CMS Releases Application Request for Third Year of MA-Hospice Demonstration

On March 1, 2022, the Centers for Medicare & Medicaid Services (CMS) released *the* information for Medicare Advantage Organizations (MAOs) interested in participating in the Hospice Benefit Component of the VBID Model; the scope of the Hospice Benefit Component under the VBID model; specific quality, network, and payment policies being tested as part of the Hospice Component for CY2023; model requirements; an overview of the planned evaluation of the Hospice Component and the application process. Calendar year 2023 will be the third year of the model, which is expected to be conducted for a total of four years.

While the model has not undergone dramatic changes and the content of the CY2023 RFA closely tracks previous RFAs (i.e., the CY2021 and CY2022 RFAs), CMS has incorporated some notable changes. Review of *NAHC Report* coverage of the previous RFAs (links provided above) may be helpful to individuals who are unfamiliar with the model specifics that have been released previously. Of particular interest in the CY2023 RFA to stakeholders are the following:

- In keeping with CMS' strategic priorities, the CY2023 RFA includes increased emphasis on advancing health equity under the model;
- Discussion of Medicare program waiver considerations to support the model;
- Additional clarity around the model's goals related to the provision of palliative care outside of hospice care;
- A new Network Adequacy standard applicable to MAO Plan Benefit Packages (PBPs) with one year or more of experience under the model (mature-year PBPs); and
- A brief explanation of the "Learning System Strategy" (Section 5) under which CMS provides support for contracted hospices and participating MAOs under the model.

As has been the case in previous years, CMS has set a deadline of mid-April for MAOs to submit their applications to participate in the model. For the CY2023 model year, mature-year PBPs will be required to submit their provider networks for CMS review during the summer. Given the expectation that established MAOs will be required to establish networks by mid-year, NAHC sent an inquiry to the CMS VBID staff to check as to when hospices should anticipate that mature-year PBPs and PBPs newly entering the program will likely be entering into contracts with hospices for the CY2023 model year.

CMS provided the following response: "CMS expects participating MAOs with experience in the Model to have networks in place already (e.g., if they participated in CY 2021, as of 1/1/21) and to continue strengthening their networks to meet the qualitative *and* quantitative network adequacy requirements for CY 2023. For some MAOs, this may mean establishing contracts with effective dates in 1/1/23 over this

spring/summer. That said, in general, we encourage MAOs and hospices to proactively outreach to each other to build networking relationships throughout the year."

ADVANCING HEALTH EQUITY. In Section 1.3 of the CY2023 RFA, CMS underscores the goals of Executive Orders 13985 and 13988 relative to "advancing health equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality", and "to prevent and combat discrimination on the basis of gender identify or sexual orientation" and "to address overlapping forms of discrimination." CMS intends to "embed" equity in all states of model design, operation, and evaluation.

In keeping with these goals, applications for participation in CY2023 require each MAO applicant for the model to describe a detailed strategy for advancing health equity as part of its approach to participation in the model. The strategy is required to include, but is not limited to, applying the principles of health equity to their palliative care strategies and to their coverage and coordination of the hospice benefit. CMS intends to expand upon these efforts in the future and is exploring initiatives such as providing model participants with additional data and/or information to facilitate use of interventions that can advance health equity. CMS is seeking feedback on the role of the model in advancing health equity. Additional information regarding CMS' intent with respect to health equity is contained in Appendix B of the RFA.

MEDICARE PROGRAM AND PAYMENT WAIVERS. CMS has expanded references to waivers of existing Medicare program and payment requirements that may be needed to operate the model. New references under this section include:

- Exclusion from the calculation of a hospice's inpatient cap and the hospice aggregate cap those enrollees in an MAO's VBID PBP(s) that receive the hospice benefit under the model.
- A discussion of QIO review of terminations of hospice services indicating that all obligations, standards, requirements, and duties imposed on, and rights of beneficiaries are not waived and shall continue to apply. Further, unless explicitly waived, obligations on hospice providers in 42 CFR §§ 405.1200 through 405.1204 remain in effect. The regulations at 42 CFR §§ 405.1200 through 422.1204 are waived only to the extent necessary to permit the MAOs and applicable QIOs to comply with the appeals process detailed in Appendix 3, Section B(8) for reviews of termination of hospice services under the Hospice Benefit Component of the Model.

o the provision of 42 CFR 405.1202(b)(4) regarding QIO review when a beneficiary does not file a timely request for review by a QIO of a termination of hospice services is waived.

o the provision of 42 CFR 405.1202(e)(7) that makes the provider liable for the cost of the hospice services being continued when the provider fails to furnish information to the QIO to support the termination of services, is waived.

o the provision of 42 CFR 405.1202(c) that relates to provider liability for the cost of hospice services in certain situations, is waived.

o 42 CFR 405.1204(b) through (f), regarding expedited reconsiderations by a Qualified Independent Contractor of a QIO's review of a termination of hospice services, is waived. The right of a Hospice Enrollee to seek review of a QIO's determination regarding the termination of hospice services in 405.1204(a) is not waived but that review is as described in Appendix 3, Section B(8).

PALLIATIVE CARE. In Section 2.2, CMS has included additional clarity around its expectations for delivery of palliative care outside of the hospice benefit. Items of note include:

- Reference that participating MAOs are expected to be mindful of the advancing health equity goals outlined elsewhere in the RFA and should tailor their palliative care proposals to be responsive to those requirements, including an explanation as to how palliative care (or other serious illness care services outside of hospice or concurrent care will be offered to enrollees with certain conditions of other indicators of serious illness;
- Reference that CMS strongly encourages MAOs' palliative care programs to include the following services when medically necessary and reasonable for the palliation or management of serious illness and related conditions:
    - palliative care assessment and consultation services;
    - care coordination by an interdisciplinary care team;
    - care planning and goals of care discussions;
    - advance care planning;
    - access to social services and community resources;
    - access to mental health and medical social services;
    - 24/7 telephonic palliative care support;
    - psychosocial and spiritual support; pain and symptom management; and
    - medication reconciliation and caregiver support.
    - A reference that, in implementing palliative care services for the model, MAOs may consider a variety of provider types, including palliative care provider, hospice providers, home health agencies, primary care providers, etc., assuming they possess all relevant certifications, interdisciplinary team configurations (e.g., physician, nurse practitioner, physician assistant, registered nurse, social worker, pharmacist, chaplain and/or community health workers, etc.), and settings of care (e.g., inpatient, outpatient, home- and community-based settings, etc.) to meet the individual needs of each patient based on his or her preferences and goals of care.

NETWORK ADEQUACY. As part of the CY2021 and CY2022 RFAs, CMS indicated plans to implement a phased in approach to allow MAOs to develop networks of

hospice providers, with imposition of an explicit network adequacy requirement modelled after the traditional MA network adequacy approach beginning in the third year of the model (CY2023). Over the last year, CMS engaged in extensive discussion with stakeholders regarding the most appropriate approach to use relative to imposing a network adequacy standard for the model. As a result, CMS developed a two-phase structure for network adequacy rather than the three-phase structure reflected in prior RFAs. Individual PBPs will be assigned to phases based on their length of their participation in the model as follow:

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

Phase One: A participating MAO offering a PBP in the model for the first time in a service area the MAO has not participated in under the model will be in Phase One for that PBP. First-year PBPs are required to offer access to in-network hospice providers as well as out-of-network hospice providers. CMS is encouraging first-year PBPs to implement a voluntary consultation process for beneficiaries to ensure they understand their care choices and both in-network and out-of-network provider options prior to selecting an out-of-network provider. This process is designed to ensure beneficiaries understand that some services – such as transitional concurrent care and (potentially) some hospice-specific supplemental benefits may not be available if the beneficiary selects an out-of-network provider.

Phase Two: For CY2023, participating MAOs with mature-year PBPs will be required to create and maintain networks of hospice providers at the participating MAO level (i.e., across all mature-year PBPs in the same participating MAO within a county) and contract with a Minimum Number of (hospice) Providers (MNP) in that county. However, participating MAOs must continue to provide coverage for in-network and out-of-network hospice services (out-of-network providers are paid at the fee-for-service rates).

Calculation of the MNP for each county in a mature-year PBPs service area is based upon existing MA network adequacy standards but has been modified such that the requirement will be applied and evaluated at the participating MAO level by totaling the MNP values for all counties in a service area. Further, no time and distance standard will be applied (because hospice services are generally provided in the home setting). CMS will also not apply broad county type designations (i.e., large metro, metro, micro, etc.).

Participating MAOs will be required to form and maintain a network of Medicare-certified hospice providers to ensure that there are at least the applicable number of hospice

providers (the MNP) at the participating MAO level serving every county in the MAO's service area(s).

As part of the RFA, CMS provides an example of how the MNP would be calculated for two hypothetical mature-year PBPs. CMS plans to release a data book and technical methodology paper to MAOs sometime this spring (the information will be available to other stakeholders and the public in late September); and mature-year PBPs are required to submit their provider networks for CMS review this summer.

As referenced above, given the requirement that mature-year PBPs must submit networks for review during the summer, hospices that have not previously contracted with MAOs/PBPs participating in the model that are interested in contracting may want to begin engagement with plans soon to optimize the potential for involvement as a contracted hospice.

As part of the process, CMS is requiring MAOs with mature-year PBPs to describe their comprehensive strategy for forming a network of Medicare hospice providers to ensure that enrollees receive a set of timely, comprehensive, and high-quality services aligned with enrollee preferences in a culturally-sensitive and equitable fashion. CMS will be monitoring applications for the following:

- MAOs' criteria and processes supporting hospice provider network selection, including those related to monitoring and oversight of quality of care provided by in-network providers;
- MAOs' processes to ensure that each in-network hospice is able to deliver care in a timely manner across all four levels of hospice care;
- MAOs' processes to ensure their hospice provider networks have adequate capacity (e.g., average daily census, staffing, access to facilities, etc.) to meet the needs of projected demand for hospice across service area(s);
- MAOs' efforts to engage hospice providers who have a history of serving underserved populations, provide additional value-added services to patients and families, have strong relationships with their local communities, and/or actively collaborate with organizations that may help meet the social needs of enrollees; and
- MAOs' efforts to ensure cultural competency throughout the hospice network.

Under all phases, participating MAOs may not charge higher cost sharing for hospice services provided in-network or out-of-network than those levels permitted under Original Medicare. As with the usual MA program rules, participating MAOs may use different cost-sharing at in-network hospice providers versus out-of-network hospice providers.

The CY2023 RFA and other materials related to the CY2023 MA VBID model are available HERE. CMS also has a MA VBID Hospice Benefit Component Model website

that is available HERE. CMS schedules periodic webinars on the model to inform stakeholders and allow for questions. The next scheduled webinar is set for April 5.

Following is the timeline for the application period for the VBID Model:

Date	Milestone
Early March 2022	VBID Model's Hospice Benefit Component Request for Application released
Early March 2022 – April 15, 2022	CMS provides feedback and technical assistance to MAOs applying for the Hospice Benefit Component
Early March 2022	CMS, in conjunction with the Office of the Actuary, releases additional information about the CY 2023 Preliminary Hospice Capitation Payment Rate Actuarial Methodology
Early March 2022	VBID Model Application Portal opens (inclusive of Hospice Benefit Component)
Spring 2022	CMS releases additional information on Phase 2 network adequacy requirements, including the Minimum Number of Provider (MNP) Technical Methodology and Operational Guidance
Mid-to-Late April 2022	Office of the Actuary releases the CY 2023 Final Hospice Capitation Payment Rate Actuarial Methodology and Hospice Capitation Ratebook

April 15, 2022	Completed Application due to CMS by 11:59pm PT
Early May 2022	CMS releases Data Book for MNP calculations at the participating MAO level
Mid-May 2022	CMS completes review of applications and provides feedback to MAOs for inclusion in their CY 2023 plan benefit package
June 6, 2022	CY 2023 MA and Part D Bid submission deadline by 11:59 pm PT
Summer 2022	Participating MAOs with mature-year PBPs submit provider networks for CMS review
Mid-to-Late September 2022	Contract addenda for Model participation executed CY 2023 Model Participants announced
October 2022	MNP Data Book made available to all stakeholders Initial hospice provider directory available, including in-network providers, as well as communication of benefits under the Evidence of Coverage
January 1, 2023	CY 2023 performance period of the Hospice Benefit Component of the VBID Model begins