go to a claims and billing or hospice network contact. Some of these contacts have been updated since being originally posted, as well, so a hospice provider could check back to see if there is a new point of contact. If a week or two has gone by and a hospice provider has not received a response or any outreach from the participating MAO, please contact CMS at VBID@cms.hhs.gov. CMS will conduct outreach to the MAO to (1) make

them aware of the outreach and (2) verify the right contact information up on the VBID Model website.

46. **Do participating MA plans need to include out-of-network hospice providers in their provider directory? How will enrollees know that they can see an out-of-network provider?**
Out-of-network hospice providers do not need to be included in a participating MA plan's provider directory, but as required by 42 CFR 422.320, MA plans must inform enrollees about the availability of hospice care (in a manner that objectively presents all available hospice providers, including a statement of any ownership interest in a hospice held by the MAO or a related entity) if a Medicare-certified hospice program is located within the plan's service area or it is common practice to refer enrollees to hospice programs outside that area. In addition, participating MA plans should, as described in section 4 of the CY2021 Technical and Operational Guidance, inform enrollees that they have the option to use an out-of-network hospice provider to furnish covered hospice services.

47. **How will enrollees know if they would have hospice benefits provided by their MA plan instead of through Original Medicare?**
For enrollees receiving coverage of hospice benefits from a participating MA plan for CY2021, their EOC and Annual Notice of Change (ANOC) provides details on hospice coverage, as well as coverage for palliative care, transitional concurrent care, and any hospice supplemental benefits. Enrollees can also contact their MA plan with any questions.

48. **Can an enrollee see if an MA plan covers the Model through Medicare Plan Finder?**
Information about the Model is not available on Medicare Plan Finder. Enrollees or others who have questions about hospice coverage should check the plan's EOC and ANOC to determine if the plan covers hospice services.

Quality

49. **How will CMS monitor quality under the Model?**
CMS has established a robust monitoring plan to ensure quality under the Model component. This plan, as well as reporting specifications for Model participants, is described in the CY2021 VBID Hospice Benefit Component Monitoring Guidelines, released in December 2020 and available on the VBID Model website.

50. **Are hospice enrollees in participating MA plans included in data submitted for the Hospice Item Set (HIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice survey?**
Existing hospice data reporting requirements for hospice providers are not changed or affected by the Model. Hospice providers must submit HIS, CAHPS, and other required data, including data on enrollees receiving coverage under the Model, as they would normally submit this data (see 42 CFR 418.312).

Plan Participation

51. Is this going live nationwide? Are all MA plans participating?
The Model is voluntary; as such, eligible MAOs have to apply and be approved to participate by CMS. Nine MAOs are participating in the Hospice Benefit Component for CY2021, with 53 plan benefit packages in select parts of 13 states and Puerto Rico.

52. Is a listing of participating MA plans available for CY2021?
A list of the participating MA plans for CY2021 is available here: https://innovation.cms.gov/media/document/vbid-cy2021-hoospice-contact-info-geo. This contains contract identification information, the PBP number, service area and contact information for the participating MA plans. Please note that this is a complete list of all plans participating for CY2021, but it may change for subsequent years of the Model.

53. How will a hospice provider determine in an enrollee is enrolled in a participating MA plan?
Here is how to determine if an enrollee is enrolled in a participating MA plan:

STEP ONE: Confirm the enrollee's Medicare eligibility and check for MA enrollment. If the enrollee shows an MA enrollment card, move to Step 2. If the enrollee shows a Medicare card with a Medicare Beneficiary Identifier, use any of the following online tools or services to check for MA enrollment: MAC Portal, MAC Interactive Voice Response (IVR) System, Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS), or Billing agencies, clearinghouses or software vendors.

STEP TWO: If the enrollee is in an MA plan and the hospice election date is on or after January 1, identify the MA contract number and plan benefit package identification information on the MA enrollment card or by using one of the online tools or services in Step 1.

It will look like this: H#######. For example, H1234-001.

Reminder: Check the effective and termination dates to ensure the enrollee's enrollment in the participating MA plan is for 2021.

STEP THREE: Compare the enrollee's plan information to the list of plans participating in the Model. If their plan is part of the Model, follow the directions here submitting claims.

54. If a parent organization that operates in multiple areas is participating, are all of its plans participating?
No. Just because an MA plan that is part of a large MAO participates in the Model does not mean that all of the MA plans for that MAO are participating.

55. If a hospice provider does not see their service area listed on the VBID Model webpage, how quickly will additional states be added?
The participating MA plans listed on the VBID Model webpage are the only MA plans that are participating for CY2021. CMS announced that the Model will be accepting applications for additional plans to participate in CY2022, so additional states and service areas may be added depending on the MAOs and MA plans that apply and are approved by CMS for CY2022.

56. Will the Model be offered in CY2022?
Yes, CMS intends that the Model will continue to be offered in CY2022.

57. Can hospices apply to participate in the Model?

No. As described in section 3.1 of the CY2022 VBID Hospice Benefit Component RFA, participation in the Model is open to eligible MAOs at the individual PBP level. Hospice providers interested in being involved with the Model can partner with their local MAOs. CMS suggests hospice providers reach out to MA plans to demonstrate interest in collaboration; the directory for MA plans can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Plan-Directory.

58. If there is no participating MA plan in a hospice provider's service area, can that hospice provider still be impacted by the Model?

If a hospice provider is not in the service area of a participating MA plan, a hospice provider will likely experience little to no impact from the Model in CY2021 in comparison to hospice providers providing hospice care in the service areas of participating MA plans. A hospice provider does not need to reach out to contract with a participating MA plan if it does not provide care in that participating MA plan's service area.

In the event that a hospice-eligible enrollee travels temporarily outside their service area (which could even mean outside his/her home state) and elects hospice care, the participating MA plan will cover Part A hospice care received at a rate equal to the Original Medicare rate for hospice services, even those provided out-of-area and out-of-network. A hospice provider should plan to check its enrollees' Medicare enrollment and coverage, and identify whether they are enrolled in a participating MA plan, prior to providing services or billing its MAC on or after 1/1/2021.