Value-Based Insurance Design Model: Hospice Benefit Component

Calendar Year 2021
Technical and Operational Guidance

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1. Background and General Information

Beginning January 1, 2021, through the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model ("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 in the Medicare Advantage (MA) program, with the goal of creating a seamless care continuum for MA enrollees who elect hospice. For MA organizations (MAOs) that volunteer to be part of the Hospice Benefit Component ("Model-participating MAOs"), CMS will evaluate the impact on cost and quality of care for MA enrollees, including how the Model improves quality and timely access to the Medicare hospice benefit, and the enabling of innovation through fostering partnerships between Model-participating MAOs and hospice providers. The Hospice Benefit Component of the VBID Model provides opportunities for Model-participating MAOs to partner with hospice providers in their respective service areas and develop creative contracting arrangements and processes to help coordinate and provide for the care of their enrollees with serious illness.

This document serves as supplemental technical guidance for Model-participating MAOs and Medicare-certified hospice providers ("hospice providers") on CMS requirements based on existing regulations and CMS guidance and common practices regarding Model-participating MAOs' responsibility for payment of services and continuity of care in enrollee coverage change scenarios, the voluntary consultation process, strategies on transitions from palliative care to hospice care, hospice provider limitations to ensure beneficiary safety, Model-related MA payment guidance for out-of-network payments related to the Model, Model-related appeals and grievances, other operational guidance on billing, and details around hospice capitation payment operations.

CMS encourages Model-participating MAOs to work with both in- and out-of-network hospice providers in their respective service areas to improve the care experience for enrollees of Model-participating MAOs ("enrollees") and their caregivers and family members. Model-participating MAOs working in concert with their local hospice providers can proactively address common operational issues leading to a more streamlined and successful process for hospice providers and Model-participating MAOs. Overall, strong communication and collaboration between hospice providers and Model-participating MAOs will ultimately benefit enrollees, their families and caregivers.

This guidance will be reviewed on an annual basis to identify needed changes and updates as the Model progresses. Additional guidance on the Hospice Benefit Component is provided in other Model documents, including the CY2021 VBID Hospice Benefit Component Request for Applications ("CY2021 VBID Hospice RFA"), the CY2021 VBID Communications and Marketing Guidelines, and the CY2021 VBID Monitoring Guidelines.

MAOs, hospice providers, and others are encouraged to email VBID@cms.hhs.gov directly with their questions on this technical and operational guidance.

Capitalized terms not otherwise defined in this CY2021 Technical and Operational Guidance for the Hospice Benefit Component of the VBID Model have the meaning provided in the CY2021 Addendum to the Medicare Managed Care Contract for Participation in the MA VBID Model ("CY2021 Addendum").

Definitions

Discharge from Hospice occurs as a result of one of the following: (1) an enrollee decides to revoke the hospice benefit ("revocation"); (2) the enrollee transfers to another hospice provider; (3) the enrollee dies; (4) the enrollee moves out of the geographic area that the hospice provider defines in its policies as its service area; (5) the enrollee's condition improves and he/she is no longer considered terminally ill; or (6) under extraordinary circumstances, a discharge for cause occurs in which a hospice provider is unable to provide hospice care to an enrollee (e.g., including issues where the safety of the enrollee or hospice staff is compromised). A live discharge means a discharge from hospice prior to an enrollee's death. Of note, once a hospice provider chooses to admit an enrollee, it may not automatically or routinely discharge the enrollee at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State requirements. The election of the hospice benefit is the enrollee's choice rather than the hospice provider's (or Model-participating MAO's) choice, and the hospice provider (or Model-participating MAO) cannot revoke the enrollee's election. The hospice provider or Model-participating MAO cannot request or demand that the enrollee revoke his/her election. See 42 CFR 418.26 and 418.28 and the Medicare Benefit Policy Manual, Chapter (Ch.) 9, section 20.2.3.

Enrollee as used in this document means the beneficiary enrolled in a Model-participating plan of a Model-participating MAO, unless otherwise specified in context.

Model-participating MAO refers to a MAO participating in the Hospice Benefit Component of the VBID Model. Participation in the Hospice Benefit Component is voluntary and open for participation to MAOs at the individual Plan Benefit Package (PBP) level. MAOs may propose one or multiple MA and Medicare Advantage-Prescription Drug (MA-PD) plans for participation for the Hospice Benefit Component in CY2021 and/or CY2022 and must include all segments within a PBP.

Model-participating plan refers to a PBP chosen by a Model-participating MAO for participation in the Hospice Benefit Component of the VBID Model.

Non-hospice care consists of two parts: (1) non-hospice care provided to a hospice enrollee during a hospice stay. This reflects the items, drugs, or services that are furnished to treat a condition that is unrelated to the terminal illness and related conditions; and (2) other non-hospice care (items, drugs, or services) that is furnished after a hospice stay ends (in the event of a live discharge, including non-hospice care provided on the last day of the stay and through the end of the calendar month in which the hospice stay ends).[1]

[1] Costs associated with drugs paid under the pharmaceutical benefit (Part D) are not reflected in the development of hospice capitation payment rates. For more information on the actuarial methodology, refer to the CY2021 Hospice Capitation Payment Rate Actuarial Methodology here: https://innovation.cms.gov/media/document/cy-2021-final-hospice-capitation-payment-rate-actuarial-methodology-paper-pdf-0

2. Executive Summary

This guidance provides information on technical and operational aspects of the implementation of the Hospice Benefit Component for both Model-participating MAOs and hospice providers located in their service areas. The intention of this guidance is to help ensure the implementation of the Hospice Benefit Component meets to goals of the Model to test the full Medicare hospice benefit as a covered benefit via Model-participating MAOs while creating a coordinated, seamless care experience for enrollees with serious illness, with an emphasis on beneficiary safety, choice and value. This guidance relies on existing policies and procedures where appropriate and aims to encourage program integrity and collaboration between Model-participating MAOs and hospice providers.

One important area of guidance for hospice providers that is fundamental to meeting Model goals is around billing and claims processing procedures. In order to streamline billing and claims processing procedures under the Model and to ensure timely payment for both Model-participating MAOs and hospice providers, CMS is leveraging existing billing and claims processing procedures. Details for the following requirements around claims processing, prompt-payment standards and communications between Model-participating MAOs and hospice providers can be found in sections 7-9.

Notices and Claims: Notices of Election (NOE) and Notices of Termination/Revocation (NOTR) and all hospice claims must be submitted (1) to the Medicare contractor for informational purposes, monitoring and evaluation (irrespective of network status), and (2) to Model-participating plans for Model-participating plans to make timely payment to hospice providers (in the case of in-network hospice providers, if in alignment with contractual agreements). After hospice providers submit claims for hospice services to their Medicare contractor, they can expect to receive a Claim Adjustment Reason Code for a non-covered charge, with the Remittance Advice Remark Code that no payment issued under FFS Medicare as patient has elected managed care. Of importance, Model-participating MAOs must allow hospice providers to submit claims and notices using the same methodology and forms used to submit claims and notices to their Medicare contractor under Original Medicare. It is the responsibility of the Model-participating MAO to ensure that out-of-network payments are made for services provided to hospice enrollees, as applicable, at least at Original Medicare rates. CMS encourages Model-participating MAOs to process hospice claims as outlined in Ch. 11 of the Medicare Claims Processing Manual to streamline claims processing and ensure timely payment.

Prompt-Payment Standards: Model-participating MAOs must comply with prompt payment standards for in-network and out-of-network hospice providers (see 42 CFR 422.520). This means that Model-participating MAOs must follow the prompt pay provisions established in their contracts with providers and pay providers under the terms of those contracts (see 42 CFR 422.520(b)(1) and (2)). This also means that for out-of-network hospice providers, Model-participating MAOs must pay all clean claims from a hospice provider in accordance with Original Medicare payment rates within 30 days of receipt.

Communications: Model-participating MAOs must communicate actively with all hospice providers in their service areas. Hospice providers should similarly conduct outreach to Model-participating MAOs and identify where to send claims and who to contact if they have any issues or concerns by conducting outreach to the MAOs participating in their service area. CMS has shared points of contact for each Model-participating MAO on the VBID Model webpage, located at https://innovation.cms.gov/innovation-models/vbid. Hospice providers may also contact CMS at VBID@cms.hhs.gov for assistance and technical support.

3. Guidance around Enrollment and Coverage Changes

This section provides guidance to Model-participating MAOs regarding enrollment and coverage change scenarios that may arise and potentially impact the following areas: (a) an enrollee's hospice coverage under the VBID Model; (b) coverage the Model-participating plan is required to provide during these changes aligned with existing regulation at 42 CFR 422, subpart B;[2] and (c) applicable CMS payment to Model-participating MAOs for enrollee coverage during these changes. No eligibility or enrollment regulations or requirements are waived under the Model so those provisions continue to apply; changes in enrollment are only permitted in accordance with 42 CFR 422. This guidance addresses how those program rules apply in the context of the Hospice Benefit Component of the Model. Three types of changes are addressed in this section: (1) enrollment changes requested by the beneficiary ("enrollment changes" or "enrollee-driven requests"); (2) MAO decisions to terminate from the Model ("MAO-driven changes"); and (3) CMS terminations of a Model-participating MAO from the Model ("CMS terminations"). When addressing such changes in this guidance, key principles include protecting beneficiary choice, minimizing disruption during coverage transitions, and ensuring continuity of care.

Enrollment Changes

During a hospice election period that starts on or after January 1, 2021, under certain circumstances (primarily the Annual Election Period (AEP) or Special Election Periods (SEPs)), enrollees in Model-participating MAOs may make a variety of enrollment changes, including discontinuing enrollment in their MA plan and enrolling in Original Medicare or switching from one MA plan to another MA plan (that may or may not be participating in the Hospice Benefit Component). Currently, based on CMS analyses, scenarios wherein a hospice enrollee changes his/her coverage are very rare (less than a percent likelihood). During an available and applicable election period, beneficiaries who have elected hospice, while enrolled in a plan of an MAO that does not participate in the Hospice Benefit Component ("non-participating MAO") or in Original Medicare, may also switch to a Model-participating plan. All of these changes are enrollee-driven requests or enrollment changes.

In order to preserve a beneficiary's choice, when a hospice enrollee of a Model-participating plan ("hospice enrollee") requests a change in his or her current plan election, the Model-participating MAO must continue providing payment for all services, including both hospice and non-hospice care, until the enrollee's coverage with the Model-participating plan ends, which generally would be at the end of the month in which the enrollee made the enrollment change request.[3] On the first day of the month of the hospice enrollee's new coverage, responsibility for payment for services depends on the enrollee's new coverage choice. Three scenarios around enrollee-driven requests that happen during 2021 using an enrollment period where coverage is effective the first of the month after the election is made are described below, followed by a summary of coverage responsibility for each scenario.

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[2] Note: All program rules and standards for coverage responsibilities continue to apply unless waived for Model-participating MAOs; this section illustrates how those existing regulations apply in the context of the Hospice Benefit Component.

[3] In a situation where an enrollee makes an election during the AEP, the election, or change in election, is effective on the first day of the following calendar year, pursuant to 42 CFR 422.68.

Scenario #1: If the hospice enrollee chooses to enroll in another participating plan ("new participating plan") and is still in an active hospice election, the enrollee's hospice and non-hospice care is covered by the new Model-participating MAO starting on the first of the month of the enrollee's new coverage with new Model-participating plan. The new Model-participating MAO will also cover Part D drugs (if included as part of the plan benefit package), transitional concurrent care, and hospice and other supplemental benefits, as applicable and aligned with its offerings, which may be different from what the hospice enrollee received originally. The goal is to minimize disruption to the enrollee's hospice care. Since the enrollee is continuing his or her hospice election, the hospice capitation payment will be at a Month 2+ rate.[4]

Scenario #2: Under circumstances where a hospice enrollee chooses to switch from a Model-participating plan to a non-participating plan and is still in an active hospice election, rules at § 422.320 apply for the non-participating MAO, starting the first of the month following the enrollee's enrollment request. In these scenarios, any transitional concurrent care and hospice supplemental benefits would be discontinued starting the first of the month following the enrollee's enrollment request. Additional guidance is available in the Medicare Managed Care Manual (MMCM) Ch. 4.

Scenario #3: If the hospice enrollee chooses to discontinue enrollment in a Model-participating plan and enroll in Original Medicare, and is still in an active hospice election, all covered services under Original Medicare for the enrollee will be paid under the FFS Medicare program and under Part D as appropriate starting on the first of the month following the enrollee's enrollment request.

In the first scenario described above, where a transition occurs between two Model-participating MAOs, both Model-participating MAOs should be mindful of the need for coordination and continuity of care during the transition period. Both Model-participating MAOs must also comply, beginning January 1, 2022, with 42 CFR 422.119(f), added by the final rule titled, "Interoperability and Patient Access final rule."[5] This regulation requires MAOs to send and receive certain enrollee data in an enrollment change situation as requested. Before that date, all MAOs must comply with 42 CFR 422.112(b)(4), which requires MAOs to have procedures to ensure that the MAO and its provider network have the information required for effective and continuous patient care and quality review.

In the second scenario, it is the responsibility of both the Model-participating MAO and the MAO offering the hospice enrollee's new MA plan to comply with 42 CFR 422.119(f) beginning January 1, 2022. Before that date, all MAOs must comply with 42 CFR 422.112(b)(4), which requires MAOs to have procedures to ensure that the MAO and its provider network have the information required for effective and continuous patient care and quality review. In the second and third scenario, the Model-participating MAOs should provide documentation to the enrollee, his or her representative and hospice provider as needed (and in the second scenario described above, the non-participating MAO) to ensure there is a smooth transition without care or billing interruption. Under 42 CFR 422.112(b), MAOs offering coordinated care plans, including Model-participating MAOs, must ensure continuity of care and integration of services through

[4] See the CY2021 Final Hospice Capitation Payment Rate Actuarial Methodology for more detail on the payment rate actuarial methodology for the Hospice Benefit Component of the Model here: https://innovation.cms.gov/media/document/cy-2021-final-hospice-capitation-payment-rate-actuarial-methodology-paper-pdf-0

[5] For reference, the Interoperability and Patient Access final rule can be found here: https://www.cms.gov/files/document/cms-9115-f.pdf.

arrangements with contracted providers, including policies that specify under what circumstances services are coordinated and the methods for coordination that include specific items listed in the regulation. Model-participating MAOs should ensure that such policies include notifying the enrollee's hospice provider and other providers that the enrollee's Model-participating MAO coverage, including for any transitional concurrent care or hospice supplemental benefits, has ended. The enrollee's new non-participating MAO, if applicable, is encouraged to participate actively in the continuity of care process to ensure the enrollee faces no disruptions or barriers to care. In all situations, the enrollee's access to the hospice provider of his or her choice should be maintained without barrier, but there is no guarantee of identical coverage when switching plans.

In addition to the scenarios listed above where an enrollee requests to end coverage with a Model-participating MAO, additional scenarios may occur where a beneficiary who has elected hospice joins a Model-participating MAO. Below are two scenarios where a hospice enrollee makes a change in enrollment during CY2021 using an enrollment period where coverage is effective the first of the month after the election is made:

> *Scenario #4:* A beneficiary in Original Medicare enrolled in hospice may choose to enroll in a Model-participating plan. In this case, Original Medicare payments will be made for the new enrollee's care until MAO coverage begins on the first of the month following the new enrollee's request to enroll in the participating plan. At the start of the enrollee's new coverage with the Model-participating MAO, all hospice and non-hospice services must be covered by the new Model-participating MAO. Payment to the Model-participating MAO will be aligned with existing Model guidance on hospice capitation payments, and will also begin with the start of MA coverage.
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> *Scenario #5:* A hospice enrollee may choose to switch from a non-participating plan to a Model-participating plan. If the new enrollee is in a current hospice election, the rules at 42 CFR 422.320 apply prior to the effective date of the change in enrollment. For additional guidance, see also MMCM Ch. 8, section 70.3 regarding CMS payments to MAOs for enrollees who have elected hospice. When the change in coverage is effective (here, the first of the month following the enrollee's enrollment election), the Model-participating MAO is responsible for coverage and payment for all services (hospice and non-hospice care) provided to its new enrollee. Payment to the Model-participating MAO will be aligned with existing Model guidance on hospice capitation payments, and will also begin when the enrollment in the new plan is effective.

In Scenario #4 and #5, coverage and continuity of care are the responsibility of the new, Model-participating MAO when the enrollment becomes effective. Non-participating MAOs are encouraged to assist with this transition, where possible, and are also required to provide information under 42 CFR 422.119(f) beginning January 1, 2022.

MAO-Driven Changes

Any change in enrollment or coverage for enrollees that is based on a Model-participating MAO terminating participation in the Hospice Benefit Component of the Model is considered to be a MAO-driven change. These enrollment or coverage changes are not requested by the enrollees of the plan, and while infrequent, can have an impact on the benefits in an enrollee's plan and coordination of the enrollees' hospice benefits. MAO-driven changes in enrollment or coverage are also subject to the rules in 42 CFR 422 and may not happen unless specifically authorized by those rules or a provision in the

CY2021 Addendum. In some cases, CMS may use its authority to establish an SEP for enrollees due to exceptional circumstances. See section 1851(e) of the Social Security Act (the Act) and 42 CFR § 422.62(b).

As stated in Article 6 of the CY2021 Addendum, a Model-participating MAO may withdraw a participating plan from the Model test, or cease participating entirely, by providing advance notice to CMS in accordance with the timeframes stated in the CY2021 Addendum. In each case of withdrawal from the Model, Model-participating MAOs are required to provide CMS, by the bid submission deadline each year that precedes the start of the upcoming Plan Year, with a Model termination plan that includes how, what, and when the Model-participating MAO will provide adequate notice to participating enrollees that are impacted by the change. If a Model-participating MAO chooses not to participate in a future year, the Model-participating MAO will propose to CMS a way to ensure enrollees eligible for VBID Model Benefits, which include any supplemental benefits specific to the Hospice Benefit Component, are made aware of any changes to their benefits. For example, this may include a written letter or outbound call to enrollees in addition to notification of the change in the required Annual Notice of Change document. If the MAO is terminating the PBP entirely, the regulations at §§ 422.506 and 422.508 will also apply.

As required in Appendix 3, section 5(D) of the CY2021 Addendum, MAOs previously participating in the Model must continue to cover through discharge, all services of an enrollee who has elected hospice in the prior year in which the MAO was participating through the future year an MAO is not participating, at the cost-sharing applicable under the hospice enrollee's plan when that MAO was participating in the Model. These MAOs may utilize existing hospice provider contracts to provide this continued care to hospice enrollees, but are required to continue to cover out-of-network hospice services for enrollees, as applicable, at Original Medicare rates if the MAO-driven change is implemented during Phase 1 or Phase 2 of the Model. Again, this requirement at Appendix 3, section 5(D) of the CY2021 Addendum is only applicable to MAO-driven changes, and allows for continuity of coverage for those enrollees who elect hospice prior to the effective date of the MAO-driven change.

CMS payment for these enrollees will be made in accordance with the payment structure described within the current plan year Addendum and the current plan year payment methodology. Applicable hospice capitation payments under the Model will be made to the previously Model-participating MAO until the hospice enrollee's death or the first of the month following a live discharge or request for enrollment change made by the enrollee.

CMS Terminations

Pursuant to Appendix 3, section 5 of the CY2021 Addendum, CMS may terminate an MAO's participation in the Model or exercise other available remedies at any time if the MAO, for example, has failed to comply with the terms of the Model, is subject to investigation or sanctions for program integrity issues, or if CMS determines that the organization's participation in the Model, or its performance of Model activities, may compromise the integrity of the Model, including by resulting in lower quality care or adverse outcomes for enrollees or the Model.

In a CMS termination, the Model-participating MAO will be notified of the date after which its Model participation is no longer effective, and after which the Model-participating MAO may not provide payment for hospice care or non-hospice care for enrollees except as required in accordance with 42 CFR 422.320.[6] The Model-participating MAO must provide documentation to the enrollee, his or her representative and hospice provider as needed to ensure a smooth transition without care or billing

[6] Refer to the MMCM Ch. 4, section 10.4 for additional guidance.

interruption. Furthermore, the Model-participating MAO must notify all hospice enrollees, and other enrollees consistent with Article 6 of the CY2021 Addendum of this change. Hospice capitation payments under the Model will end for all hospice enrollees with the month in which the termination date occurred, subject to reconciliation. For enrollees who opt to remain in the plan after termination from the Model, payments made for hospice enrollees to the former Model-participating MAO, as well as the former Model-participating MAO's responsibility for coverage, will be in accordance with 42 CFR 422.320. For enrollees who request an enrollment change, the Model-participating MAO must provide data in accordance with 42 CFR 422.119(f), added by the final rule titled, "Interoperability and Patient Access final rule;" to the enrollee, their treating providers, or the enrollee's new MAO as requested (beginning when the rule becomes effective in 2022).

Model End

The performance years of the Model component are currently scheduled to be CY2021 through CY2024, but CMS may expand or terminate the Model, or Model component, early or in accordance with section 1115A(b)(3) of the Act. If the Model component is expanded, CMS will provide future guidance as applicable and necessary. After the end of the Model, or Model component, as applicable, plans must continue to cover the hospice and non-hospice care of hospice enrollees who have elected hospice prior to the end of the Model as described in Appendix 3, section 5(D) of the CY2021 Addendum. Guidance above on MAO-driven changes related to payment for services and payment from CMS for enrollee coverage is considered applicable in this circumstance.

Applicability of Other Guidance

This guidance does not waive any program rules relating to enrollment as set forth at 42 CFR 422, subpart B. All program guidance, including MMCM Ch. 2 relating to enrollment and disenrollment under MA, MMCM Ch. 3, and the CY2021 VBID Marketing and Communications Guidelines remains applicable to Model-participating MAOs and is not changed by this guidance. All applicable regulations for coverage of prescription drugs under Part D and Coordination of Benefits for Part D drugs as articulated in 42 CFR 423.464 and applicable guidance in Ch. 14 of the Medicare Prescription Drug Benefit Manual also remain applicable.

4. Consultation Process Guidelines

Under Phase 1 of the Hospice Benefit Component of the VBID Model, Model-participating MAOs have the flexibility to create a voluntary consultation process for enrollees who have a terminal illness. While Model-participating MAOs have flexibilities in developing these processes, these processes should be established in a manner that does not create restrictions on an enrollee's hospice provider choice or access to hospice care. It is important to note that in Phases 1 and 2 of the Hospice Benefit Component, enrollees must be able to access hospice care from any Medicare-certified hospice provider, if they wish to do so.[7]

Model-participating MAOs are encouraged to implement a consultation process that is integrated with enrollees' existing providers and provides a personalized, enrollee-focused approach to choosing a hospice provider. This process should help provide enrollees with a coordinated transition into hospice care, in alignment with the intent of the Hospice Benefit Component. Consistent with the CY2021 Addendum, at a minimum, when implementing these consultation processes under Phase 1:

- Model-participating MAOs must ensure that enrollees understand that the consultation process is voluntary and they (or their representative) are not required to elect hospice or choose a particular hospice provider.
- Model-participating MAOs must include as part of the consultation process some language reminding enrollees that they have an out-of-network option, and that the Model-participating MAO will make payments on the enrollee's behalf to an out-of-network hospice provider of the enrollee's choice. Model-participating MAOs are encouraged to inform enrollees that out-of-network hospice providers may choose not to accept the enrollee as a patient, and the Model-participating MAO may offer to work with the out-of-network hospice provider on the enrollee's behalf if the enrollee or his/her representative has trouble communicating with a particular hospice provider or the enrollee needs assistance with his or her coordination of care.
- Model-participating MAOs may not use the consultation process to create a real or implied barrier for enrollees seeking to receive services from an out-of-network hospice provider, including but not limited to the Model-participating MAO requiring additional pre-election or pre-service documentation or written confirmation of the enrollee's choice of hospice provider or creating a prior authorization process.
- Model-participating MAOs may emphasize the value of their network, including the quality of in-network hospice providers or the coordination of those providers with the plan and other network providers who furnish services to the enrollee.
- As applicable, consistent with unwaived MA regulations, plan rules and the Approved Proposal, Model-participating MAOs are required to clarify that hospice supplemental benefits and transitional concurrent care are only available through election of an in-network hospice provider. As required at 42 CFR 422.111, Model-participating MAOs must identify any differences in cost-sharing at in-network hospice providers vs. out-of-network hospice providers, as applicable and in agreement with the Approved Proposal.
- Model-participating MAOs must provide, as applicable, a description of transitional concurrent care that may be made available to enrollees, including the plan's policy regarding payment of transitional

[7] Please note that plans may request to limit payment to providers under certain circumstances; see section 6 for additional guidance.

concurrent care, the enrollee's eligibility for transitional concurrent care services during hospice, and any process for informing providers of the enrollee's hospice election. CMS encourages Model-participating MAOs to provide this information in clinically appropriate setting, e.g., having a physician advise the enrollee regarding the specific services that he or she may be eligible to continue to receive while transitioning to hospice.

- Model-participating MAOs must ensure that enrollees are aware that hospice election is a choice. The Model-participating MAO may not use the consultation process to steer unsure or uninformed enrollees towards or away from hospice care.
- While Model-participating MAOs may emphasize to enrollees the benefits of their coordination with in-network providers, Model-participating MAOs must make a good faith attempt to assist with an enrollee's transition to an out-of-network hospice provider if the enrollee chooses an out-of-network hospice provider.
- Model-participating MAOs must also remind enrollees, as appropriate (e.g., on inquiry), about hospice providers for which the plan will not provide coverage or payment, as applicable and approved by CMS (see section 6), or as required based on the CMS Preclusion List and/or the OIG Exclusion List. Enrollees should be reminded that only hospice providers with Medicare participation agreements may be used (see 42 CFR 422.204(b)(3)). Model-participating MAOs may explain to the enrollee (or his or her representative) why particular hospice providers are excluded from payment in order to provide information that may help to better inform the enrollee's choice of hospice provider.

Model-participating MAOs must meet all requirements related to informing enrollees about hospice care set forth at 42 CFR 422.320(a), including informing enrollees about all area hospice providers and objectively presenting all available hospice providers (and disclosing any ownership interest in a hospice provider held by the Model-participating MAO or a related entity). Model-participating MAOs have the option to either create a separate consultation process or leverage their existing palliative or other serious illness care management programs to provide such a consultation aimed at counseling the individual (and/or caregiver(s) and representatives) regarding hospice and other care options. For example, Model-participating MAOs may include counseling on hospice, hospice provider choices, and other care options including palliative care as part of advance care planning provided through the Model-participating MAO's Wellness and Health Care Planning (WHP) strategy, shared decision-making discussions, or community-based palliative care programs. Counseling may be provided by the beneficiary's individual physician, plan care managers, social workers, discharge planners, or non-physician providers with the goal of assuring that an enrollee and his or her family or caregiver understands options for care.

Given that an enrollee, or his or her representative, may reach out for a consultation independent of the coordinated support within a palliative care or other serious illness care management program, in implementing a consultation process, Model-participating MAOs are encouraged to provide training on the process to any and all providers who may provide care to hospice-eligible enrollees. This training may include, but is not limited to:

- Information on palliative care, transitional concurrent care, hospice care, and, in general, the Hospice Benefit Component of the VBID Model;
- Details on how to refer an eligible enrollee to the consultation process;
- The consultation process, including how the process supports enrollees or their representatives in choosing a hospice provider; and
- Notice that the consultation process is voluntary for the enrollee.

Overall, as described in section 2.6 of the CY2021 VBID Hospice RFA and section 2(E)(3)(ii) of Appendix 3 of the CY2021 Addendum, in implementing any type of consultation process, Model-participating MAOs must ensure services are provided by specially trained staff that are accessible by phone and other means available 24/7 with enhanced standards for average speed of answer and first call resolution, and serviced in a way that is clear, immediately available, culturally competent, and knowledgeable about the Medicare hospice benefit administered through the participating MAO and enrollee choices.

5. Collaborative Coordination Strategies on Transitions from Palliative to Hospice Care

As stated in the CY2021 VBID Hospice RFA, to ease care transitions and ensure that hospice-eligible enrollees do not need to choose between curative or hospice care when considering a hospice election, Model-participating MAOs must work with their network of hospice providers, as well as non-hospice providers, to define and provide a set of concurrent care services related to a hospice enrollee's terminal condition and related conditions that are appropriate to provide on a transitional basis and aligned with an enrollee's wishes, consistent with the Approved Proposal as stated in Appendix 3, section 2(D) of the CY2021 Addendum. In operationalizing transitional concurrent care strategies, CMS provides the below requirements and recommendations in order to meet the Model's goals of increasing transparency, improving shared decision-making, and ensuring enrollees are able to access and experience the full benefits of hospice care, as clinically appropriate and reflective of patients' needs and wishes.

Partnering with Providers on Coordination and Transitions
CMS encourages Model-participating MAOs to collaborate with their network of hospice providers, as well as non-hospice providers (including primary and palliative care providers), on strategies to increase education and outreach efforts to their provider community, and local community more broadly, to improve understanding of how palliative care and transitional concurrent care can help enrollees with serious illness earlier in their disease course and across care transitions, e.g., into hospice care if aligned with enrollee wishes. With the availability of transitional concurrent care, CMS encourages Model-participating MAOs and in-network hospice providers to build relationships with referring providers or other referral sources to raise awareness about transitional concurrent care services and communicate with treating providers, who have been directing the care of enrollees until the point of hospice election, regarding the option of transitional concurrent care that can improve patient care experiences in clinically appropriate situations.

Based on stakeholder input, CMS recommends the following strategies for Model-participating MAOs to build collaboration and coordination across care sites: providing education to network providers to expand overall awareness of advance care planning, palliative care and transitional concurrent care, and developing evidence-based educational materials to help network providers understand the impact of palliative, hospice and transitional concurrent care and the circumstances when transitional concurrent care can be especially helpful. By engaging and educating providers who care for enrollees before hospice, and by cultivating strong partnerships with referring providers and other clinicians involved in enrollees' care, Model-participating MAOs and in-network hospice providers can ensure enrollees and their caregivers understand the available care pathways, including hospice, as well as the use of transitional concurrent care as clinically appropriate. Such coordination and collaboration strategies may help to ensure that all delivered services are complementary, avoid adverse outcomes or unnecessary duplicative treatment, and lead to better patient and caregiver experiences.

Hospice Election Statement
In the Fiscal Year (FY) 2020 hospice proposed rule (84 FR 17589), CMS stated that in order to make an informed choice about whether to receive hospice care, the beneficiary, family, and caregiver must have an understanding of what services are going to be provided by the hospice provider and that, because there is no longer a reasonable expectation for a cure, care should then focus on comfort and quality of life. The services covered under the Medicare hospice benefit are comprehensive such that, upon election, the individual waives all rights to Medicare payment for services related to the treatment of the beneficiary's condition with respect to which a diagnosis of terminal illness has been made, except when provided by the designated hospice provider or attending physician. Because of the significance of this

decision, the beneficiary with terminal illness must elect hospice care in order to receive services under the Medicare hospice benefit. Because the receipt of hospice services under the Medicare hospice benefit is dependent upon the eligible beneficiary electing to receive hospice care, the regulations at § 418.24 provide the requirements of the hospice election statement, as finalized by the FY 2020 hospice final rule (84 FR 38484) and apply in this Model.

With the inclusion of transitional concurrent care under the Model, CMS recommends that Model-participating MAOs work with network hospice providers to modify the hospice election statement as appropriate and aligned with their Approved Proposal to ensure that enrollees who elect hospice and choose an in-network hospice provider, as well as their families and caregivers, understand the clinically-appropriate concurrent care services that may be provided to them on a transitional basis. Hospice enrollees should be fully informed, at the time of hospice admission or throughout the hospice election, of the items, services, and drugs the hospice provider, in coordination with other treating providers including a Model-participating MAO's assigned care manager (as applicable), has determined to be transitional concurrent care. This is necessary information for enrollees, their families and caregivers to make informed care decisions and to anticipate any financial liability associated with transitional concurrent care items, services, and drugs. Not having this information may hinder coverage transparency such that, with enrollees unaware of their financial liability for transitional concurrent care items, services, and drugs while under a hospice election. Two examples of modifications to the hospice election statement related to transitional concurrent care are (1) removal of language around beneficiary acknowledgement that certain Medicare services are waived by the election (as waived in the Model, cited in Appendix 3, section 6(d) the CY2021 Addendum); and (2) an inclusion of a notification of the beneficiary's option to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice provider has determined to be transitional concurrent care, as clinically appropriate and aligned with the beneficiary's preferences and goals of care.

Consistent with (2) above and the Model goal of increasing beneficiary understanding while minimizing confusion, Model-participating MAOs may work with their in-network hospice providers on the inclusion of an election statement addendum specifically addressing the provision of transitional concurrent care items, services and drugs that will be covered by the Model-participating MAO. To increase beneficiary understanding, CMS encourages the following be included in an election statement addendum focused on transitional concurrent care:

1. Name of the hospice provider;
2. Enrollee's name and hospice medical record identifier;
3. Identification of the enrollee's terminal illness and related conditions;
4. A list of the enrollee's current diagnoses/conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs, that will be covered as transitional concurrent care;
5. A written clinical explanation, in plain language the enrollee and his or her representative can understand, as to why the identified conditions, items, services, and drugs are considered appropriate for transitional concurrent care and any associated limitations (e.g., duration, units).[8] This clinical explanation would be accompanied by a general statement that the decision around transitional concurrent care is made for each patient and that the enrollee should share this

[8] When this description of approved or denied (in whole or in part) transitional concurrent care for the individual enrollee represents an organization determination (i.e., a pre-service determination about coverage), it must comply with the applicable requirements in 42 CFR 422, subpart M and 42 CFR 423, subparts M and U.

clinical explanation with other health care providers from which they seek transitional concurrent care services (see also section 8 of this guidance about appeals and grievances);
6. Name of other treating providers who will be providing transitional concurrent care;
7. Information about enrollee cost-sharing for transitional concurrent care services;
8. References to any relevant clinical practice, policy, or coverage guidelines;
9. Information on:
    a. the purpose of an election statement addendum focused on transitional concurrent care; and
    b. the patient's right to Immediate Advocacy; and
10. Name and signature of enrollee (or representative) and date signed, along with a statement that signing this election statement addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily the enrollee's agreement with the hospice provider's determinations.

CMS encourages that such an election statement addendum be focused on transitional concurrent care, separate from the hospice election statement and the hospice election statement addendum titled, *''Patient Notification of Hospice Non-Covered Items, Services, and Drugs,"* be furnished to enrollees, their representatives, non-hospice providers, or the Model-participating MAO where applicable, and that information around transitional concurrent care be regularly communicated within the plan of care. On a related note, CMS recommends that hospice providers share the Patient Notification of Hospice Non-Covered Items, Services, and Drugs with Model-participating MAOs as applicable to arrange for and coordinate needed care consistent with the enrollee's wishes and to aid in minimizing the occurrence of any medically unnecessary unrelated items and services, which will reduce the potential for out-of-network referrals and reduce the extent to which hospice providers may undergo prepayment or other review (see section 8 for additional detail on appeals and grievances).

Plan of Care

While the expectation is that through the Model's focus on WHP and palliative care (and the voluntary consultation process as described in section 4), patient-centered discussions around goals of care will occur often and on a timely basis, CMS understands that some clinical and psychosocial situations may result in a more rapid entry into hospice. That said, discussions around transitional concurrent care must occur as part of establishing an individualized written plan of care. As set out in 42 CFR 418.56, the plan of care must reflect the enrollee's and family's goals based on the problems identified in the initial, comprehensive, and updated comprehensive assessments.

The hospice provider's individualized written plan of care for each hospice enrollee must meet the standards described in 42 CFR 418.56, and in addition should identify services and items specific to delivery of transitional concurrent care, as applicable. This may include: (1) Transitional concurrent care interventions to address continuing care needs, as clinically appropriate, for the treatment of hospice enrollees' terminal conditions; (2) A detailed statement of the scope, frequency and duration of transitional concurrent care services necessary to meet the specific patient and family needs; (3) How transition of concurrent care services will occur (as clinically appropriate) to ensure the enrollee is being informed of these determinations in order to make treatment decisions that best align with his or her preferences and goals of care; (4) Measurable outcomes anticipated from implementing and coordinating the plan of care overall; (5) Transitional concurrent care drugs and treatment necessary to meet enrollee needs; (6) Transitional concurrent care-related medical supplies and appliances necessary to meet the needs of the enrollee; and (7) The interdisciplinary team's documentation of the enrollee's or

representative's level of understanding, involvement, and agreement with the plan of care, including transitional concurrent care, in accordance with the hospice provider's own policies, in the clinical record.

All transitional concurrent care services provided or coordinated by the hospice provider must be in accordance with an enrollee's individualized plan of care that is established and updated by the hospice interdisciplinary group, in consultation with the enrollee's attending physician (if any). It is equally important that any treating physicians (e.g., specialists providing transitional concurrent care services) also be included in the development of the plan of care. A Model-participating MAO's assigned care manager could be directly or indirectly involved as well (if one is assigned). Additionally, CMS recommends that hospice providers share the plan of care and exchange other necessary information with Model-participating MAOs as applicable to aid in coordination of care.

The individualized plan of care is a continually evolving document. As such, CMS continues to require that the plan of care be initiated based upon the information gathered in the enrollee's initial assessment, and the plan of care will be expanded upon, as appropriate, based on the information that is gathered during the comprehensive assessment. Further, CMS requires that the hospice interdisciplinary team (in collaboration with the individual's attending physician and treating specialists providing transitional concurrent care, if any) must review, revise and document the individualized plan as frequently as the enrollees' condition(s) require, including assessment around clinical appropriateness of transitional concurrent care, but no less frequently than every 15 calendar days.

Physician Consultation in Transitional Concurrent Care Medical Policies
Consistent with 42 CFR 422.202(b), Model-participating MAOs must establish a formal mechanism to consult with network providers who have agreed to provide services under the MA plan offered by the organization regarding the organization's medical policy, including around transitional concurrent care, quality assurance/improvement programs and medical management procedures.

As stated in the CY2021 Addendum, as part of providing transitional concurrent care, Model-participating MAOs must establish transparent guidelines and processes for enrollees to access transitional concurrent care through their network providers. Consistent with 42 CFR 422.202, Model-participating MAOs must ensure that the following standards are met in regards to transitional concurrent care:

1. Practice guidelines and utilization management guidelines:
    a. Are based on reasonable medical evidence or a consensus of health care professionals, including hospice providers;
    b. Consider the needs of hospice enrollees;
    c. Are applied consistently to all enrollees;
    d. Are developed in consultation with contracted physicians; and
    e. Are reviewed and updated periodically.
2. The guidelines are communicated to providers, and, as appropriate to enrollees.
3. Decisions with respect to organization determinations, enrollee education, and other areas in which the guidelines apply are consistent with the guidelines.

6. Hospice Provider Limitations to Ensure Beneficiary Safety

As stated in Appendix 3, section 2(E) of the CY2021 Addendum, Model-participating MAOs 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). Furthermore, Model-participating MAOs must offer access and cover all hospice care furnished to their enrollees by either in-network hospice providers or out-of-network (non-contracted) hospice providers. However, beyond the application of the usual limitations on MAOs at 42 CFR 422.222 and 422.224 that prohibit payment to providers on the CMS Preclusion List and OIG Exclusion List, consistent with the Approved Proposal, a Model-participating MAO may request to prohibit access to a hospice provider that presents a risk of harm to enrollees as stated in Appendix 3, section 2(E) of the CY2021 Addendum.

For CY2021, through the VBID Model application process, CMS did not receive any proposals from Model-participating MAOs that identified any hospice providers that presented a risk of harm to enrollees. CMS understands that as Model-participating MAOs gain insights from data and experience developing networks while maintaining broad access to safe hospice care choices in CY2021, Model-participating MAOs may identify hospice providers that present a risk of beneficiary harm. In such circumstances, Model-participating MAOs should submit to CMS through the VBID@cms.hhs.gov mailbox a written justification identifying those providers and documenting allegations of beneficiary abuse, neglect and/or other harm, supporting evidence and any additional information as necessary, for further review by CMS. Information sent by a Model-participating MAO on these hospice providers will be submitted to the Center for Program Integrity (CPI) within CMS and, as applicable, to OIG within HHS, for review and consideration by CPI and investigation by the OIG respectively.[9] These requests may be submitted to CMS at any time throughout the year as needed to prevent beneficiary harm. In instances where there are substantiated or suspicious activities of a hospice provider related to fraud, waste, and abuse, Model-participating MAOs should make a referral to the Inspector General of the HHS or other law enforcement entities directly, pursuant to section 1859 of the Act.

If a hospice provider is added to CMS' Preclusion List and/or is excluded by the OIG, the hospice provider will be precluded and/or excluded from out-of-network payment from all Model-participating MAOs, will not be able to participate in the network of any Model-participating MAO, will be precluded from participation in Medicare, and will be excluded from participation in all Federal health care programs, including Medicare. A Model-participating MAO must deny payments to a precluded and/or excluded provider as described in the relevant regulations. For the CMS Preclusion List, see 42 CFR 422.222 and for the OIG Exclusion List, see 42 CFR 1001, subpart E.

[9] The process for additions to the CMS Preclusion List and OIG Exclusion List are described at 42 CFR 422.222 and 42 CFR 1001, respectively.

7. MA Payment Guidance for Out-of-Network Payments

As described in Appendix 3, section 2(E) of the CY2021 Addendum, Model-participating MAOs must allow enrollees to access out-of-network hospice services, and provide payment for these services.[10] Payment for these services must be made in accordance with section 1852(a)(2) of the Act and 42 CFR 422.214. CMS has issued guidance on the obligation to pay the amounts that providers would receive under Original Medicare payments in the MA Payment Guide for Out-of-Network Payments.[11] The guidance in this section for Model-participating MAOs is based on that existing guidance for out-of-network payments made under the Model, which may be applicable to in-network payments depending on contractual agreements between Model-participating MAOs and network providers. Of importance, Model-participating MAOs must allow providers to submit claims using the same billing methodology and forms used to submit claims to their Medicare contractor for reimbursement under Original Medicare. Hospice providers must submit notices and claims to Model-participating plans for payment, and must still submit notices and claims to its Medicare contractor for informational processing, as detailed in section 9. CMS outlines guidance below in subsection, "Out-of-Network Billing Protections for Hospice Providers" on payment requirements for Model-participating plans in situations where a hospice provider does not file a NOE in a timely manner in CY2021 with a Model-participating plan.

Applicability to In-Network Payments

Except as specified, section 7 does not pertain to in-network agreements between Model-participating MAOs and contracted hospice providers. As described in section 2.7 of the CY2021 VBID Hospice RFA, Model-participating MAOs and hospice providers have the flexibility to create contractual agreements that may or may not align with existing Medicare guidance on payments to hospice providers. In building arrangements with in-network providers, as stated in Appendix 3, section 2(G) of the CY2021 Addendum, Model-participating MAOs are required to ensure that cost-sharing for hospice enrollees does not exceed the amount a beneficiary would pay for the same care outside of the Model. Consistent with 42 CFR 422.504(g)(1), Model-participating MAOs must include certain contract provisions with their in-network hospice providers to ensure no more than the Original Medicare cost sharing for hospice care is charged or collected.

Of note, section 1854(a)(6)(B)(iii) of the Act prohibits CMS from interfering in the payment arrangements between MAOs and contract providers. The statute specifies that CMS "may not require any MA organization to…require a particular price structure for payment under such a contract…" Thus, whether and how these elements might affect a Model-participating MAO's payments to its contracted hospice providers are governed by the terms of the contract between the Model-participating MAO and the hospice provider. CMS notes that Model-participating MAOs must follow the prompt pay provisions established in their contracts with providers and pay providers under the terms of those contracts (see 42 CFR 422.520(b)(1) and (2)).

The below guidance in this section is provided to help Model-participating MAOs in situations under the Model where they are required to pay at least the Original Medicare rate to out-of-network providers. This is a general outline of Medicare payments, and the payment rates described in this section may not necessarily inform Model-participating MAOs' contractual agreements with in-network providers.

[10] Except as limited by approval from CMS in alignment with section 6 of this guidance.

[11] The MA Payment Guide for Out-of-Network Payments can be found here: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.

Billing and Payment for General Hospice Services
Under Original Medicare, Medicare pays Medicare-certified hospice providers a daily rate for each day a beneficiary is enrolled in the hospice benefit in accordance with 42 CFR 418, subpart G. Daily payments are made regardless of the amount of services furnished on a given day and are intended to cover the costs incurred in furnishing services identified in the beneficiary's plan of care, including services provided directly or arranged by the hospice provider. Payments are made based on the level of care required to meet the beneficiary's and family's needs. The levels of hospice care and associated prospectively-determined rate categories include: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP). RHC payments are made at a higher payment rate for the first 60 days of hospice care and a reduced payment rate for hospice care for 61 days and over. Payment for CHC is an hourly rate for care delivered during periods of crisis if care is provided in the home for eight or more hours within a 24-hour period beginning at midnight.

In addition to the per diem RHC rate, a service intensity add-on (SIA) payment is made for services furnished during the last seven days of a patient's life if the following criteria are met: (1) the day is a RHC level of care day; (2) the day occurs during the last seven days of the patient's life, and the beneficiary is discharged due to death; and (3) direct patient care is furnished by a registered nurse or social worker as defined by 42 CFR 418.114(c) and 42 CFR 418.114(b)(3), respectively, that day. The SIA payment is equal to the CHC hourly payment rate multiplied by the amount of direct patient care furnished by a registered nurse or social worker during the seven-day period for a minimum of 15 minutes and up to four hours total per day.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each level of care's base rate has a labor share and a non-labor share. The labor share of the base payment rate is adjusted by the hospice wage index. Base rates are updated annually based on the hospital market basket update. In alignment with sections 1814(i)(5)(A) through (C) of the Act, hospice providers that do not submit quality data to CMS have their market basket percentage update reduced by two percentage points for non-compliance with quality data submission requirements.

Billing and Payment for Hospice Services Provided by a Physician
Payment for physician services provided in conjunction with the hospice benefit is made based on the type of service performed. Payment for administrative and general supervisory hospice services furnished by physicians is included in the hospice per diem rates described above. These activities include establishing, reviewing, and updating plans of care, supervising care, and establishing governing policies. Payment for physicians, nurse practitioners, or physician assistants serving as the attending physician, who provide direct patient care services and who are hospice employees or working under arrangement with the hospice, is made in the following manner:

- Payments are made for services provided by a hospice attending physician (as defined at Medicare Claims Processing Manual, Ch. 11, section 40.1.2) according to the lesser of the billed amount, or 100 percent of the Medicare physician fee schedule for physician services or 85 percent of the fee schedule amount for nurse practitioner or physician assistant services. Of note, this payment is in addition to the daily hospice payment rates.
- No payment is made for volunteer services, and no payment is made to a nurse practitioner for services that can be performed by a registered nurse.
- Beneficiaries may also receive services that are reasonable and necessary related to their terminal illness or condition from an independent attending physician (as defined at Medicare Claims

Processing Manual Ch. 11, section 40.1.3), and these professional services are billed and paid according to the Medicare Physician Fee Schedule under Part B. Payment and deductible rules applicable to each covered service are used to determine payment. Under Phase 1 and 2 of the Model, enrollees must be allowed to choose an attending physician that is out-of-network with the Model-participating MAO, consistent with their ability to choose a hospice provider that is out-of-network, as hospice services provided by an attending physician are considered part of the hospice benefit.

Please see the MA Payment Guide for Out-of-Network Payments for more details on out-of-network payments for physician services here: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.

Please see the Medicare Claims Processing Manual Ch. 11, section 40, for additional detail on billing and payment for hospice services provided by a physician here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf.

Deductible and Coinsurance for the Hospice Benefit
As under Original Medicare, an MA enrollee who has elected hospice has no deductible and is responsible for the following applicable coinsurance amounts, which are relatively small, pursuant to section 1813 of the Act:

1. Coinsurance on outpatient drugs and biologicals: a coinsurance amount equal to 5 percent of the reasonable cost of the drug or biological to the hospice provider, but not more than $5, for each prescription furnished on an outpatient basis. The individual is not liable for any coinsurance for hospice-related drugs or biologicals provided while he or she is receiving general inpatient care or respite care. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances; and
2. Coinsurance on inpatient respite care: a coinsurance amount equal to 5 percent of the national Medicare respite care rate, after adjusting the national rate for local wage differences. The amount of an individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

Caps and Limitations on Hospice Payments (Note: Not Applicable under the Hospice Benefit Component)
Under Original Medicare, hospice providers are subject to two payment caps—one for inpatient care, and another an aggregate payment cap. The number of days of inpatient care a hospice provider furnishes is limited to not more than 20% of total patient care days. The aggregate hospice cap amount limits payments to a hospice provider to the cap amount (updated annually by CMS pursuant to 42 CFR 418.309) times the number of Medicare patients served. Of importance, Model-participating MAOs' enrollees' hospice experience will not be included in either payment cap calculation.

Prompt Payment for Out-of-Network Hospice Providers
Under current regulations for "prompt payments" by MAOs (42 CFR 422.520), Model-participating MAOs must comply with prompt payment standards for out-of-network hospice providers. This means that for out-of-network hospice providers, Model-participating MAOs must pay all clean claims from a hospice provider in accordance with Original Medicare payment rates within 30 days of receipt. Additionally, a hospice claim that is compliant with Original Medicare billing standards, as defined in the Medicare Claims Processing Manual, Ch. 11, must be considered a clean claim as defined at 42 CFR 422.500(b) if such claim has "no defect, impropriety, lack of any required substantiating documentation (consistent with 42 CFR

422.310(d)), or particular circumstance requiring special treatment that prevents timely payment and that otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare."

Other Notes and Resources
Please note that updates on hospice pricing and other Original Medicare pricing can be found online using the below resources. It is the responsibility of the Model-participating MAO to ensure that out-of-network payments are made for services provided to hospice enrollees, as applicable, at Original Medicare rates. Claims processing for these out-of-network payments should be aligned with the process outlined in Ch. 11 of the Medicare Claims Processing Manual, "Processing Hospice Claims."

- Fee schedules can be found on: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.
- Medicare PC Pricers are on: http://www.cms.gov/Medicare/Medicare-Fee-forService-Payment/PCPricer/index.htmlhttps://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/index. They are generally updated quarterly.
- Another important resource for payment policies is https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive. It has a link to a search engine for these articles.
- Another very helpful link for a description of Original Medicare payments is http://www.medpac.gov/. Click on "documents," then "Medicare background," then "payment basics."
- The Medicare manuals and transmittals link is: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals.
- The Internet-Only Manuals (IOMs) link is: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs
- Transmittals can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals
- The Medicare Benefit Policy Manual, Ch. 9, Coverage of Hospice Services under Hospital Insurance can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf
- The Medicare Claims Processing Manual, Ch. 11, Processing Hospice Claims can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf
- The Provider Reimbursement Manual – Part II can be found here https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935
- The National Coverage Determinations (NCD) Manual - Pub. 100-03 can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961

Billing Rules for Hospice Providers
Appendix 3, section 2(E) of the CY2021 Addendum establishes that Model-participating MAOs must cover Hospice Care provided by the out-of-network hospice provider and make payments at the same amount that the hospice provider would receive from Original Medicare for Hospice Care. Aligned with Original Medicare claims processing, Model-participating MAOs 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. For reference, 42 CFR 418.24 states that, "when a hospice does not file the

required Notice of Election for its Medicare patients 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 notice of election. These days are a provider liability, and the provider may not bill the beneficiary for them."

Prepayment or Postpayment Review Related to Hospice Care

In line with OIG's recommendations in 2016 to CMS,[12] Model-participating MAOs may implement appropriate program integrity safeguards in line with the Model-participating MAO's policies and procedures. These policies and procedures should be focused on program integrity safeguards to ensure appropriate Medicare spending and to protect beneficiaries and must not be used to deny access to covered services. These should not be used to create unnecessary burden for hospice providers or impose a barrier to or discourage access to care. In essence, prepayment or postpayment review approaches should match general pre-payment or postpayment review strategies used by Model-participating MAOs. More specifically, CMS expects that these strategies are in accordance with the CY2021 Addendum and is in alignment with how the MACs handle such reviews as referenced below.

CMS strongly recommends that Model-participating MAOs implement prepayment or postpayment review strategies based on overall experience, flagging for review a set of claims that represent a program integrity risk or risk of beneficiary harm based on a pattern or practice of activity (i.e., an identified problem) with a certain provider or provider(s).[13] Another approach is reviewing multiple factors that in concert highlight a program integrity or beneficiary safety issue (e.g., a combination of a pattern of exceeding the aggregate hospice provider cap, a high live discharge rate, a low median length of stay and high average length of stay).

For example, Model-participating MAOs could implement the following prepayment or postpayment review policies (with indicators potentially considered alone or collectively):

- A prepayment or postpayment review strategy to address a hospice provider with a high proportion of unrelated claims to assess whether or not care is being appropriately billed;
- A prepayment or postpayment review to address long lengths of stay (for example, greater than 180 days) to assess whether recertification was appropriate;
- A prepayment or postpayment review strategy to address a pattern of lengthy general inpatient care stays (e.g., an average length of a general inpatient care stay of over six to seven days), which may be indicative of program integrity issues and/or poor quality care in some cases (e.g., if the hospice provider was not able to effectively manage symptoms or medications, leaving enrollees in pain for many days);
- A prepayment or postpayment review strategy to address multiple emergency department or inpatient visits following live discharge to assess whether revocation was a choice made by the enrollee (or representative);

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

[13] This is an important distinction from prior authorization. Prepayment and postpayment review is seen as a program integrity tool focused on an aggregate review. By contrast, prior authorization often involves an occurrence-by-occurrence request for payment authorization prior to an individual service or procedure being provided.

- A prepayment or postpayment review strategy to address high rates of revocation within the first 30 days of a hospice election, suggesting potential issues with explaining the hospice benefit prior to an enrollee's election of hospice;
- A prepayment or postpayment review strategy to address high rates of live discharge; and
- A prepayment or postpayment review strategy to address a billing issue that may occur when a hospice provider has consistently not submitted any notices (e.g., an NOE) and claims to the Medicare contractor for a Model-participating MAO's hospice enrollees, as this will impact a Model-participating MAO's payment from CMS. In these situations, Model-participating MAOs may request that the hospice provider submit documentation, e.g., remittance advice codes received from CMS.

Any prepayment or postpayment review process developed by a Model-participating MAO should be designed in collaboration with appropriately qualified clinical staff (including, where possible, in-network hospice providers), should align with CMS standards for prepayment or postpayment review of claims (as applicable),[14] and should create policies and procedures for prepayment or postpayment review that are standardized and administratively simple. The process can provide opportunities for learning for Model-participating MAOs and hospice providers. That said, Model-participating MAOs may develop prepayment or postpayment review strategies that differ based on the Model-participating MAO's relationship with a particular provider (e.g., may develop policies that differ in application for in-network versus out-of-network providers). One approach recommended by a stakeholder is for Model-participating MAOs to leverage a "gold card" or exclusion program for high-quality hospice providers exempt from any prepayment or postpayment review for a specified period, with review of medical activity on a periodic basis, with some potential for financial reconciliation and emphasis on collaboration and fostering understanding of how clinical standards are being applied. Such an approach may reduce administrative burden for both hospice providers and Model-participating MAOs.

Aligned with guidance set forth in the Medicare Program Integrity Manual, Ch. 3, Model-participating MAOs have the discretion to initiate prepayment and/or postpayment review processes in certain circumstances, and are encouraged to build policies aligned with Medicare Program Integrity Manual (MPIM), Ch. 3, section 3.2.1, which outlines how MACs are to set priorities for prepayment and postpayment review. Model-participating MAOs must complete review of a claim, including all prepayment review, and provide prompt payment within 30 days as specified at 42 CFR 422.520 and in the Medicare Claims Processing Manual, Ch. 1, section 80.2, unless requesting additional documentation from the provider. Claims where additional documentation is needed for review are generally considered other than clean; additional guidance on processing these claims can be found in the Medicare Claims Processing Manual, Ch.1, section 80.3, and additional guidance on requesting documentation can be found in MPIM, Ch. 3.

Decisions made in the context of a prepayment and/or postpayment review may also be subject to the rules on organization determinations in 42 CFR 422, subpart M, and the rules on coverage determinations in 42 CFR 423, subpart M, to extent that the prepayment and/or postpayment review results in a decision that is described in 42 CFR 422.566(b) or 423.566, respectively. As stated above, all organization determinations and appeals related to hospice care must be considered expedited in accordance with 42 CFR 422.570, 42 CFR 422.584, 42 CFR 423.570, and 42 CFR 423.584 in order to ensure enrollees have timely access to needed care. Any prepayment and/or postpayment review determination that effectively

[14] See CMS guidance on prepayment and postpayment review by MACs and Z-PICs in the Medicare Program Integrity Manual, Ch. 3, "Verifying Potential Errors and Taking Corrective Actions," as well as CMS-4182-F for background on MAO prepayment review.

terminates an inpatient service the enrollee was receiving as part of his or her hospice care requires the Model-participating MAO to inform the enrollee as described at 42 CFR 422.624, providing advance written notification of termination of coverage to the enrollee. Model-participating MAOs must also ensure that enrollees impacted by a determination related to prepayment and/or postpayment review have access to a complaint process through a BFCC-QIO, as established at 42 CFR 422.562(a)(2)(ii). If the prepayment and/or postpayment review results in an adverse determination that terminates the enrollee's inpatient coverage, the enrollee has the right to request immediate QIO review as described at 42 CFR 422.622.

Palliative Care outside the Medicare Hospice Benefit

Model-participating MAOs have the flexibility to provide palliative care services that are covered by Medicare Part A or Part B outside their plan's network, if applicable and in alignment with the enrollee's plan of care. Plans that include some out-of-network coverage (i.e., Health Maintenance Organization (HMO) Point-of-Service (POS) and Preferred Provider Organization (PPO)) must provide Original Medicare covered palliative care services in accordance with existing plan network rules. Plans that do not include out-of-network coverage as part of existing plan rules (i.e., HMOs) are not required to cover palliative care services out-of-network, except where required by MA program rules (e.g., 42 CFR 422.100(b), 422.112(a)(3), 422.113).

In April 2018, CMS provided guidance that home-based palliative care services not covered under Original Medicare may be covered as a supplemental benefit.[15] Specifically, this guidance continues to apply to stand-alone services provided to enrollees of Model-participating MAOs with serious illness who are not eligible for hospice services (e.g., stand-alone palliative nursing and social work services in the home not covered by Medicare Part A or Part B). Model-participating MAOs may continue to offer these stand-alone, home-based services that are supplemental to Original Medicare as a supplemental benefit in accordance with existing plan network rules and their CY2021 approved bids.

Transitional Concurrent Care

Section 2.3 of the CY2021 VBID Hospice RFA and Appendix 3, section 2(D) of the CY2021 Addendum identify transitional concurrent care services necessary to address continuing care needs, as clinically appropriate, for the treatment of hospice enrollees' terminal condition, as an important part of the Hospice Benefit Component. For transitional concurrent care specifically, as required by Appendix 3, section 2(D) of the CY2021 Addendum, Model-participating MAOs may only provide coverage for these services when an enrollee chooses an in-network hospice provider, as transitional concurrent care is intended to be provided to the enrollee on a transitional basis in a setting where the enrollee's care can be closely coordinated.

Care Outside the Medicare Hospice Benefit

Model-participating MAOs may follow existing plan rules in regards to out-of-network coverage for any unrelated care. Once an enrollee is discharged from hospice care or revokes, all care received after a live discharge is also immediately subject to existing plan rules.

[15] CMS HPMS Memo. Reinterpretation of "Primarily Health Related" for Supplemental Benefits. April 27, 2018. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27

Balance Billing

Consistent with Medicare rules in section 1852(k)(1) and 1866(a)(1)(O) of the Act, balance billing is not permitted for Medicare-covered services, which includes the hospice and non-hospice Part A and Part B benefits provided under the Model, as all hospice, concurrent care, and palliative care providers are assumed to have accepted assignment when providing care under the Model. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. Additional guidance on Medicare participating and non-participating Medicare providers can be found in MMCM Chs. 4 and 6.

Applicability of Other Guidance

Model-participating MAOs must comply with regulations at 42 CFR 422.100, 42 CFR 422.112, 42 CFR 422.113, and 42 CFR 422.214. All current guidance regarding out-of-network payments included in the MA Payment Guide for Out-of-Network Payments and MMCM Ch. 4 is applicable to Model-participating MAOs except as specifically discussed here. For additional guidance on topics not specifically covered here, including Cost Settlements, Sequestration, the Medicare Coverage Database, and Payment Disputes, please see MMCM Ch. 4 and the most current MA Payment Guide for Out-of-Network Payments.

8. Appeals and Grievances

This section provides guidance to Model-participating MAOs on how to comply with existing regulations set forth at 42 CFR 422 subpart M and 42 CFR 423 subparts M and U on organization determinations, appeals, and grievances in situations in palliative care, hospice care and transitional concurrent care under the Hospice Benefit Component. Guidance in this section is intended to supplement existing guidance in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance[16] regarding timeliness for review of grievances, organization determinations, appeals procedures, and notification to enrollees of their rights and of the Model-participating MAO's determinations as applicable. This guidance does not supersede existing guidance (or regulations) in these areas. This guidance is relevant to care provided both in- and out-of-network, as applicable. The applicability of different parts of 42 CFR 422, subpart M and 42 CFR 423 subparts M and U is summarized in the table below. A decision regarding payment is a decision about coverage for purposes of this guidance.

Table 1. Summary of Applicability of Organization Determinations and Grievances under the Model

Type of Care	Organization Determinations	Grievances	Timeline
Palliative Care Outside the Hospice Benefit	Applicable for all decisions regarding coverage	May be applicable if the MAO receives concerns not related to a coverage decision	Expedited
Hospice Election	Never applicable	Applicable if the MAO receives concerns relating to hospice elections.	Expedited
Transitional Concurrent Care	Applicable for all decisions regarding coverage	May be applicable if the MAO receives concerns not related to a coverage decision	Expedited
Hospice Care	Applicable only to prepayment or postpayment decisions that have impact on coverage. No other organization determinations should be made regarding hospice care.	Primarily applicable for concerns related to hospice care	Expedited
Unrelated Care	Applicable for all decisions regarding coverage	May be applicable if the MAO receives concerns not related to a coverage decision	Expedited
Post-Live Discharge Care	Applicable for all decisions regarding coverage	May be applicable if the MAO receives concerns not related to a coverage decision	Expedited

All organization determinations, grievances, and appeals related to care delivered during a hospice election period (i.e., the overall period between a hospice election and hospice discharge) and post-live discharge (i.e., from the end of the hospice discharge until the first of the following month) must be addressed on an **expedited** basis in accordance with regulations at 42 CFR 422.564, 422.570, 422.584, 423.570, and 423.584 in order to ensure enrollees have timely access to needed care.

Palliative Care Outside the Medicare Hospice Benefit

[16] Please see the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance here: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf.

Enrollees living with serious illness and who have begun a process of progressive and significant decline may benefit from palliative care either prior to their becoming eligible for the Medicare hospice benefit, or, when eligible, their choosing not to elect hospice. Unlike the Medicare hospice benefit, palliative care does not require an enrollee to have a life expectancy of six months or less, and may be provided together with curative treatment at any stage in serious illness. As required by Appendix 3, section 2(C) of the CY2021 Addendum, Model-participating MAOs must develop and implement a strategy regarding access to and delivery of palliative care services for enrollees with serious illness who are either not eligible for or who have chosen not to (or not yet chosen to) receive hospice services. Given flexibility in the clinical application of palliative care, CMS expects that there may be some coverage decisions made by Model-participating MAOs regarding palliative care.

As a result, Model-participating MAO decisions regarding prior authorization of, or payment for, palliative care services are organization determinations as defined at 42 CFR 422.566(b). Model-participating MAOs should provide palliative care as recommended by the enrollee's providers and must ensure palliative care provided is in alignment with their plan-defined criteria for receiving palliative care services as set forth in the Model-participating MAO's CY2021 VBID application or other documentation. Model-participating MAOs must comply with all regulations set forth regarding organization determinations, and as applicable, appeals and grievances under 42 CFR 422, subpart M in the context of palliative care. As described above, organization determinations, grievances, and appeals related to palliative care must also be considered expedited in accordance with 42 CFR 422.564, 422.570, and 422.584. As applicable, Model-participating MAO decisions regarding prior authorizations of payment for Part D drugs associated with palliative care are considered coverage determinations as defined at 42 CFR 423.566 and are subject to expedited review and reconsideration (as applicable) at 42 CFR 423.570 and 42 CFR 423.584.

Hospice Care

As stated in Appendix 3, section 2(G)(iii) of the CY2021 Addendum, Model-participating MAOs cannot require prior authorization or implement other utilization management protocols in connection with the coverage or provision of hospice care (with the exception of prepayment and/or postpayment review strategies, as described below). This is also applicable to hospice services provided by a physician (see 42 CFR 418.304). As a result, in relation to hospice election and hospice care, CMS expects organization/coverage determinations by Model-participating MAOs to be rare (the primary exception should be any decisions associated with prepayment review strategies and post-service payment).

In regard to the voluntary consultation process described in section 4 (prior to hospice election), an enrollee's (or their representative's) expressions of dissatisfaction with respect to the operations, activities or behavior of a plan, or its delegated entity, surrounding the voluntary consultation process must be considered an expedited grievance, subject to the processes outlined at 42 CFR 422.564. Under Phase 1, the consultation process is voluntary for both the Model-participating MAO and the enrollee, and must not result in any organization/coverage determinations.

Hospice elections should represent the decision of a patient and/or caregiver with advice from their providers, and care provided to a Model-participating MAO's enrollee while in hospice is expected to reflect the coordinated, comprehensive care plan developed by the hospice interdisciplinary team, who works with the enrollee, family and caregivers. There should be no organization determinations made regarding hospice elections; organization determinations regarding hospice care should only occur as outlined in this section. Complaints raised by enrollees related to hospice care or hospice elections must be considered expedited grievances, and subject to the processes outlined at 42 CFR 422.564. Model-participating MAOs must also ensure that enrollees have access to a complaint process through a

Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO), as established at 42 CFR 422.562(ii). Enrollees may submit grievances related to hospice elections, hospice care, and other related or unrelated care to either the Model-participating MAO, the BFCC-QIO, or both, as described at 42 CFR 422.564(c).

Transitional Concurrent Care

As described in section 2.3 of the CY2021 VBID Hospice RFA and section 5 of this guidance (and required at 42 CFR 422.202(b) and Appendix 3, section 2(D) of the CY2021 Addendum), Model-participating MAOs are expected to work with their in-network providers to have policies and procedures for coverage of concurrent care that are standardized, administratively simple, and consistent for all enrollees. At a minimum, Model-participating MAOs must provide transitional concurrent care in alignment with plan-defined criteria for receiving these services as set forth in the CY2021 Addendum and the Model-participating MAO's CY2021 Approved Proposal. In alignment with the Model parameters, Model-participating MAOs must limit the provision of transitional concurrent care to enrollees who elect an in-network hospice provider. This may result in organization determinations as defined at 42 CFR 422.566 or coverage determinations as described at 42 CFR 423.566.

To ensure Model hospice enrollees are protected, Model-participating MAOs must comply with all regulations regarding these organization determinations, and applicable appeals and grievances under 42 CFR 422, subpart M; additional guidance on this can be found at MMCM Ch. 13. Organization determinations, grievances, and appeals related to transitional concurrent care must be considered expedited in accordance with 42 CFR 422.570, 42 CFR 422.564, and 42 CFR 422.584, respectively. Enrollees must also have access to a complaint process through a BFCC-QIO, as established at 42 CFR 422.562(a)(2)(ii). As applicable, plan decisions regarding prior authorizations of payment for Part D drugs associated with transitional concurrent care are considered coverage determinations as defined at 42 CFR 423.566 and are subject to expedited review and reconsideration (as applicable) at 42 CFR 423.570 and 42 CFR 423.584.

Unrelated Care Provided During a Hospice Election Period

Background: There is ongoing concern that many unrelated care services separately billed should have been provided under the Medicare hospice benefit as they likely were for services related to the terminal illness and related conditions. For example, for Parts A and B, the beneficiary cost-sharing amounts in FY 2017 totaled approximately $138 million, which includes Part A payments for inpatient hospitalizations and SNF stays, as well as Part B payments for outpatient and physician services, diagnostic tests and imaging, and ambulance transports. In FY 2017, for Part D, the beneficiary cost-sharing totaled approximately $68.6 million (83 FR 20946 through 20947). CMS believes that this is a substantial financial burden being placed on terminally ill individuals for services that potentially should have been covered by hospice providers. Additionally, OIG recently estimated Part D total cost was $160.8 million for Part D drugs that hospice providers should have furnished as part of the Part A hospice benefit, for which the Part A payment is made. Although hospice providers told OIG they (the hospice providers) should not have paid for the drugs associated with the remaining $261.9 million of the $422.7 million Part D total cost for drugs during a hospice stay, a review of CMS communications with hospice providers and Part D sponsors between 2012 and 2016 indicates otherwise—hospice organizations or hospice beneficiaries likely should have paid for many of these drugs, not Part D.[17] Together, this strongly suggests that hospice services are being "unbundled," negating the hospice philosophy of comprehensive, holistic care and

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

shifting the costs to other parts of Medicare, and creating additional cost-sharing burden to those vulnerable Medicare beneficiaries who are at end-of-life. Duplicative payments for hospice-covered services also threaten the program integrity and fiscal viability of the hospice benefit.

To date, CMS has not made a regulatory specification of services that are unrelated to hospice care because of the wide variation of individual patient circumstances. Therefore, these clinical decisions must be made on a case-by-case basis. To the extent that individuals seek and receive services outside of the hospice benefit, Medicare coverage is determined by whether or not the services are for treatment of a condition completely unrelated to the individual's terminal illness and related conditions. However, as articulated upon implementation of the benefit (48 FR 56009, 56010, December 16, 1983), CMS expects services unrelated to the terminal illness and related conditions to be exceptional, unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit. Additionally, the aforementioned 1983 regulations describe and Medicare hospice rulemaking emphasizes that when an individual is terminally ill, many health problems are brought on by underlying conditions, as bodily systems are interdependent.

Currently, Medicare Administrative Contractors may conduct pre-payment development or post-payment review to validate that services unrelated to the terminal illness and related conditions (billed with the appropriate modifier or condition code) are not related to the patient's terminal condition (see Ch. 11 of the Medicare Claims Processing Manual).

Additionally, two CMS memoranda, published on March 10, 2014 and July 18, 2014,[18] provide guidance for Part D sponsors and hospice providers regarding Part D coverage of prescription drugs for those in hospice. More specifically, these memos, together, encourage Part D sponsors to create a process for requests to cover drugs under Part D for enrollees in hospice, including instituting a prior authorization process for four categories of prescription drugs and working with the hospice provider and pharmacy to ensure there is documentation of the drug as being unrelated to the enrollee's terminal condition. The categories subject to prior authorization under that guidance include analgesics, anti-emetics, laxatives and anti-anxiety drugs.

Model Guidance on Unrelated Care Provided during a Hospice Period: In order to minimize confusion over determinations of unrelated care and align with existing FFS guidance in Ch. 11 of the Medicare Claims Processing Manual, CMS encourages Model-participating MAOs to establish prepayment or postpayment review processes (similar to processes currently in place by Medicare Administrative Contractors) to review whether Part A and Part B services and items received by an enrollee and billed outside the hospice benefit are unrelated to the enrollee's terminal illness and related conditions or not. This review, similar to guidance shared in the subsection, "Prepayment and Postpayment Review Related to Hospice Care,"

[18] Please see these memos online here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2014-PartD-Hospice-Guidance-Revised-Memo.pdf, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Part-D-Payment-Hospice-Final-2014-Guidance.pdf

should be conducted to identify and resolve program integrity risks or risk of beneficiary harm based on a pattern or practice of activity with a certain provider or provider(s). Related to Part D drugs for hospice enrollees and determinations of unrelated care, Model-participating MAOs (those with MA-PD offerings) should use the existing process and rely upon in the most current guidance for Part D drugs for hospice enrollees.

Application of Plan Rules around Networks: Model-participating MAOs may separately deny coverage for unrelated care services in alignment with existing plan coverage policies and regulation. This includes denial of coverage for *out-of-network* unrelated care, as applicable based on the plan's structure and rules.[19] The Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance is applicable, in alignment with the plan's coverage rules for those services. All grievances, organization determinations, and appeals for unrelated care must be considered expedited when an enrollee is in a current hospice election, and adjudicated in alignment with 42 CFR 422.564, 42 CFR 422.570, and 42 CFR 422.584 respectively. As applicable, plan decisions regarding prior authorizations of payment for Part D drugs while an enrollee is in hospice are considered coverage determinations as defined at 42 CFR 423.566 and are subject to expedited review and reconsideration (as applicable) at 42 CFR 423.570 and 42 CFR 423.584.

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., Model-participating MAOs 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 Model-participating MAOs 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 MMCM Ch. 4, section 10.4, and coverage of unrelated care under the Model, Model-participating MAOs must inform enrollees of their coverage rules for unrelated care. CMS also recommends that Model-participating MAOs conduct outreach to hospice providers in their service areas regarding plan rules so that the hospice providers do not inappropriately refer an enrollee for unrelated services that do not align with the plan's rules.

If the enrollee desires to continue receiving services that would not be covered under the Medicare hospice benefit (specifically because the items, services, or drugs would not be covered under Original Medicare, in alignment with §1862(a)(1)(A) or §1862(a)(1)(C)), then the hospice provider should fully inform the enrollee of his or her financial liability for those services. Model-participating MAOs must disclose coverage rules to enrollees to ensure that enrollees are aware of coverage limitations, including those that apply to unrelated care after a hospice election. Model-participating MAOs may wish to engage in additional education and outreach to hospice enrollees who use out-of-network hospice providers. Please see section 9 for more detail on related notifications. Enrollees may also submit quality of care complaints to a BFCC-QIO when the enrollee prefers a particular course of treatment because, for example, it's believed to be more efficacious than the course of treatment prescribed by the hospice provider or approved by the Model-participating MAO.

Consistent with the guidance set forth above, CMS recommends that hospice providers share the plan of care and exchange other necessary information (e.g., the Patient Notification of Hospice Non-Covered Items, Services, and Drugs) with Model-participating MAOs. That said, providing hospice care in a

[19] Please note that per 42 CFR 422.4(a)(1)(C), PPO plans may not limit care received out-of-network.

comprehensive, holistic approach that minimizes the occurrence of exceptional, unusual and rare unrelated items and services will reduce the potential for out-of-network referrals for unrelated care and reduce the extent to which hospice providers may undergo prepayment or other review.

Post-Live Discharge Care

Once an enrollee is discharged from hospice or revokes his or her hospice election, all care received by an enrollee post-live discharge from hospice should be provided consistent with existing plan rules for non-hospice care, and is subject to 42 CFR 422, subpart M, similar to any other care provided to an enrollee of the Model-participating MAO and 42 CFR 423 subparts M and U, as applicable. That said, Model-participating MAOs must make any organization determinations and redeterminations as expeditiously as the enrollee's health condition requires.

9. Other Operational Guidance

This section provides guidance to hospice providers and Model-participating MAOs on preparing for a billing relationship in the context of the Model. This guidance is also intended to offer clarification on billing and documentation in the context of the Hospice Benefit Component. Overall, CMS encourages Model-participating MAOs to process hospice claims as outlined in Ch. 11 of the Medicare Claims Processing Manual to streamline process and ensure timely payment in Phase 1 of the Model.

General Outreach by Model-Participating MAOs and Hospice Providers
Model-participating MAOs and their contracted hospice providers have the flexibility to create contracting arrangements that work best for each entity and support the goals of the Model. In the initial years of the Model, Model-participating MAOs and hospice providers have the opportunity to work together in new ways which will require up front collaboration and coordination to maximize efficient billing arrangements. Where there are no existing contractual arrangements between a Model-participating MAO and a hospice provider in its service area, CMS encourages Model-participating MAOs to reach out to their local hospices to discuss the Model and billing process for enrollees to minimize confusion and maximize efficiencies, even if the parties do not ultimately contract with each other.

Model-participating MAOs must communicate actively with all hospice providers in their service areas to inform them of the following:

- The Model-participating MAO is a CMS Innovation Center model participant;
- The Model-participating MAO's participation in the Hospice Benefit Component of the VBID Model;
- The structure of the Hospice Benefit Component of the VBID Model;
- The hospice provider's contract status with the Model-participating MAO (including if it is non-contracted, out-of-network);
- The Model-participating MAO's contracting process;
- Any information needed by the Model-participating MAO to ensure the hospice provider is able to offer services to the Model-participating MAO's enrollees;
- Information on how to identify an enrollee as an enrollee of the Model-participating plan;
- Details on the Model-participating MAO's network structure (i.e., PPO, HMO-POS, HMO), enrollees' ability to seek non-hospice care out-of-network, how to help an enrollee coordinate receiving unrelated care if needed (e.g., prior authorization process for non-hospice care if applicable, finding a provider), and information on how to find providers that are in-network with the Model-participating MAO;
- Timeline for claims and notice submission and Model-participating MAO payment to the hospice provider;
- Contact information for CMS at VBID@cms.hhs.gov for questions about the Model and how to get in touch with the Beneficiary Liaison for Innovation Models, who provides Medicare Beneficiary Ombudsman supports; and
- Contact information for the Model–participating MAO.

Consistent with MA program requirements in 42 CFR 422, subpart E regarding MAO relationships with providers, Model-participating MAOs must be responsive to hospice providers' outreach to them with requests to participate in the Model-participating MAO's hospice network or to enter into a contracting process with the Model-participating MAO. Model-participating MAOs 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. Even in situations where a Model-participating MAO

does not intend to contract with a hospice provider, Phases 1 and 2 of the Hospice Benefit Component require Model-participating MAOs to permit enrollees to choose any hospice provider, which may require a billing relationship between the non-contracted hospice provider and Model-participating MAO. Hospice providers are encouraged to expect and respond to outreach from Model-participating MAOs in order to ensure smooth working relationships under the Model as maintenance of good coordination and communication can contribute significantly to ensuring high levels of enrollee care.

Timely Identification of Enrollees by Hospice Providers
Proper and timely identification of hospice beneficiaries who may receive coverage through a Model-participating MAO's plan is important in ensuring coordination and high quality care. Both Model-participating MAOs and hospice providers (in- and out-of-network) have essential roles in ensuring accuracy and timeliness. CMS notes that enrollee identification processes between Model-participating MAOs and in-network hospice providers should be made clear in their contractual arrangements or other related materials.

In regards to out-of-network hospice providers, Model-participating MAOs must work with out-of-network hospice providers as needed to ensure continuity of care for their enrollees, and are encouraged to develop working relationships with these providers. For example, as part of this, Model-participating MAOs are encouraged to verify out-of-network hospice providers are eligible for payment in advance of the start of the Model and to ensure out-of-network hospice providers have the information needed to identify their enrollees. CMS recommends that Model-participating MAOs have call center and other staff trained and readily available 24/7 to answer questions from both hospice providers and/or enrollees as applicable regarding the Model, the Hospice benefit, an enrollee's eligibility and hospice claims processing. Model-participating MAOs are also encouraged to provide basic access to eligibility systems, as applicable, to out-of-network providers within their service areas in order to facilitate the hospice providers' ability to verify enrollee coverage, collect appropriate cost-sharing, and submit claims. As a practice, CMS recommends that Model-participating MAOs relay to hospice providers such information. In addition, hospice providers are encouraged to contact Model-participating MAOs with questions regarding enrollment, billing, claims, and contracting. CMS encourages out-of-network hospice providers to work jointly with Model-participating MAOs to establish a method for exchanging clinical and administrative information and implementing best practices to work towards ensuring referrals to in-network providers for any rare, but necessary, unrelated care.

Model-participating MAOs are also encouraged to develop and implement other ways for hospice providers to easily identify enrollees, including leveraging existing information system infrastructures to minimize administrative burden. For example, this could include leveraging or setting up real-time, automated Admission, Discharge and Transfer (ADT) alerts and/or using state-based health information exchanges (HIEs) that support the transfer of enrollee information between hospice providers and Model-participating MAOs in lieu of creating a new administrative process. CMS recommends that Model-participating MAOs back up electronic systems by utilizing health insurance cards for proper identification (e.g., a Model-participating MAO may add an identifier to enrollees' health insurance cards along with contact information for providers regarding hospice services).

Hospice providers are also encouraged to use the HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS) to submit HIPAA-compliant 270 eligibility request files over a secure connection and receive 271 response files to view MA enrollment data, which will include an MA Contract Number and MA Plan Number (as applicable). This information should be cross-referenced

against the list of Model-participating plans' contract numbers and plan numbers, which would indicate whether an enrollee is enrolled in a Model-participating plan.

Notices

A distinctive characteristic of the Medicare hospice benefit is that it requires beneficiaries (or their representatives) to intentionally choose hospice care through an election. As part of that election, beneficiaries (or their representatives) acknowledge that they fully understand the palliative, rather than curative, nature of hospice care. Another important aspect of the election is a waiver of beneficiary rights to Medicare payment for any Medicare services related to the terminal illness and related conditions during a hospice election except when provided by, or under arrangement by, the designated hospice, or by the individual's attending physician if he/she is not employed by the designated hospice (§ 418.24(d)).[20] Because of this waiver, providers other than the designated hospice or attending physician cannot receive payment for services to a hospice beneficiary unless those services are unrelated to the terminal illness and related conditions. For Model-participating MAOs' and CMS' claims processing systems to properly enforce this waiver, it is necessary for the hospice election to be recorded in the claims processing system as soon as possible after the election occurs. Again, it is crucial that the NOE be filed promptly to safeguard the integrity of the Medicare Trust Fund and enable smooth and efficient operation of other Medicare benefits and to protect hospice beneficiaries from inappropriate financial liability due to cost sharing and deductibles for services related to their terminal prognosis.

Operationally, outside the Model, a hospice provider notifies the Medicare program that a beneficiary's election is on file by submitting a NOE. The NOE processes through Medicare systems, which updates beneficiary records and later uses the information to adjudicate hospice claims. This NOE must be filed with the Medicare contractor within five days of hospice election in order to transmit the data in a timely manner to CMS' Common Working File (CWF) in electronic format. The data are reported by the CWF to other CMS systems. However, there is some time (often multiple days) between when a beneficiary elects the hospice benefit and when MAOs can see that election in the Medicare Advantage Prescription Drug (MARx) system.

In order to ensure coordination of benefits under the Model, hospice providers – both in-network and out-of-network – must submit an NOE to the enrollee's Model-participating plan and must timely submit the NOE with the Medicare contractor (see Appendix 1 for a chart of the data flow under the Model). CMS strongly encourages hospice providers to immediately notify Model-participating MAOs of hospice elections in order to ensure timely payments to providers and prevent inappropriate payment of hospice-covered services separately by the Model-participating MAO. In turn, this also ensures good communication and care coordination between Model-participating MAOs and hospice providers.

Similarly, to provide timely notice and due to the importance of coordination of benefits for enrollees, hospice providers must submit a Notice of Termination/Revocation (NOTR) to Model-participating MAOs. Hospice providers must continue to submit the NOTR to their Medicare contractor. Prompt recording of revocations or discharges is necessary to ensure that enrollees are able to access needed items or services, and to ensure that payment for the item or service is from the appropriate source.

[20] Under the Model, section 1812(d)(2)(A)(ii)(I) of the Act is waived to the extent necessary, with respect to waiver of payment for treatment of the individual's condition(s) with respect to which the diagnosis of terminal illness has been made, so that in-network transitional, concurrent care can be made available, in alignment with Model-participating MAOs' Approved Proposals.

Hospice providers must submit other notices with CMS and should submit these notices to Model-participating MAOs. CMS encourages hospice providers to immediately notify Model-participating MAOs of hospice terminations or revocations for the aforementioned reasons. Medicare contractors will continue to process the NOEs and other notices.

Hospice Election Periods and Hospice Benefit Periods in Medicare Systems

Medicare FFS hospice care is provided in one or more hospice benefit periods. The initial certification and hospice benefit period is for 90 days. After the initial period, subsequent periods consist of one additional 90-day period and an unlimited number of 60-day periods. Claim submissions create these hospice benefit periods, which trigger the hospice capitation payments to Model-participating MAOs. While Medicare contractors will not do any processing of these claims, in order for hospice benefit periods to be created and the Model-participating MAO to receive the hospice capitation payment, these claims must be submitted to the Medicare contractor. These claims must also be submitted directly to the Model-participating MAO for the Model-participating MAO to make timely payment to hospice providers. Model-participating MAOs are strongly encouraged to follow Ch. 11, "Processing Hospice Claims" of the Medicare Claims Processing Manual to permit hospice providers to have 12 months from the date of service in which to file their claims timely. In contrast, Model-participating MAOs may require claim submission in shorter periods of time than 12 months for in-network hospice providers, based on contractual agreements.

Situations where Notices and Claims Are Not Submitted to CMS

To assure Model-participating MAOs receive proper payment, it is important that Model-participating plans reconcile their beneficiary records with the Daily Transaction Reply Report (DTRR), the Monthly Membership Report (MMR) and the Plan Payment Report (PPR). For example, in a situation where a hospice provider does not submit NOEs, NOTRs, or hospice claims to its Medicare contractor, a Model-participating MAO's corresponding payment from CMS to the Model-participating MAO may be impacted.

In situations where there is a discrepancy between Model-participating plans' beneficiary records and CMS-provided reports, Model-participating MAOs are encouraged to notify CMS via the VBID Model mailbox, vbid@cms.hhs.gov, and the Division of Payment Operations (DPO) Central Office (CO) contact person. Model-participating MAOs are also encouraged to reach out to the hospice provider with the missing notice or claim to explain the discrepancy and request that the hospice provider submit the appropriate documentation to the Medicare contractor.

In interactions between a Model-participating MAO and a hospice provider where the hospice provider has not routinely submitted a notice or claim to the Medicare contractor, causing subsequent disruptions in the Model-participating MAO's hospice capitation payments, it may be helpful for the Model-participating MAO to implement a prepayment review strategy requiring the hospice provider to submit remittance codes demonstrating submission of the NOE, NOTR and claims to its Medicare contractor prior to receiving payment from the Model-participating MAO. This prepayment review strategy must be reviewed and approved by CMS as described above in section 8. In the spirit of the Model's collaborative stance, CMS expects that Model-participating MAOs implementing these types of prepayment review strategies with hospice providers have made demonstrable efforts to work with applicable hospice providers prior to CMS's approval of a pre-payment review strategy to resolve operational billing issues so that payment can be made efficiently.

Face-to-Face Encounters for Hospice Benefit Period Certification Recertification

Pursuant to 42 CFR 418.22, a written certification must be on file in the hospice patient's record prior to submission of a claim to the Medicare contractor and Model-participating MAO. Clinical information and

other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. While Medicare contractors will not conduct any medical review of claims for enrollees, Model-participating MAOs may conduct prepayment and/or postpayment review activities, where such documentation will be important as part of implementing appropriate program integrity safeguards.

Hospice Information Reported on the DTRR

Hospice election information is sent to Model-participating MAOs on the DTRR. As specified in the Plan Communications User Guide, the DTRR includes a hospice indicator, hospice provider number, a hospice start date and a hospice termination date. Hospice data are reported on the DTRR at the time of the beneficiary's enrollment in a MA plan, or hospice election if that election is made later. Updated data are reported when the hospice start dates change to reflect a new hospice benefit period or a termination date is added due to death, discharge, or revocation of the election by the beneficiary.

Only one hospice benefit period can be reported on the DTRR. Thus, the start date of a hospice benefit election will be the date the current hospice benefit period started. When the current hospice benefit period ends, a new start date will be reported reflecting the start date of the new hospice benefit period. Termination dates are reported on the DTRR only when the hospice benefit has terminated due to death, discharge, or revocation of the beneficiary's election. Thus, if no hospice termination date is reported on the DTRR, the new start date is the beginning of a new hospice benefit period.

Therefore, a new start date of the hospice benefit election (without a prior termination date) should not be viewed as an indication that the enrollee revoked his/her hospice election and then re-elected the benefit, or was discharged and re-elected, creating an entirely new election. Additionally, payment continues to be at the Month 2+ hospice capitation rate as described in section 10. When an enrollee revokes a hospice election or is discharged, the effective date of the revocation or discharge will be reported as the hospice termination date on the DTRR. If the enrollee revoked the election, a hospice revocation indicator will be included in the MARx system. When an enrollee revokes his/her hospice election or is discharged from hospice care, the Model-participating MAO must provide all covered benefits (i.e., services and items) to that enrollee consistent with the benefits of the Model-participating plan and applicable MA program rules and requirements.

Since only a single hospice benefit period can be reported on the DTRR, Model-participating MAOs will need to store the hospice data in their systems so historical data are available when needed for claims adjudication and adjustments. Sponsors can also access additional hospice data via MARx User Interface, including prior hospice benefit period start and end dates and the hospice revocation indicator.

Hospice Information Available through the Health Plan Management System (HPMS) and on the cms.gov Website

Consistent with current procedures, Model-participating MAOs may use the MARx User Interface or information supplied by the hospice provider or beneficiary to identify the hospice provider and, once the hospice provider is identified, the hospice provider's contact information will be available to sponsors through HPMS prior to the effective date of the guidance.

The hospice provider information from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) also will be accessible on the CMS Website on the Hospice Center Webpage located at http://www.cms.gov/Center/Provider-Type/Hospice-Center.html in the Spotlight section.

According to Medicare Enrollment policy, providers are required to submit any changes to their enrollment information in PECOS in a timely manner. Therefore, we expect hospice providers will ensure that their information is current and complete and will review the list and submit any required changes electronically to PECOS.

The system is accessible via the CMS Website at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

Billing for Hospice Services Provided by a Physician, for Services Unrelated to Terminal Illness, or Services after the End of a Hospice Election Period

For enrollees, the following claims must be submitted to the Model-participating MAO for payment:

- Applicable services provided by a physician (see the Medicare Claims Processing Manual);
- Services unrelated to the terminal illness and related conditions; and
- Services provided upon revocation of Medicare coverage of hospice care for a particular election period.

CMS encourages providers to submit claims for hospice services provided by a physician for services unrelated to the terminal illness and related conditions or for services after the end of a hospice election period (post-live discharge or revocation) to the appropriate Medicare contractor to aid in timely monitoring and evaluation of the Hospice Benefit Component. Please note that claims for unrelated care or post-live discharge care may be subject to plan rules and require the hospice provider to complete a prior authorization process with the Model-participating MAO.

Use of Notices of Medicare Non-Coverage (NOMNC) and Advance Beneficiary Notices of Noncoverage (ABN) in Hospice

In some circumstances, a hospice provider may be required to provide a NOMNC to an enrollee. Instructions for the NOMNC found in §260 of Chapter 30 of the Medicare Claims Processing Manual. This instruction is consistent with guidance on the NOMNC pursuant to 42 CFR 422.624 and 422.626. For additional guidance, including a copy of the NOMNC and its accompanying instructions, see the MA Expedited Determination Notices webpage:
www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.

The ABN used in the Original Medicare program is not applicable to the MA program and is not appropriate for use by a Model-participating MAO with respect to its enrollees. Model-participating MAOs 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.

Remittance Advice Messages and Associated Codes

For services provided to hospice enrollees, the FFS Medicare program, through the Medicare contractors, will deny payment for all claims with dates of service during a hospice election (only those with a hospice election start date on or after January 1, 2021 through December 31, 2024) and upon discharge or revocation, through the end of the month of that discharge or revocation.

As noted above, hospice providers (both in-network and out-of-network) MUST still submit claims for these services to their Medicare contractor, and providers that submit claims for these services, both hospice and non-hospice providers, can expect the following messaging:

- Claim Adjustment Reason Code (CARC) 96: Non-covered charge(s)
- Remittance Advice Remark Code (RARC) MA73: Information remittance associated with a Medicare demonstration. No payment issued under FFS Medicare as patient has elected managed care
- Group Code CO

10. Hospice Benefit Component Payment Structure and Related Operations

This section provides background information on the hospice capitation payments made to Model-participating MAOs by CMS in exchange for providing Medicare Part A and B coverage to enrollees of Model-participating plans with a hospice stay beginning on or after January 1, 2021. Examples are provided to aid in understanding of the hospice capitation payment structure and calculation and timing of these payments to offer context for operational planning of Model-participating MAOs.

Background on the Hospice Capitation Payments under the Model
Model-participating MAOs will be paid consistent with current law for their enrollees who do not elect hospice.

On behalf of their enrollees who have elected hospice care under 42 CFR 418.24, Model-participating MAOs will be paid per the following payment structure:

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

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

  In the event an enrollee has live discharge from hospice and re-enrolls in hospice in Month 1, for the calculation of the number of days in Month 1, for purposes of pricing, the sum of days in Month 1 during which the enrollee had a hospice stay will be used to calculate the tier of the Month 1 hospice capitation rate.

- Consistent with 42 CFR 422.320(c)(2), the **beneficiary rebate amount** (as described in 42 CFR 422.304(a)); and

- Consistent with 42 CFR 422.320(c), the **monthly prescription drug payment** described in 42 CFR 423.315 (if any).

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

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

However, if, and only if, an enrollee elects hospice on the first day of a calendar month (e.g., March one), the basic benefit capitation rate will not be paid (e.g., for March). Instead, MARx will prospectively pay a Month 2+ hospice capitation rate for Month 1. This payment may be more (or potentially less) than the cost to the Model-participating MAO of furnishing hospice services during that period. As applicable, an adjustment to reconcile the Month 2+ hospice capitation payment against the appropriate Month 1 hospice capitation rate will be reflected in the retrospective quarterly lump-sum payments described below for Month 1 hospice capitation payments. (Refer to the illustration below.)

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

For any calendar month hospice enrollee experience after Month 1, a Model-participating MAO will receive through MARx the Month 2+ hospice capitation rate, the beneficiary rebate amount, and the monthly prescription drug payment, if applicable, for an enrollee who continues hospice. This will be paid prospective to the extent that hospice status information is up-to-date in MARx.[21] If hospice status information is delayed in MARx, MARx will calculate retroactive adjustments. These payments and any adjustments will be seen within the MMR at the enrollee level.

Illustrative examples are provided below.

Beneficiary A Example:

Beneficiary A elects hospice on March 22nd and continues in hospice through May 15th. The Model-participating MAO receives the following payments:

- With respect to March:
    - An A/B capitation payment;
    - A beneficiary rebate;
    - A prescription drug payment (if any); and
    - A Month 1 Hospice Capitation payment at the 7-15 day rate. This payment will be paid as part of the quarterly retrospective Month 1 payment process.
- With respect to April and May (for each month):
    - A beneficiary rebate;
    - A prescription drug payment (if any); and
    - A Month 2+ Hospice Capitation payment.

[21] See subsection, “Notices” within section 9 of this document and Appendix 1 for a chart of the NOE data flow.

Table 2. Beneficiary A Example

Dates of Stay: March 22 – May 15
Length of Stay: 55 days

Beneficiary A Example	Month 1 (March)	Month 2 (April)	Month 3 (May)
A/B Capitation	✓		
Hospice Month 1 (adjusted for 1-7 days)			
Hospice Month 1 (adjusted for 7-15 days)	✓		
Hospice Month 1 (adjusted for 16+ days)			
Hospice Month 2+		✓	✓
Beneficiary Rebate	✓	✓	✓
Prescription Drug Payment (if applicable)	✓	✓	✓
Reconciliation of Month 1 +/-			

Beneficiary B Example:

Beneficiary B elects hospice on March 1st and continues in hospice through May 15th. The Model-participating MAO receives the following payments:

- With respect to March:
  - A beneficiary rebate;
  - A prescription drug payment (if any); and
  - A Month 2 Hospice Capitation payment. *(Note: This payment will be reconciled with Hospice Month 1 16+ day rate during the quarterly retrospective Month 1 payment process.)*
- With respect to April and May (for each month):
  - A beneficiary rebate;
  - A prescription drug payment (if any); and
  - A Month 2+ Hospice Capitation payment.

Table 3: Beneficiary B Example

Dates of Stay: March 1 – May 15
Length of Stay: 76 days

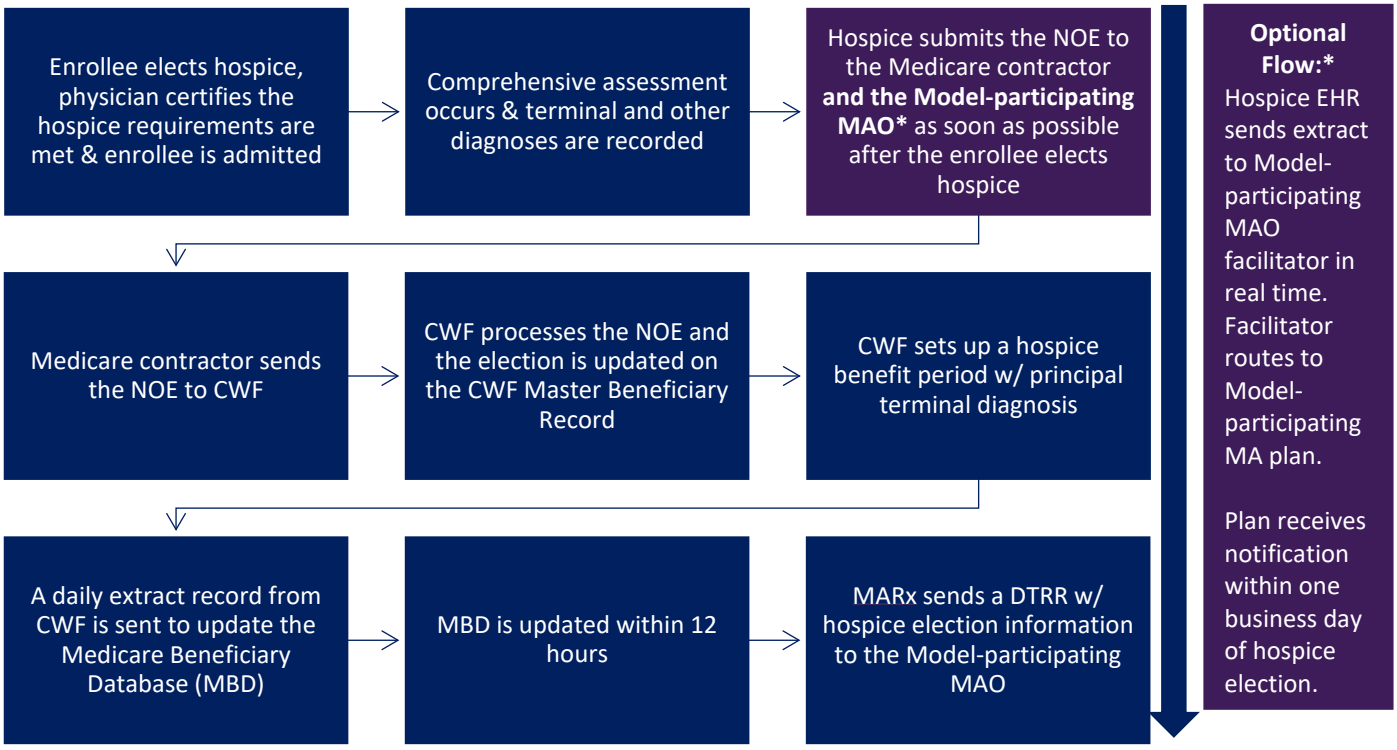
Beneficary B Example	**Month 1 (March)**	**Month 2 (April)**	**Month 3 (May)**
A/B Capitation			
Hospice Month 1 (adjusted for 1-7 days)			
Hospice Month 1 (adjusted for 7-15 days)			
Hospice Month 1 (adjusted for 16+ days)	✓		
Hospice Month 2+		✓	✓
Beneficiary Rebate	✓	✓	✓
Prescription Drug Payment (if applicable)	✓	✓	✓
Reconciliation of Month 1 +/-	✓		

Resources

MARx Monthly Calendar: The MARx Monthly Calendar and other useful calendars and schedules can be found on the MAPD Help Desk website on the MAPD/MARx Calendars and Schedules page at the following link:
https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/MAPD-MARx-Calendars-and-Schedules

MAPD Plan Communications User Guide (PCUG): The MAPD Plan Communications User Guide (PCUG) contains information for using the MARx System and descriptions of the specific data files and reports that are exchanged between plans and CMS. The PCUG is available at the following link:
https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide

Appendix 1. Hospice Data Flow for the Notice of Election (NOE) under the Model



* Indicates a step where the information flow is different from FFS Medicare