Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
Value-Based Insurance Design Model
Hospice Benefit Component
Calendar Year 2023 Monitoring Guidelines

Table of Contents

1. Background and General Information

Through the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model, the Centers for Medicare & Medicaid Services (CMS) is testing the impact on payment and service delivery of incorporating the Medicare Part A hospice benefit in the Medicare Advantage (MA) program with the goal of creating a seamless care continuum for MA enrollees. For MA Organizations (MAOs) that apply and are accepted to participate in the Hospice Benefit Component, CMS will evaluate the impact on cost and quality of care for enrollees, including whether the Model improves quality and timely access to the hospice benefit, and whether there is innovation created through fostering partnerships between MAOs and hospice providers. In order to help ensure enrollees' experience at the end of life and in hospice reflect high quality care and care coordination, to evaluate the service model being tested, and to create transparency for enrollees and their families and caregivers, CMS will monitor enrollee experience and provider quality at the start of the Hospice Benefit Component and over time.

These monitoring guidelines provide MAOs participating in the Hospice Benefit Component in Calendar Year (CY) 2023 ("participating MAOs") with guidance pertaining to Model component reporting activities that support CMS monitoring and evaluation activities. Participating MAOs must also comply with the CY 2023 VBID Monitoring Guidelines for Wellness and Healthcare Planning (WHP) summary-level reporting. Participating MAOs must comply with these Monitoring Guidelines pursuant to the Addendum to Medicare Managed Care Contract for Participation in the MA VBID Model ("Addendum"). In the interest of transparency, CMS is making these monitoring guidelines publicly available.[1]

1.1 Hospice Benefit Component Monitoring and Evaluation Strategy

The Model's monitoring strategy is aimed at protecting enrollees, assuring participating MAOs' compliance with the terms of the Model test, and tracking implementation of the Hospice Benefit Component. CMS or its contractor will conduct compliance monitoring on a regular basis to track MAO compliance with the terms of the Model test. Model monitoring and evaluation activities will chiefly rely on existing data sources. These guidelines are designed so that participating MAOs are required to report additional data to address situations where (1) no existing data are available and (2) this information is necessary for monitoring and/or evaluation of the Hospice Benefit Component. CMS or its contractor may also conduct specific audits in identified risk areas and may initiate audit activity that requires additional data or site visits, particularly in response to high levels of complaints or other indicators of poor performance.

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

- Conducting ongoing review and tracking of participating MAOs' efforts and progress and potential issues in implementation of the Hospice Benefit Component;
- Ensuring MAO compliance with the Hospice Benefit Component terms of the Addendum and Model Technical and Operational Guidance;

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[1] Capitalized terms not otherwise defined in these CY 2023 Hospice Benefit Component Monitoring Guidelines have the meaning provided in the Addendum.

- Identifying any unintended or unexpected consequences of operating the Hospice Benefit Component (i.e., beneficiary harm or program integrity issues, and/or spillover effects of operating the Hospice Benefit Component on care, quality, health equity and utilization in other Medicare benefits);
- Assessing the impact of the Model on access to and quality of palliative and hospice care for underserved communities;[2]
- Ensuring that beneficiaries are not harmed or discriminated against; and
- Making sure that beneficiary choice of hospice provider is protected.

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

- Rigorously assessing the impact of the Hospice Benefit Component on enrollee experience, behavior, service use, quality of care, and cost;
- Evaluating data that is (1) submitted to CMS by participating MAOs as part of their monitoring activities and (2) from administrative data sources already available to CMS; and
- Assessing the reach and impact of the Hospice Benefit Component on the accessibility, use, and experience of care for enrollees at the end of life, including on underserved communities.

CMS will collect monitoring data and information to allow for real-time Model monitoring. Delays in reporting will impede CMS' efforts to monitor and evaluate the Hospice Benefit Component. As such, CMS will work with participating MAOs to ensure these data are submitted in a timely fashion to CMS. Per § 422.310, MAOs must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of *each item and service* provided to an enrollee by a provider, supplier, physician, or other practitioner. Therefore, **participating MAOs must submit accurate and complete encounter data related to Hospice Benefit Component-specific activities in their usual encounter data submissions so that this Model's monitoring and evaluation have the benefit of those data.**[3] Additionally, for monitoring and learning, CMS will conduct outreach to hospice providers that are providing hospice care in the service areas of participating MAOs (which may include hospice providers who do not provide hospice services to any enrollees of a participating MAO) to understand the impact of the Model on these hospice providers.

A guiding principle in CMS's approach to data collection and reporting is to minimize burden for participating MAOs, consistent with the government's need to monitor and evaluate model tests. Therefore, CMS has developed guidelines around data collection and reporting with consideration of the data needed to support model activities (see section 2) and what data are already available to CMS. CMS may ask for additional information if clarification of submitted data is necessary. CMS may make changes to the Model as necessary to ensure beneficiary safety and the integrity of the Model test (see also section 1115A of the Social Security Act).

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[2] Section 2(b) of Executive Order 13985 defines "underserved communities" as referring to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the communities listed in the definition of "equity" in section 2(a) of the Executive Order.

[3] For reference, please see the most recent Encounter Data Submission and Processing Guide.

CMS also emphasizes its commitment to addressing health inequities and the underlying inequities within the health care system. Having more granular data for enrollees will allow for better understanding of these individuals' needs and how care may be tailored to eliminate barriers to health and health care access, quality, and outcomes among the individuals CMS serves.

1.2 Overview of Hospice Benefit Component: Transparency and Monitoring Measures

To ensure compliance with the Addendum and the scope of activities described in the CY 2023 Request for Applications (RFA) for the Hospice Benefit Component of the VBID Model ("CY 2023 VBID Hospice RFA"), CMS will monitor the impact of the Hospice Benefit Component, based on the following quality and monitoring domains: (i) Palliative Care and Goals of Care Experience; (ii) Enrollee Experience and Care Coordination at End of Life; and (iii) Hospice Care Quality and Utilization. Additionally, this guidance document includes a new fourth domain based on the requirement in the 2023 RFA for the Hospice Benefit Component for all participating MAOs to submit a health equity plan: Implementation of Health Equity Plans (HEPs). These quality and monitoring domains were selected to address key improvement opportunities which are relevant both to beneficiaries who choose hospice and those who do not, as well as their families and their caregivers.

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

CMS is leveraging the following existing CMS and other data sources for the majority of the beneficiary-focused measures in these domains. Such data and data sources include:

- MA Encounter Data, Medicare Claims, Prescription Drug Event Data (PDE) and Part C and D reporting;
- Beneficiary enrollment, eligibility, and payment data (Medicare Advantage and Prescription Drug system (MARx), CMS Enrollment database);
- Plan data submitted for bids using the plan benefit package (PBP) software and available in the Health Plan Management System (HPMS);
- Quality data (e.g., Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcome Survey (HOS), MA Consumer Assessment of Healthcare Providers and Systems (CAHPS), CAHPS Hospice Survey);
- Data from Quality Improvement Organizations (QIOs);
- Data from the Center for Disease Control/Agency for Toxic Substances Disease Registry/Social Vulnerability Index (CDC/ATSDR/SVI) and Area Deprivation Index (ADI);
- Medicare Complaint Tracking Module (CTM) and 1-800-Medicare;
- VBID annual application data; and
- Other items as deemed necessary to ensure compliance with all Model terms, beneficiary protections, and program integrity.

Table 1 provides a list of these measures by domain, source of data and frequency of monitoring review. Each measure is described more fully in Appendix 5. CMS may monitor for additional impacts on quality, beneficiary safety, and potential discrimination beyond those described in these guidelines, using existing CMS data. For example, because hospice providers will continue to submit claims for informational and operational processing and monitoring (sometimes referred to as "shadow billing") to Medicare

Administrative Contractors, CMS will continue to rely on hospice claims for many of the monitoring measures such as the proportion of enrollees admitted to hospice for less than seven days.

1.3 Addition of Progress Reports to Monitor Implementation of Health Equity Plans

As described in Section 1.3 and Appendix B of the CY 2023 VBID Hospice RFA, all MAOs participating in the Hospice Benefit Component for 2023 must have a strategy to advance health equity with respect to palliative care, transitional concurrent care, and hospice care. This strategy is hereafter referred to as a health equity plan (HEP). In order to monitor and support implementation of the HEPs that were submitted as part of the CY 2023 application, CMS will require all participating MAOs to submit biannual progress reports. These progress reports will provide additional information on the implementation status of the efforts described in the HEPs.

More information on how to complete the HEP progress reports can be found in Section 2.4 and Appendices 4 and 5 of this document.

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

Transparency and Monitoring Measures	Source of Data – CMS	Source of Data – Plan Reported	Frequency of Monitoring Review
Palliative Care and Goals of Care Experience			
Development of WHP, including Advance Care Plans (ACPs)		X	Annually[1]
Access to, and use of, Palliative Care		X	Biannually
Proportion of Enrollees Admitted to Hospice for Less than 7 Days	X		Quarterly, beginning Quarter 2 2023
Enrollee Experience and Care Coordination at End of Life			
Days Spent at Home in Last Six Months of Life	X		Annually
Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life	X		Annually
Hospice Care Quality and Utilization			
Pre-Hospice Consultation Process		X	Biannually
Availability of and Access to Hospice Providers		X	Biannually
Hospice Utilization	X		Quarterly, beginning Quarter 2 2023
Delivery of Transitional Concurrent Care		X	Biannually
Hospice Supplemental Benefits		X	Biannually
Part D Duplicative Drug Utilization	X		Annually
Unrelated Care Utilization	X	X	Annually for CMS-sourced data & Biannually for Plan Reported
Proportion of Lengths of Stay beyond 180 Days	X		Quarterly, beginning Quarter 2 2023
Visits in the Last Days of Life	X		Annually
Transitions from Hospice Care, Followed by Death or Acute Care	X	X	Annually for CMS-sourced data & Biannually for Plan Reported
Experience of Care Measures	X		Annually

Transparency and Monitoring Measures	Source of Data – CMS	Source of Data – Plan Reported	Frequency of Monitoring Review
Appeals and Grievances Processes	X	X	Rolling basis for CMS-sourced data & Bi-annually for Plan Reported
Provider Complaints and Disputes [2]	X	X	Rolling basis for CMS-sourced data & Biannually for Plan Reported
Timeliness of Claims and Payments		X	Biannually
Implementation of Health Equity Plans			
Inequities in access, outcomes, and/or enrollee experience among identified sub-populations		X	Biannually
Development and implementation of targeted interventions to address potential inequities		X	Biannually
Engagement of enrollees, caregivers, and providers to understand needs and craft potential interventions		X	Biannually
Advancing equitable access and delivery of palliative care, transitional concurrent care, and hospice care		X	Biannually

[1] Reported at summary level as part of VBID Model participation, and not separately for the Hospice Benefit Component; see CY 2023 VBID Model Monitoring Guidelines for more information

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

2. General Reporting Guidance and Requirements

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

2.1 Applicability of Other Guidance and Requirements

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

2.2 Overview of Types of Monitoring Data

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

Table 2: Attributes of Different Types of Monitoring Data

Type of Monitoring Data	Reporting Frequency	Data Content - Examples	File Format	Transmission Method
Beneficiary-level Data Reporting[1]	Biannually	Benefit Eligible date; Medicare Beneficiary Identification # (MBI), etc.	.txt file	VBID Hospice Web Portal only
Summary Reports and Other Reporting	Biannually/Annually	Summary-level information; qualitative survey questions	Variable format	VBID Mailbox: VBID@cms.hhs.gov
	Biannually	HEP Progress Report	N/A	Qualtrics survey
	Biannually	Network File (adapted Health Service Delivery (HSD) file listing all hospice providers in network[2] (Appendix 3))	.xlsx file	VBID Hospice Web Portal only

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

[2] SSA State/County Code, Health Service Delivery (HSD) files can be found in HPMS under Network Management>Documentation>Reference Files.

2.3 Plan Reported Beneficiary Level Data

Table 3 identifies the plan reported transparency and monitoring measures for CY 2023[4] and includes a description of the beneficiary-level data to be reported for each measure. Beneficiary-level data reporting by participating MAOs will be required on a biannual basis in CY 2023. The beneficiary-level data reporting is cumulative in each submission such that all VBID Hospice Benefit Component enrollees year to date are included. Please also note that beneficiary-level data should be reported for enrollees whose experience began **during the applicable calendar year**. For example, when reporting on palliative care for CY 2023, the beneficiary-level data should only reflect enrollees whose palliative care experience began no earlier than January 1, 2023. More detail about the data being collected for each of these categories can be found in Appendix 1 of this document.

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[4] These are described in detail in Appendix 5 of these guidelines; a provisional list was provided in Section 2.5 of the CY 2023 VBID Hospice RFA.

Table 3. Required Plan Reported Beneficiary-Level Data

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

CMS recommends that participating MAOs use claims data or other data that are already in their systems rather than reaching out to providers for beneficiary and summary-level reporting. Hospice providers might not have the complete information on the beneficiary's post-live discharge care or unrelated care; this also limits provider burden.

Participating MAOs are required to submit the Beneficiary-level Hospice Benefit Component Data File in accordance with the schedule presented in Table 4. The "performance period," as referenced in Table 4, refers to the period when services were provided to enrollees. The "report submission period," also referenced in Table 4, refers to the period during which a participating MAO must submit the required Beneficiary-level Hospice Benefit Component Data File to CMS.

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

CMS will also provide an **optional test submission** of the Beneficiary-level Hospice Benefit Component Data File via the portal. The option to provide a test submission will be provided prior to the July report submission period, between June 1-June 30, 2023. CMS will review test submissions, and notify participating MAOs with guidance for their July submission.

Table 4: Beneficiary-level Data Reporting Schedule (CY 2023)

Bi-Annual Submission	Cumulative Performance Period	Report Submission Period
Bi-Annual Submission Period One, 2023	1/1/23 – 6/30/23	7/1/23 – 7/31/23
Bi-Annual Submission Period Two, 2023	1/1/23 – 12/31/23	03/1/24 – 03/31/24

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

Note: The final file layout and contents may vary marginally from this sample; however, this sample is provided with the intent of representing close approximation of the final file. The final file layout and contents will be provided in Quarter 2 of CY 2023.

Participating MAOs must keep a record of each unique enrollee engaged in activities that are specific to the Hospice Benefit Component throughout the year and use the bi-annual update to provide the most current history of enrollees. Each bi-annual submission should serve as a "snapshot" of beneficiary-specific activity to date for the performance year ("cumulative data"). Submissions for the Period Two Report Submission Period must include all information for CY 2023, regardless of what was reported for the Period Two Report Submission Period. If, for example, an enrollee's information was delayed or not reported accurately in the CY 2023 Bi-Annual Submission Period One, CMS requires that the cumulative information to be updated by the participating MAO in the CY 2023 Bi-Annual Submission Period Two.

Additional instruction and training on beneficiary-level data reporting will be provided to participating MAOs prior to the Bi-Annual Submission Period One. In addition to the reporting requirements for the Hospice Benefit Component referenced above and the CY 2023 VBID Model Monitoring Guidelines (as applicable, e.g., for the WHP component), MAOs must also comply with the record retention requirements set forth in the Addendum and unwaived regulations. (For purposes of MA regulations and guidance, hospice services are a Medicare-covered benefit and shall be treated as basic benefits.)

2.4 Summary Reports and Other Reporting

Summary-Level Data Reporting

CMS will collect additional data that do not include beneficiary-level data in several forms and in accordance with the data-reporting schedule in Table 5 below. This additional data will be used to provide a more holistic approach to monitoring the Hospice Benefit Component. These data are described in Appendix 2 and include summary-level data and survey questions likely to be asked of the participating MAOs in order to provide additional context for other data collected regarding the Hospice Benefit Component.

Appendix 2 includes plan-level summary measures regarding hospice supplemental benefits, appeals and grievances, provider complaints, and claims payment timeliness. Please also note that summary-level data should be reported for enrollees whose experience began **during the applicable contract year**. For example, when reporting on hospice supplemental benefits for CY 2023, the summary-level data should only reflect hospice supplemental benefit utilization which began no earlier than January 1, 2023.

Survey questions included in Appendix 2 represent examples of what may be asked of participating MAOs by CMS and/or a CMS contractor. These questions may be edited in advance of discussion with the participating MAO and may be tailored to the participating MAO's interventions or submitted data. The questions provided in Appendix 2 are included to give a representative example of the type of questions that may be asked, but do not provide a complete list of what may be asked.

Table 5: Summary-level Data Reporting Schedule (CY 2023)

Biannual Submission	Cumulative Performance Period	Report Submission Period
Biannual Submission Period One, 2023	1/1/23 – 6/30/23	7/1/23– 7/31/23
Biannual Submission Period Two, 2023	1/1/23 – 12/31/23	3/1/24 – 3/31/24

Hospice Provider Network Reporting and Monitoring

Participating MAOs are required to not only establish networks of hospice providers consistent with their applicable phase of the Model Component's network adequacy policy but also maintain these networks during their participation in the calendar year. These requirements are described in Section B(5)(a), B(5)(b)(i), Section B(7), and Section B(8) in Appendix 3 of the Addendum. Participating MAOs must submit information about their CY 2023 hospice provider networks twice to report the scope and composition of the hospice provider network at various points in time, as shown in Table 6. The provider network table should include all hospice providers in the participating MAO's network at the time of data submission. This information may be used to compare against the hospice provider network submissions part of an MAO's application to verify the information in the application. Please note that CMS may reach out for additional information from a participating MAO or a hospice provider listed as being in-network to confirm a hospice provider's status as in-network.

As a reminder, per the requirements described in Section 6 of CY 2023 Phase 2 Network Adequacy Requirement Policy and Technical Guidance and Section B(8) of Appendix 3 of the Addendum, participating MAOs with mature-year PBPs must inform CMS of any provider termination considered to be "significant" 90 days prior to the termination. CMS considers significant changes to hospice provider networks to be those that go beyond individual or limited provider terminations that occur during the routine course of plan operations; affect, or have the potential to affect, a large number of the MAO's hospice enrollees;[5] or would affect the participating MAO's ability to meet MNP requirements for its service area(s). Participating MAOs with mature-year PBPs should email the VBID mailbox (VBID@cms.hhs.gov) to inform CMS of any significant provider terminations.

Table 6: Hospice Provider Network Reporting Schedule (CY 2023)

Bi-Annual Submission	Cumulative Performance Period	Report Submission Period
Bi-Annual Submission Period One, 2023	1/1/23 – 1/31/23	2/1/23– 2/28/23
Bi-Annual Submission Period Two, 2023	1/1/23 – 12/31/23	3/1/24 – 3/31/24

The information required is detailed in Appendix 3, and the file layout represents an adapted version of

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[5] For the purposes of this Model, CMS defines "a large number of the MAO's hospice enrollees" as ten percent or more of all enrollees in a PBP who have elected hospice.

the Health Service Delivery (HSD) table that MAOs use in other reporting to CMS regarding provider networks.

HEP Progress Reports

CMS will use a qualitative survey, that is the HEP progress report, to collect information about and monitor the implementation of the HEPs from the MAOs participating in the Hospice Benefit Component. Appendix 4 includes the template for the HEP progress report. Table 7 below lays out the reporting and cumulative performance periods for the HEP progress report. Participating MAOs will biannually complete and submit cumulative progress reports through a Qualtrics survey.

When completing the HEP progress report, a participating MAO must directly reference the narrative included in their Approved Proposal's HEP and, in general, explain in further detail how the participating MAO has advanced its efforts initially described in the HEP. Not all questions in the HEP progress report may be applicable to all participating MAOs based on the type of information originally included in a HEP.

CMS anticipates and allows for participating MAOs to improve upon the HEP initially submitted based on lessons learned throughout the implementation of the HEP. In cases when a participating MAO has changed its approach compared to the submitted HEP and/or the implementation approach to support advancing health equity, the participating MAO must add any new details or information about its HEP implementation activities that may not have been available at the time of the Approved Proposal. Any changes must be identified through the HEP Progress Reports with the original and revised approach clearly identified.

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

Table 7: HEP Progress Report Reporting Schedule (CY 2023)

Biannual Submission	Cumulative Performance Period	Report Submission Period
Biannual HEP Progress Report Submission One, 2023	1/1/23 – 6/30/23	7/1/23– 7/31/23
Biannual HEP Progress Report Submission Two, 2023	1/1/23 – 12/31/23	3/1/24 – 3/31/24

Table 8 below provides an overview of the various types transparency and monitoring measures that will be collected through the Summary Level reports, the provider network file submissions, and the HEP Progress Report. Please refer to the listed appendices for more information.

Table 8: Summary Level or Provider Network Data and Reporting

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

Data Source	Transparency and Monitoring Measure[1]	Data Description
HEP Progress Report (Appendix 4)	May be applicable to a variety of measures in Table 1	Report on (1) inequities in access, outcomes, and/or enrollee experience among identified sub-populations; (2) development and implementation of targeted interventions to address potential inequities; (3) engagement of enrollees, caregivers, and providers to understand needs and craft potential interventions (and any other interactions related to the refinement or implementation of the HEP); and (4) advancing equitable access and delivery of palliative care, transitional concurrent care, and hospice care.

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

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

Appendix 1: File Layout for Beneficiary-level Hospice Benefit Component Data File Required from MAOs.
This file layout is a .txt file; data variables are separated by a single pipe delimiter with no pipe delimiters needed at the beginning or end of the row (i.e., no pipe delimiter “end”/“cap”). The total number of pipes in each row should be n-1, where n= the number of header variables/data fields. Two pipes indicate the data fields in between and after, respectively, have missing values.

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

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Segment ID	SEGMENT_ID		R	Must be valid segment for indicated PBP/Contract	For non-segmented plans, enter a single numerical value of "0". For segmented plans, the numeric field is three digits. Must include a valid segment for indicated PBP/Contract, reflected in 3 characters, with leading zeroes as needed. (e.g. "003")
First Date of Enrollment in Palliative Care or Similar Program	FIRST_DATE_OF_ PALLIATIVE_CARE_ ENROLLMENT		Required if the enrollee receives any palliative care	Must be in Date Format [YYYYMMDD], numeric values only	The first date enrollee is enrolled in a non-hospice palliative care or similar program of care or services; leave blank if no palliative care provided. The first date of palliative care should be prior to hospice election.
Total Days in Palliative Care or Similar Program	TOTAL_DAYS_IN_ PALLIATIVE_CARE		Required if the enrollee receives any palliative care	Must be in numeric values only	Total days in a year that the enrollee was enrolled in a non-hospice palliative care or similar program of care or services; leave blank if no palliative care provided.
Beneficiary Cost-Sharing for Palliative Care or Similar Program	BENEFICIARY_COST_ SHARING_PALLIATIVE _CARE		Required if the enrollee receives any palliative care	Must be in Dollar Value [XXXX.XX], numeric values only	Beneficiary payment amount for the cost-sharing of palliative care services that were approved in the application. Enter 0.00 if no beneficiary payment for the Palliative Care services received and leave blank if no palliative care provided. If FIRST_DATE_OF_ PALLIATIVE_CARE_ ENROLLMENT and TOTAL_DAYS_IN_ PALLIATIVE_CARE are populated, this field should also be populated.

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

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Start date of receiving transitional concurrent care services, if applicable	TRANSITIONAL_ CONCURRENT_START _DATE		Required if the enrollee received Transitional Concurrent Care	Must be in Date Format [YYYYMMDD], numeric values only	Start date when an enrollee who has elected hospice begins receiving Transitional Concurrent Care services (as provided in the Approved Proposal; this includes clinically-appropriate items, services and drugs related to a hospice enrollee's terminal illness and related conditions, provided by network providers on a transitional basis outside the hospice benefit. Leave blank if no Transitional Concurrent Care services received. The start date of Transitional Concurrent Care should be on or after date of hospice election.
End date of receiving transitional concurrent care services, if applicable	TRANSITIONAL_ CONCURRENT_END_ DATE		Required if Applicable	Must be in Date Format [YYYYMMDD], numeric values only	End date representing the last date a hospice enrollee receives Transitional Concurrent Care services. Leave blank if no Transitional Concurrent Care services received.
Up to five most common transitional concurrent services, items or drugs provided for an enrollee receiving Transitional Concurrent Care	FIVE_MOST_COMMO N_SERVICES_FOR_ TRANSITIONAL_ CONCURRENT_CARE	List HCPCS Codes or NDC, as applicable	Required if the enrollee received Transitional Concurrent Care	Alphanumeric for HCPCS code, 11-digit character for NDC code	Up to five most frequently used services, items or drugs by an enrollee receiving Transitional Concurrent Care. List HCPCS codes or NDCs as applicable. The codes need to be separated by comma (e.g. CD01, CD02). Leave blank if no Transitional Concurrent Care services received. If TRANSITIONAL_ CONCURRENT_START_DATE is populated, this field should also be populated.

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Beneficiary Cost-Sharing for Transitional Concurrent Care	BENEFICIARY_COST_SHARING_TRANSITIONAL_CONCURRENT_CARE		Required if the enrollee received Transitional Concurrent Care	Must be in Dollar Value [XXXX.XX], numeric values only	Beneficiary payment amount for the cost-sharing of Transitional Concurrent Care services during the period. Enter 0.00 if no beneficiary payment for the Transitional Concurrent Care services received and leave blank if not applicable. If TRANSITIONAL_ CONCURRENT_START_DATE is populated, this field should also be populated.
Provider Payment for Transitional Concurrent Care to an enrollee during the period the enrollee received Transitional Concurrent Care	TOTAL_COST_OF_ TRANSITIONAL_ CONCURRENT_CARE	Total Cost of Transitional Concurrent Care Utilization During Receipt of Transitional Concurrent Care	Required if the enrollee received Transitional Concurrent Care	Must be in Dollar Value [XXXX.XX], numeric values only	Provide the total cost of providing Transitional Concurrent Care to an enrollee during the period the enrollee received Transitional Concurrent Care. **Cost is defined as the payment to the providers** (plan paid amount). Leave blank if no Transitional Concurrent Care received. If TRANSITIONAL_ CONCURRENT_START_DATE is populated, this field should also be populated.

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

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

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Beneficiary Cost-Sharing for Unrelated Care	BENEFICIARY_COST_SHARING_UNRELATED_CARE		Required for hospice enrollees under the Model	Must be in Dollar Value [XXXX.XX], numeric values only	Beneficiary payment amount for the cost-sharing of services that is (1) unrelated to the beneficiary's terminal illness and related conditions and is outside the scope of Transitional Concurrent Care, and (2), provided during a hospice election period, including Part A inpatient services, Part B outpatient services, professional provider services and durable medical equipment (DME) services. Part D drugs are excluded. The unrelated care should be rendered during a hospice election period, excluding care provided on the first and last day of a hospice stay. Enter 0.00 if no unrelated care services received and leave blank if not applicable (i.e., enrollee did not elect hospice).

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Provider Payment for Providing Unrelated Care	TOTAL_COST_OF_ UNRELATED CARE	Total Cost of Unrelated Care	Required for hospice enrollees under the Model	Must be in Dollar Value [XXXX.XX], numeric values only	Total cost of care that is (1) unrelated to beneficiary's terminal illness and related conditions and is outside the scope of Transitional Concurrent Care, and (2) provided during a hospice election period, including the same specifiers and exclusions as above. Cost is defined as the payment to the providers. Enter 0.00 if no unrelated care services received for hospice enrollees under the Model and leave blank if not applicable (i.e. enrollee did not elect hospice).

ELEMENT	HEADER LABEL	VALUES	REQUIRED (R) or OPTIONAL (O)	FORMAT VALIDATION	DEFINITION
Total Cost of Providing Post-Hospice Live Discharge Care	TOTAL_COST_OF_ POST_LIVE_ DISCHARGE_CARE	Total Cost of Post-Discharge Care	Required for hospice enrollees under the Model	Must be in Dollar Value [XXXX.XX], numeric values only	Total cost of care that is provided post-hospice live discharge, including Part A inpatient services, Part B outpatient services, professional provider services and durable medical equipment (DME) services. **Part D drugs are excluded.** Cost is defined as the payment to the providers. Hospice live discharge is when the beneficiary's hospice status terminates due to being discharged alive from the hospice or revoking the election of hospice services. Patient being transferred to another hospice provider is not considered a live discharge. **Post-live discharge period is the time between the live discharge and the end of the calendar month in which the live discharge from hospice occurred.** Enter 0.00 if no post live discharge services received for hospice enrollees under the Model. Leave blank if not applicable (i.e. enrollee did not elect hospice).

Appendix 2: Summary Level Reporting Worksheet

Summary-level Hospice Benefit Component Information Worksheet

Target Reporting Date to CMS: Bi-Annually, between 7/1/23 – 7/31/23 and 3/1/24 – 3/31/24

Plan Year: 2023
Parent Organization: [NAME OF PARTICIPATING PARENT ORGANIZATION]
Model-Participating Contracts: [PLEASE LIST CONTRACT AND PBP IDENTIFICATION INFORMATION]

Summary Statistics[6]

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

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[6] Please refer to 2023 VBID Model Monitoring Guidelines' WHP Monitoring Worksheet for WHP reporting.

Metric	Metric Description	Unit Description	Participating Contract-PBP "A" [LIST ID]	Participating Contract-PBP "B" [LIST ID]	Participating Contract-PBP "C" [LIST ID]
Hospice Supplemental Benefits, not including reduced cost-sharing (cont.)	A – home and bathroom safety devices				
	B – OTC benefits				
	C – Support for care givers				
	D - Meals				
	E – Transportation				
	F – Pest control				
	G – Room and Board				
	H – Others, Describe				
Beneficiary Appeals and Grievances[7]	Number of total Hospice Benefit Component-related grievances (i.e., may relate to non-hospice palliative care, Transitional Concurrent Care, hospice care, unrelated care and/or post-hospice live discharge care)	▨			

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[7] To define which event should be used to determine the performance period for the "Beneficiary Appeals and Grievances" metric, please use the notification date if the notification date is during the performance period for consistency with HPMS reporting and program audits.

Metric	Metric Description	Unit Description	Participating Contract-PBP "A" [LIST ID]	Participating Contract-PBP "B" [LIST ID]	Participating Contract-PBP "C" [LIST ID]
Beneficiary Appeals and Grievances[8] (cont.)	Number of total Hospice Benefit Component-related appeals (i.e., may relate to non-hospice palliative care, Transitional Concurrent Care, hospice care, unrelated care and/or post-hospice live discharge care)				
	Number appeals related only to hospice care[9]				
Hospice Provider Complaints and Disputes[10]	Total number of hospice provider complaints and disputes (including related to service delivery and/or timeliness and accuracy of payments)[11]				
Timeliness of Claims and Payments[12]	Percent of all (in-network and out-of-network) hospice clean claims paid within 30 days				

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[8] To define which event should be used to determine the performance period for the "Beneficiary Appeals and Grievances" metric, please use the notification date if the notification date is during the performance period for consistency with HPMS reporting and program audits.

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

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

[11] For complaints that apply to multiple VBID-Hospice PBPs, the complaint should be reported for each PBP that it applies to, and a footnote should be included in the worksheet to note that this scenario applies.

[12] Notices of Election (NOEs) should not be included in any of the claims counts for the Timeliness of Claims and Payments metric.

Metric	Metric Description	Unit Description	Participating Contract-PBP “A” [LIST ID]	Participating Contract-PBP “B” [LIST ID]	Participating Contract-PBP “C” [LIST ID]
Timeliness of Claims and Payments (cont.)	Percent of all other (in-network and out-of-network) hospice claims that are not “clean” as defined in 42 CFR 422.500 and paid within 60 days				
	Percent of claims (including for unrelated care) related to the Hospice Benefit Component subject to prepayment and/or postpayment review				

Survey Questions

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

- What quality improvement activities is your MAO conducting related to non-hospice palliative care and to hospice care, such as activities to improve the identification of patients that can benefit from palliative or hospice care, referral criteria and/or relationships with referral sources?
- Please provide an overview of how an enrollee and his/her providers (hospice and non-hospice) would interact with your pre-hospice consultation program.
- How does your pre-hospice consultation program ensure timely access to high-quality hospice care, including from both in and out of network providers? Are there any delays or deferral in getting an enrollee into the enrollee’s choice of hospice?
- How do you define a high-quality hospice provider? A low-quality hospice provider? How did these definitions apply to the process you used to create your network of hospice providers?
- What, if any, changes or enhancements have you made to the targeting criteria for non-hospice palliative care and/or Transitional Concurrent Care that were detailed in your application?
- How does your MAO work with enrollees and their caregivers as well as upstream referral sources to ensure access to out-of-network hospice where requested?
- What are the primary reasons for enrollees discontinuing Transitional Concurrent Care (after electing hospice)?
- As applicable, what hospice supplemental benefits have been most frequently used and valued by enrollees and/or their caregivers? If you did not offer hospice supplemental benefits, are there other supplemental benefits that have been most valued by enrollees and/or their caregivers during a hospice stay?
- Are there any differences in timeliness, including accuracy, of all types of hospice claims payments between in and out-of-network hospice providers? In receiving Notices of Elections (NOEs) and/or Notices of Termination/Revocation (NOTRs)?
- How are you monitoring and ensuring that underserved communities, that may have historically been underserved in end-of-life care, are receiving equitable access and care that is tailored to their cultural needs?

Appendix 3: Hospice Provider Network File

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

*SSA State/County Code, Health Service Delivery (HSD) files can be found in HPMS under Network Management>Documentation>Reference Files.

Appendix 4: HEP Progress Report Template

Parent Organization Name ____
Name of Point of Contact Completing This Report ______________________________________
E-mail Address of Point of Contact ____

Please note this document represents a template of the HEP Progress Report. MAOs will be provided with a link to complete and submit the HEP Progress Report. Each MAO will be directed to the appropriate questions and sub-questions based on initial responses provided in the survey. When completing the HEP progress report, MAOs must directly reference the narrative included in their Approved Proposal's HEP.

Please also note that the phrase "palliative care, transitional concurrent care, and/or hospice" will hereafter be referred to as "the three types of care."

Identified Inequities in Access, Outcomes, and/or Enrollee Experience among Identified Sub-populations

Q1. *[All Respondents Must Answer]* Please describe how you are applying CMS's definition of health equity[13] to inform your overall efforts to advance health equity within the Hospice Benefit Component and, if applicable, to identify specific inequities among the three types of care.

Q2. *[All Respondents Must Answer]* Were there any specific and measurable inequities identified in access, outcomes, and/or enrollee experience of care as it relates to the three types of care? If yes, please move to Q3. If no, move to Q7.

Q3. *[Only if Answered Yes to Q1.]* Please briefly describe the subpopulation(s) and/or general population identified as experiencing inequities in the three types of care.

> Q3.1. How has your organization advanced its understanding of the needs of the population(s)? Please delineate any potential inequities in the sub-populations across the three types of care (e.g., the subpopulation for hospice is enrollees with X condition but the subpopulation for palliative care is enrollees with X condition or Y condition).

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[13] CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes. More information can be found here: https://www.cms.gov/files/document/health-equity-fact-sheet.pdf

Q3.2. Please describe any barriers in advancing your organization's understanding of the needs of the subpopulation and/or general population as it relates to advancing health equity.

Q4. *[Only if Answered Yes to Q1.]* What inequities were initially identified across 1) access, 2) outcomes, and/or 3) enrollee experience of care for the three types of care?

Q4.1. How has your organization advanced its understanding of the inequities (e.g., prevalence of the inequity, impact of the inequity, enrollee perceptions of the inequity, etc.)? Please delineate any potential differences across the three types of care (e.g., "We identified X inequity for palliative care but Y inequity for hospice care.")

Q4.2. Please provide a description of the specific method(s) and data source(s) your organization used to identify these measures of inequity and how often they were measured.

Development and Implementation of Targeted Interventions to Address Potential Inequities

Q5. *[Only if Answered Yes to Q1.]* What targeted intervention(s) is/are your organization implementing to address the inequity/inequities the population(s) identified above? and

Q5.1. How has your organization made progress on the implementation of the intervention? (e.g., conducting internal staff training, conducting outreach to enrollees, caregivers, providers, and/or local community organizations, and expanding provider capacity to deliver more equitable care.) Please delineate any potential differences across these three types of care

Q5.2. Please describe any barriers in implementing the intervention(s) described previously.

Q6. *[Only if Answered Yes to Q1.]* Do you have defined evaluation metrics to monitor, evaluate and sustain the interventions you implement to address the inequities for the identified priority population(s)?

Q6.1 If yes, please list the measures, provide a narrative description of the measure, how often it is measured, and if the performance target was achieved.

Q7. *[Only if Answered No to Q1.]* If your organization has not identified any specific and measurable health inequities across the three types of care, how has your organization advanced its capability to identify and track health inequities across the three types of care?

Q8. *[Only if Answered No to Q1.]* How has your organization advanced its understanding of potential interventions that can address health inequities across the three types of care?

Engagement of Enrollees, Caregivers, and Providers to Understand Needs and Craft Potential Interventions

Q9. *[All Respondents Must Answer]* Please describe how your organization has engaged enrollees, caregivers, and providers in assessing and advancing health equity.

Q10. *[All Respondents Must Answer]* Do you have established partnerships with key community members and organizations that serve your priority populations to help address any identified inequities?

Q10.1If yes, please share an example of one of those partnerships.

Advancing Equitable Access and Delivery of Palliative Care, Transitional Concurrent Care, and Hospice Care

Q11. *[All Respondents Must Answer] [Applicable to Mid-Year Progress Report]* What are other specific activities/actions your organization will pursue through the end of the year?

Q12. *[All Respondents Must Answer]* Who is the Health Equity Champion or person responsible for the success of the health equity plan?

Q13. *[All Respondents Must Answer]* What additional support could CMS provide to help you improve or execute your HEP?

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

Appendix 5: Narrative Descriptions of the Transparency and Monitoring Measures

Building on section 2.5 of the CY 2023 VBID Hospice RFA, Appendix 5 is intended to provide additional detail on the transparency and monitoring measures contained in this document, in order to demonstrate how each measure contributes to a robust monitoring approach for the Hospice Benefit Component of the VBID Model. For questions on the measures, contact VBID@cms.hhs.gov (VBID Mailbox).

I. Palliative Care and Goals of Care Experience

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

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

In alignment with the VBID Model's required WHP component, participating MAOs must develop systems to improve the offer of ACP for enrollees with serious illness. This includes, but is not limited to, mechanisms to ensure that each enrollee is aware of the availability of WHP services. More information for this specific requirement can be found in Section 2.1 of the CY 2023 RFA for the VBID Model and in Article 3.C of the Addendum. ACP promotes patient choice by providing an opportunity for patients to discuss preferences with their provider that impact the kind of care they would like to receive, should they not have the capacity to do so at some time in the future. It can also be a time to prepare documents, including Advance Directives, explaining their wishes. Further requirements related to the WHP component can be found on: https://innovation.cms.gov/initiatives/vbid/. Participating MAOs should review the CY 2023 VBID Monitoring Guidelines for WHP summary-level reporting.

B. Access to, and use of, Palliative Care

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. This type of care throughout the course of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitates patient autonomy, access to information, and choice. See also 42 CFR § 418.3.

To assess access to and use of palliative care, CMS requires participating MAOs to capture enrollee experience data with respect to palliative care during the Model period. This includes the duration of palliative care received, the timeliness of the election to receive non-hospice

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palliative care, beneficiary cost-sharing amounts for palliative care services and the election rate of hospice care for those who received non-hospice palliative care.

To ensure optimal care for beneficiaries who do not elect or are not eligible for hospice but may benefit from palliative care, MAOs must submit beneficiary level data on palliative care provided to those eligible enrollees who do not elect hospice, as well as summary level data on palliative care that is agnostic regarding hospice election.

C. Proportion of Enrollees Admitted to Hospice for Less than 7 Days

Although the use of hospice and other palliative care services at the end of life has increased, many beneficiaries are enrolled in hospice for less than seven days before their death, which limits the benefit they may gain from these services. The existing evidence-base demonstrates that beneficiaries enrolled in hospice experience better quality of life – benefits that increase the longer beneficiaries are enrolled in hospice. To evaluate whether integration of WHP and non-hospice palliative care services and access to Transitional Concurrent Care improves the timeliness of optimal hospice election, CMS will use claims data submitted by hospice providers as part of the “shadow billing” process to assess the percentage of enrollees who elect hospice less than 7 days prior to their death. Results will be assessed in the context of any potential geographic variations using regional benchmarks.

II. Enrollee Experience and Care Coordination at End of Life

CMS is testing different service delivery approaches with the goal of improving enrollees’ experiences at the end of life, including better coordination across the continuum of care and concordance with patient preferences for place and types of care received. The Model will monitor the below measures to understand and monitor overall enrollee experience and care coordination at end of life:

A. Days Spent at Home in Last Six Months of Life

Since its inception, the Medicare Hospice Benefit has placed a strong emphasis on care in the home setting. As stated in the August 22, 1983 proposed rule entitled "Medicare Program; Hospice Care" (48 FR 38146), "[T]he hospice experience in the United States has placed emphasis on home care. It offers physician services, specialized nursing services, and other forms of care in the home to enable the terminally ill individual to remain at home in the company of family and friends as long as possible." This is codified in regulations that provide continuous home care services as needed with the goal of maintaining the patient in the home and the general inpatient (GIP) level of care only for temporary crises that cannot be managed at home.

At the end of life, and consistent across different demographics and regions, most enrollees prioritize spending days at home rather than at health care facilities. Research has used days at home in the last six months of life as a patient-centered measure calculated using administrative data. CMS will assess the number of days within the last six months of life that participating MAOs’ enrollees utilized acute care services (i.e., inpatient days in an acute care facility, an inpatient rehabilitation facility, a skilled nursing facility, or an inpatient hospice unit) using Part A claims and encounter data.

B. Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life

ICU admissions may be a proxy to gauge the types and levels of care provided to patients with terminal illnesses. Among all enrollees who die (not just those who elect hospice), CMS will monitor on an annual basis the proportion of enrollees admitted to ICUs in the final 30 days of life. This measure will examine the extent that different approaches to delivering timely and appropriate advance care planning, palliative care, Transitional Concurrent Care and hospice services as a part of coordinated and patient-centered care changes the types and levels of care received by enrollees at the end of life.

III. Hospice Care Quality and Utilization

An important goal through testing the Hospice Benefit Component is to improve access to high-quality hospice care for MA enrollees who elect the hospice benefit. Through monitoring of the Hospice Benefit Component, CMS aims to ensure that testing this component does not decrease the quality of care furnished to beneficiaries. In addition to the total number of beneficiaries electing hospice for each MAO, CMS will monitor hospice elections by terminal conditions, age, race, and Medicare eligibility status (e.g., aged, disabled, ESRD, dually eligible for Medicaid). CMS will also monitor election by day of the month and evaluate average and median number of hospice service days. Wherever appropriate and possible, CMS will compare these data against regional benchmarks for similarly situated enrollees.

Also, CMS will monitor the following measures:

A. Pre-Hospice Consultation Process

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

If this process is utilized, MAOs must submit descriptions of the consultation process as part of the application process. CMS will also seek beneficiary level data to compare "Consult to Care" time for those who eventually seek care from both in-network and out-of-network hospices, which could highlight its benefits or identify issues with a participant MAO's pre-hospice consultation process. CMS recognizes that not all Participating MAOs have a consultation process. CMS also recognizes that not all enrollees considering hospice will have such pre-hospice consultations and may make such a decision through other referrals. In these situations, reporting can be left blank for that enrollee.

B. Availability of and Access to Hospice Providers

CMS will monitor the availability of and access to in-network hospice providers. MAOs must submit a list of in-network providers two times per year. The format of this list (included in Appendix 3) is an adapted version of the HSD tables the participating MAO submits to CMS for general program network monitoring in order to largely align with existing program requirements for network monitoring. Based on the network adequacy standards described in the CY 2023 VBID Hospice RFA for all MAOs with mature-year PBPs, CMS will use hospice provider network file submissions part of the application process to participate in CY 2023 and hospice network submissions during CY 2023 to monitor ongoing compliance with the Phase 2 network adequacy requirements.

C. Proportion of Lengths of Stay beyond 180 Days

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

D. Transitions from Hospice Care, Followed by Death or Acute Care

Avoiding unnecessary hospital and Emergency Department (ED) admissions and re-admissions was identified by the National Quality Forum (NQF) as a high priority measurement opportunity for hospice. In addition, MedPAC suggests that while there are many reasons for live discharges from hospice care, including patient preference-driven revocations, problematic patterns of live discharges followed by negative outcomes could signal a quality of care issue. Thus, CMS will monitor for number of live discharges (including those initiated by the hospice and those initiated by the enrollee, such as when the enrollee revokes his or her hospice enrollment) followed by death within 30 days or transfer to another hospice, inpatient, ED, or observation visit stay within 7 days.

Additionally, CMS will monitor total number of live discharges, live discharges by day of the month, live discharges for enrollees who are determined to no longer be terminally ill, average cost of post-live discharge care, and the number of days between live discharges and reelection, when applicable.

E. Visits in the Last Days of Life

To help identify high-quality hospice care, CMS will monitor and identify the number, length, and type of hospice care visits received in the last three days of life for an enrollee. CMS will assess the documented care provided by MAO network hospices and out-of-network hospices in the last three days of life. CMS will conduct outreach calls to participating MAOs to understand quality improvement activities regarding access to hospice care visits and will also review and monitor FFS claims.

Specifics of this measure can be found in the CMS Measures Inventory Tool: (https://cmit.cms.gov/CMIT_public/ReportMeasure?measureRevisionId=3320).

F. Experience of Care Measures

To assess consumer and family experiences with hospice care, CMS will assess the following specific experience of hospice care measures available in the current Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey: (i) caregiver's perception of the timeliness of receiving help; (ii) the adequacy of training for families to care for the patient; (iii) the help received for pain and symptoms; and (iv) net promoter score-like survey question pulled from the CAHPS Hospice Survey around the extent to which the patient's caregiver would recommend the hospice. Survey results will be gathered from hospice participation in the CAHPS Hospice Survey, which will be available because all Medicare-certified hospices must participate in the CAHPS Hospice Survey and the MAO may only use hospice programs that have a Medicare participation agreement to furnish the Medicare hospice benefit (42 CFR 422.204(b)(3)).

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

G. Hospice Supplemental Benefits

Consistent with the overall VBID Model, participating MAOs may offer a broad set of mandatory supplemental benefits to enrollees who elect hospice (called "hospice supplemental benefits" under the Model) in addition to mandatory supplemental benefits offered to all enrollees in the MA plan. CMS recognizes that the set of items and services that a hospice enrollee may benefit from could be broad, depending on the hospice enrollee's individual circumstances.

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

H. Part D Duplicative Drug Utilization

CMS will quantify and monitor Part D covered drug utilization patterns and PDE data for enrollees who elect hospice. OIG found that duplication and fragmentation of Part D coverage results in costs for beneficiaries and their families, as well as Medicare, that should have been covered by the hospice provider as related to the terminal illness and related conditions. CMS will assess PDE data for enrollees of participating plans relative to those of non-participating plans and beneficiaries in Original Medicare. CMS will assess different factors such as specific hospice providers, MAOs, and hospice diagnoses as part of assessing the impact of the Model component on decreasing duplicative payment for Part D covered drugs.

I. Unrelated Care Utilization

CMS will monitor participating MAOs' encounter data, as well as beneficiary-level data reported by the plan, to determine spending for unrelated care and will monitor any changes in the patterns of delivery of unrelated care and cost consistent with testing whether this payment and service delivery model reduces care fragmentation. Over time, this measure is also an important payment safeguard as the hospice capitation payment rates paid under this Model reflect a combined payment rate of related and unrelated spending as detailed in the CY 2023 Final Hospice Capitation Payment Rate Actuarial Methodology.[14]

Accordingly, CMS will quantify and monitor the amount of utilization and spending for services provided during hospice election that are unrelated to a participating MAO's enrollee's terminal illness and related conditions, including unrelated Part A inpatient services, Part B outpatient services, professional provider services and durable medical equipment (DME) services. CMS will use data from the beneficiary-level and summary-level reports to inform this monitoring effort. CMS will also monitor beneficiary cost-sharing amounts for services provided during a hospice election period that are unrelated to the beneficiary's terminal illness and related conditions. CMS intends to compare utilization among hospice enrollees in the Model who choose an in-network vs those who choose an out-of-network hospice provider. CMS will also compare utilization among hospice enrollees in the Model against hospice enrollees in MA but outside the Model and beneficiaries in the Medicare FFS program.

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

J. Hospice Utilization

In order to understand the impact of the Model on hospice utilization, CMS will monitor the number of total hospice enrollees, admission by day of month, average and median service days by level of care, length of stay (median and average) by terminal condition, age, race and

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[14] View the CY 2023 Final Hospice Capitation Payment Rate Actuarial Methodology at the following link: https://innovation.cms.gov/media/document/vbid-hospice-final-actuarial-2023-meth

eligibility-status (aged, disabled, ESRD, dually eligible for Medicaid)), and the amount of Routine Home Care that is delivered in Assisted Living Facilities, Nursing Facilities, and Skilled Nursing Facilities.

K. Appeals and Grievances Processes

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

L. Provider Complaints and Disputes

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

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

M. Delivery of Transitional Concurrent Care

Under the Model test, MAOs are permitted to offer innovative, individualized Transitional Concurrent Care services to help more patients access and receive the full benefits of hospice care. The official start date for the Transitional Concurrent Care period always begins on or after election of the hospice benefit. The end date is the last date in which Transitional Concurrent Care services were received by a hospice enrollee during their hospice stay. Examples of types of concurrent care include but are not limited to chemotherapy, heart failure treatment, HIV treatment, blood transfusions, radiation therapy, hemodialysis and COPD treatment. Any Transitional Concurrent Care must be appropriate and reflective of patients’ needs and wishes as identified in their plans of care and coordinated among hospice providers, MAOs, and other treating providers. To evaluate the utilization of Transitional Concurrent Care, CMS will monitor the number of beneficiaries receiving Transitional Concurrent Care and stratify the data across demographics including race, age, gender, terminal diagnoses and eligibility status (i.e. aged, disabled, ESRD, dually eligible for Medicaid). CMS will monitor and review the types of Transitional

Concurrent Care delivered, beneficiary cost-sharing amounts for Transitional Concurrent Care services and the mean and median duration of Transitional Concurrent Care. This will be collected in beneficiary-level and summary-level plan reporting from participating MAOs.

IV. Implementation of Health Equity Plan (HEP)

As described in the CY 2023 VBID Hospice RFA, each participating MAO must have a detailed strategy for advancing health equity, also known as a HEP. This plan must include, but is not limited to, information regarding how the participating MAO will apply principles of health equity to the delivery of palliative care and transitional concurrent care, and to the coverage and coordination of the Medicare hospice benefit. CMS will gather information on a biannual basis from the participating MAOs to monitor both their progress in implementing the HEP and the impact of implementation activities on any health inequities identified in the HEP. This monitoring will cover the following topics: (i) inequities in access, outcomes, and/or enrollee experience among identified sub-populations, (ii) development and implementation of targeted interventions to address potential inequities identified in the HEP, (iii) engagement of enrollees, caregivers, and providers to understand needs and craft potential interventions, and (iv) advancing equitable access and delivery of palliative care, transitional concurrent care, and hospice care.