Calendar Year (CY) 2022 Hospice Benefit Component Payment Methodology Office Hours

April 13, 2021

Nate Hoffman:
[00:00:06] Thank you for joining the Calendar Year 2022 Hospice Benefit Component Payment Methodology office hours webinar. Throughout today's presentation, attendees will be on mute. However, questions are encouraged, and questions can be submitted through the WebEx Q&A panel. Select "Q&A" followed by "All Panelists." The VBID Model Team will read submitted general questions and provide answers. Some inquiries may require additional research. In these cases, the VBID Model Team will investigate and reply via email at a later time. At this time, I would like to turn it over to Laurie McWright, the deputy director for CMMI's Seamless Care Models Group. Laurie?

Laurie McWright:
[00:00:57] Thank you, so much Nate, and as Nate said, I'm the deputy director for the Seamless Care Models Group, and I get the pleasure of reading the disclaimer language for this session. As with all webinar sessions for CMMI, the information provided in this presentation is really intended as educational, doesn't constitute legal advice, and so please take it as such. Next slide.

[00:01:36] Great, and I'd like to introduce Rich Coyle from our Office of the Actuary. He is going to walk us through the materials for today, and then we'll talk about next steps. This is a really exciting time of the year – exhausting, I know for many of you who are preparing Model applications submissions as well as bid submissions. We stand ready to support this final week push for the Model applications, which we'll talk more about at the conclusion of this presentation, and we'll look forward to receiving your applications at the end of the week. Rich, I'm going to turn it over to you. Thank you.

Richard Coyle:
[00:02:28] Okay, thank you, Laurie, and good afternoon. So as you can see, we're going to discuss three high-level topics this afternoon. First, to walk through some of the key assumptions supporting the 2002 VBID hospice rates. These assumptions are spelled out in the actual methodology report that you can find on our website, but we'll certainly highlight some of the key items. Next, we'll give an overview of the materials posted on CMS.gov on the Innovation Model website and then, as Laurie mentioned, we'll end with the question-and-answer session. Next slide.

[00:03:08] So for those of you who have participated in one of these prior years, you're familiar with this slide. And I'm just going to walk through the first line of this, and if you have any questions about the rest of it, please enter it into the "Q&A" panel. At a high-level, and it does say calendar year 2021, it applies to calendar year 2022 as well. But at a high level, there's probably three components to the rate. First, there's a national hospice capitation base rate, and

actually, there's going to be two of them for 2022, one for the year-one rates and one for the year-two rates, and we'll talk about that in a moment.

[00:03:48] And then the next component of the rate is the monthly rating factor. And again as you can see, in the second graphic from the bottom, there's three rating factors for month one, days 1 through 6, 7 to 15, and 16 and longer, and one for month two and later. And the days in the rating factor for month one represent the total days of care in that first month of coverage, so it could be more than one episode of care that comprises that. It's the total days during that first month of coverage. So that's the monthly rating factor.

[00:04:26] And then the third component is the average hospice geographic adjustment, which is obviously a local area factor to reflect the specific utilization and cost of that area. So the product of those three factors would equal the capitation rate, and we have publicly published those last Friday. Next slide.

[00:04:55] So these are what we're calling the national average values for the year-one rates. The next slide will have comparable data for the year-two rates. And as I mentioned, there's the development of the rates is different for participants that were in the Model last year or this year for 2021 because there's a carryover of the month-two claims. You know there'll be more month-two claims that began in the prior year for the year-two rates. The year-one is limited to just claims that began in that calendar year. So that's what I'm going to talk about first.

[00:05:37] So the first two columns here just represent the coverage period. As I just mentioned, month one has three different coverage periods, then in the month two and later, there's a separate coverage period. The next column is the monthly service days, and this is just an illustration of the number of days representing each of those coverage periods. And next we have the distribution of stay months, and again that just represents for each of those tiers, the percentage of stay months represented by those. So you can see that in total, month one represents about 39 percent of the stay month and month two and later is about 61 percent.

[00:06:18] Next column shows the monthly rating factors. Again, they vary by coverage period, and the rating factors for month one 0.340, 0.640, and 1.003. These are the factors that were announced or proposed in the preliminary announcement that went out on March 8; they are unchanged. As we'll talk about year two, there is a change there because of what was proposed.

[00:06:51] And the final column is what we call the monthly base rate. This is the rate that the national rate of what we'll receive for each of those coverage periods. A key number here is the month two, gross monthly base rate of $5,375.83. The other rates are built off of that. So for example, the month one, days one through six, gross monthly rate of $1827.78, that is equal to a product of the month-two value and the monthly rating factor. So you can check them out there, but it's -- that's how you develop the gross monthly rate for the month one, and the month two is what it is.

[00:07:41] The final value at the bottom of the page-- bottom right, that is composite when -- if you weight the month -- gross monthly rates by the distribution of stay months, that is the resulting value. So, one could look at that as on the national basis that is what you may expect to

get on average on a per-member-per-month basis throughout the whole year. But of course that's a national number, so actual results will vary. Next slide.

[00:08:13] And as I mentioned, this is the same chart but for year two. These are for counties that were in the Model last year. I think it's a little over 200 counties were in the Model last year. So average monthly service days are going to be slightly different, particularly for month two, I think it's going to be a little bit higher than for the month one. The distribution of stay months is certainly different than the month two and later. It was 61 percent per year for year one, it's about 72 percent for year two, and again that's a recognition of more episodes that carryover from the prior year.

[00:08:58] The next column is the monthly rating factor. You may notice that these are different than what was proposed in the preliminary announcement. In going through the more detailed development of the rates, we realized that the gross monthly base rates for year one for month one, would yield different results had we not changed these factors. That if we kept them for instance the month one at the 0.340 the same as the year one, that gross monthly base rate would be lower than it would be for the year-one rates. Our objective was to pay the month one the same whether it was a new entrant or a continuing county in the plan. So we did bear these factors, and in fact, one of the comment was indicating that they felt we should change the factors. So we agreed with that, and we did change these monthly rating factors to yield monthly base rates that are approximately the same for year two as year one. They are within a dollar in all cases for those month-one rates.

[00:10:12] Now, if you go down to the month-two gross monthly base rates, that is lower. I think it's about 2.6 percent lower for the year-two rates. And again, that's in recognition or that takes into account that there's more continuing claims that generally have lower intensity of services. That was expected and that's about 2.6 percent lower for year two than year one. Next slide.

[00:10:50] So one of the key assumptions used in the development of the rates is what is the trend in hospice benefits. The hospice benefit itself represents over 90 percent of the expenditures in the base period, and therefore, the trending of it is important. So what still is demonstrated here is the development of the trend rate for calendar year 2019 experience, the year-one rates. The resulting value is shown in table 3 of the report, and I'm hoping to provide you some insight as to how that's developed.

[00:11:31] So the first thing, first bullet point there is that we start with historical utilization, and we price it for fiscal year 2021. And this involves both changing the per-diem rates for fiscal 2021 and to recognize the wage index in 2021. And then we have to project those claims in 2022 because, of course, these payments represent calendar year 2022 so that's, at a high level, the exercise we're looking to accomplish. When you think about claims that will be paid in calendar year 2022, claims on the first nine months of the year in 2022 will fall under fiscal year 2022 parameters, the wage index and the per diems. Those that occur in the last three months of 2022 will actually fall under fiscal year 2023 per diems and wage index.

[00:12:35] Our trending account as I'll just show you in a moment. Last thing I want to point out before we get into the table is that the projected update for fiscal year 2022 is estimated to be 2.3

percent, and the additional update for 2023 fiscal year is 3.3 percent. So looking at this table, the first column is the type of service that's represented in each realm. So we've summarized it for this purpose into three categories: routine home care days 1 through 60, routine home care days 61 and later, and then non-routine home care that's consolidated all the more intense services.

[00:13:25] The next column is incurred month, and like I mentioned, we separated the first nine months of the year from the last three months. We have January through September and then October through December. The next column, as I mentioned, for those claims incurred in the first nine months but didn't receive one month of -- one year of trend are going to be trended from basically fiscal year '21 to fiscal year '22. However, those that occur in the last three months of the year will actually receive two years' worth of trend: first to go from fiscal year '21 to '22 and then going from fiscal year '22 to '23. So that's where you see the two trends, 1.023 and 1.033.

[00:14:14] Next column is the distribution of stay months that will come into play in the calculation of the average per diems. We have the average diem on the fiscal '21 basis, and you can see that, of course, they vary by type of service, and the composite value was 198.48, and again that's weighted by the distribution of stay days.

[00:14:38] And then the last column is the fiscal year '21 average per diem trended by the trend in the third column. So for example, the per diem in calendar year 2022 for routine home care days 1 through 60, that's $203.83 is equal to the fiscal year '21 average per diem of $199.25 multiplied times the trend of 1.023, and that's what results there. As opposed to the last row on the table, the nonroutine home care days for October '19 to December '19, we're trending that value by two years. The 1.023 and the 1.033 is multiplied to the both years. So '21 average per diem of $974.74 has grown to $1,030.07, which is the product of both of those trend rates.

[00:15:42] So the composite value based on calendar year 2022 is $205.26, and we picked that $205.26 divided by the 198.48, that yields a trend value of 1.0342. This value is shown in table 3A in the report. Obviously, there's a different trend rate for each year, each experience year of 2017 and 2018 and also the different trend rates for year two versus year one, but this is just an illustration of one of those values. Next slide.

[00:16:23] Next, we have the trend in the non-hospice claims, and here, it's a little more straightforward. We're just trending from the calendar year to the calendar year base for calendar year 2022. And listed here are -- we're trending this based on what we call the United States per capita cost. This is the per capita cost used in the Medicare Advantage ratebook and in this case, we're using what's called the fee-for-service non-ESRD USPCC, and these are found in the 2022 rate announcement.

[00:17:00] So again, for Calendar Year 2017, we start with a USPCC of $822.82. In calendar year 2022, that USPCC is $1,028.38, and the trend is simply the calendar year 2022 value divided by the base year value. And in 2017, it results in a 1.2498 trend rate. Next slide.

[00:17:31] Next, we're going to talk about something called claim pass-throughs and claim carve-outs. This is a change from what we did in 2021, and we made this change to be consistent

with how we did the Medicare Advantage ratebook. So the claim pass-throughs are payments made at hospitals that are outside the claims systems. They're not directly related on a per-claim basis. And they're falling to several categories: one is direct graduate medical education, there's also organ acquisitions costs, and some other miscellaneous things related to education, typically. In aggregate, these pass-through payments are equal to 1.99 percent of the non-hospice claims, which results in about a 17-basis point impact of total claims. So they're relatively small when you look at them in a total-claim basis.

[00:18:28] Now, offsetting this to some degree is what we call claim carve-outs, and again, this is consistent with the Medicare Advantage rate development. And claim carve-outs are paid directly by Medicare fee-for-service program. These include the direct graduate medical education, they also include the kidney portion of the acquisition cost and indirect medical education. In aggregate, the carve-outs equal about 24-basis points relative to total claims, about 10-basis points for DGME and kidney acquisition cost, and about 14-basis points for IME. Next slide.

[00:19:18] This slide pertains to the claim completion multipliers or completion factors. They're turned into a multiplicative just because it's a lot easier to carve in in that way. For the hospice fee-for-service claims, the completion multiplier is based exclusively on claim run-out -- that is the claims that are within the system. You'll notice that those factors are uniformly 1.0. That's partially, or that's exclusively, because we used claims paid through December 31, 2020, which means that there was 24 months of run-out for 2019, 48 months of run-out for 2017, and based on our experience, those claims are fully complete 24 months after, 24 months or later after the calendar year or after the beginning of the year.

[00:20:13] The other category is for non-hospice claims. And in this case, we have the factor that accounts for both claim run-out and some within the hospice that it's a relatively small factor. And then also for claims paid outside the system, which in -- you consider resulting factors are right around 1.07: 1.0177 or 1.0176. Next slide.

[00:20:46] We also look at another trend in the rate development called service intensity trend. And what this is, is to account for trends in the number of service days and the per-diem cost or the distribution of services that may go beyond the historical period. So in this illustration, we're looking at, and this is a component of what's represented in the report, we're looking at 2017 to 2019 trend. So when you look at the service days per month, 2017, we averaged 22.62 service days per month. That increased to 23.05 in 2019, and that yields a 95-basis point trend on an annual basis from '17 to '19.

[00:21:42] For the weighted per diems, effectively we're looking at the distribution by service days with about a national per-diem rates for the four level of care or five levels of care: routine home care, general inpatient, respite care, etc. So you can see in 2017, weighting the fiscal year per diem, especially year '21 per diems, we end up with $186.73 in 2017. That value drops to $183.58 in 2019 reflecting a general reduction in intensity of services. So the annual trend for that period is minus 85-basis points. When you combine that trend, the minus 0.85 to the positive trend for the service days of positive 0.95, that yields a combined annual trend of 0.09 percent. Again, this is just '17 to '19.

[00:22:46] A comparable calculation was performed for ’18 to ’19, which yielded a 24-basis-point trend. Combined, the trend was 14-basis points, and we determined that this was not a reliable measure for trending, and we did not build in a trend for service intensity days based on the results of the experience. Next slide.

[00:23:20] And so many of you are probably familiar with the aggregate and inpatient caps. The claim experience that we use to develop the rates, 2017, 2019 is prior to the effects of the caps, so therefore -- and a separate adjustment will need to be applied. On a weighted average revenue basis, the aggregate cap is 85-basis points negative and the inpatient cap is minus 1-basis point. And this is an adjustment that is applied to the month two and later rates. The adjustment is illustrated in the data book, which we’ll talk about. Next slide.

[00:24:08] Okay, so transitioning to the material that we have posted on our website, and again this is under the Innovation Model page of the website. So the first thing that was posted, and this was put back in March in conjunction with the preliminary announcement, we have a spreadsheet that illustrates at a county level what the CBSA mapping is both for the 2021 and the 2022 rates. At that time, it was just a proposed mapping, and we ended up finalizing that as that is proposed. So there’s only one file, it’s the same file that was there, and it’s been out there for a month. So that’s the county the CBSA mapping is from.

[00:24:57] Next we have two data books, one of the year-one rates and one for the year-two rates, and I’ll just talk about, more about that in a moment. We also have the final capitation payment ratebook. This is at a county level very similar to what we published last year, and it’s also similar to the Medicare Advantage capitation ratebook. And finally, I mentioned a methodology paper. This is the document that the describes the key methodology and assumptions is in the rate development, and I’ve referred to many of those things in this presentation. Next slide.

[00:25:42] So like I mentioned, there’s two data books, one for year one and one for year two. And listed here are some of the key tabs in that data book and a little bit about what each tab includes. So there’s three tabs listed “Summary By Year,” so there’s a Summary 2017, Summary 2018, Summary 2019, and this includes the historical claims broken out by the coverage periods. And it also illustrates the projection of these factors repriced to fiscal year 2021, that is the fiscal year 2021 per-diem rates and wage index and then those are further trended for calendar 2022. Those three sheets are the real foundation for the rate development, and they’re a great resource if you want to understand how the rates are developed and maybe some differences by geography.

[00:26:47] The next tab I was going to mention is the “Hospice AGA Summary,” and that builds upon the data from the summary tabs, and it illustrates the development of the hospice average geographic adjustment separately for both for month one and then month two and later rates. Next, we have “Data Dictionary” tabs for both the summaries and the hospice AGA, and it describes each of the fields and a little bit of the methodologies to develop that. Then, we have a sample calculation tab, it’s called, “Sample Calc – Hospice AGA,” and this shows the

development of an AGA factor for a specific CBSA. And again, it's a great resource to really understand how we go from the source data to the final AGA factors.

[00:27:46] And then finally, we have a tab that demonstrates the CBSA-level carve-out factors. It's named, "DGME, IME, and KAC Factor." And as I mentioned, these factors are developed off the factor sheet in the Medicare Advantage ratebook. The difference here is that these are consolidated at the CBSA level whereas the Medicare Advantage ratebook, they're developed and posted at a county level. Next slide.

[00:28:18] This is an excerpt from the hospice capitation ratebook that I just mentioned. This illustrates I think seven counties in Colorado. The first column is what's called the SSA code. This is a code that identifies the county, county residence. Next, we have the state, as I mentioned these are all Colorado. Next is the county name. Then we have the CBSA-state identifier. This is the mapping that will allow you to identify which CBSA that county -- the rates fall in. Then we have an indicator of whether the rates for that county or year one or year two basis, and then finally, the last four columns are the rates for each of the four coverage periods. Next slide.

[00:29:17] So building upon the prior slide, this is an illustration of the development of the payment rates for the first county in that slide. So as I mentioned in, I think, the second slide, I talked about effectively the rate is product of the national base rate, monthly rating factor, geographic adjustment. I did not mention the carve-out factor, and that's the fourth component, but this is how the rate's developed.

[00:29:48] So the national base rate that is effectively from one of the earlier slides, it's also included in table 1 of the actuary report. The average hospice geographic adjustment, again that's from the data book. You can see how that's developed and what that factor is. The monthly rating factor, again from one of the earlier slides, there was month -- separate monthly rating factors for year one and year two. For this particular county, they're receiving the year-one rates and so these factors correspond for the year-one monthly factors. Then we have the carve-out factor that I mentioned, and these are also contained in the data book. And so row e, the rate, it's the product of the first three items, the base rate, the HGA, and the monthly rating factor, and then with adjustment for the carve-out factor. Next slide.

[00:30:59] Okay, so with that, I'll turn it to Laurie McWright, who will talk about the rest of the presentation.

LM:
[00:31:06] Great, thank you so much, Rich. Wow, so impressive, grateful to have you on board for so many years and working on the hospice piece, really appreciate it. So with this one, we want to focus now to what's next, and this is just the picture of the RFA that came out in December, and you can see the notation of where it's available. And really I think the best thing to say about this is really just your guidebook, your road map for applying and knowing kind of the rules of the road, etc. And we are happy to answer any questions. May we go to the next slide now?

[00:31:57] In terms of our next steps, we received lots of great questions over the last several months from many of you from some who are, we'll say, the gone on the maiden voyage this year and others who are planning to join for '22, so very exciting. As you can see, there's an important date coming up, April 16, where we as, that you no later than I believe would be 11:59 [pm] Pacific Coast Time, get your applications submitted via the Qualtrics portal. We will work as hard as we can to review all the applications as quickly as possible. Many of you we'll be in touch with to clarify questions. We have a great team to be reviewing VBID and hospice applications.

[00:33:04] We're hoping by the middle of May that you will receive what's called the provisional approval. And really the concept there is that we're telling you that we think based on your Model application, you are approved to participate in the Model. That doesn't supersede the bidding process that Rich and Jennifer Lazio, who's on the call run through the Office of the Actuary. And obviously those bids for the overall MAOs' bids plus information around the VBID pieces are all due June 7 as well.

[00:33:47] And so then we obviously engage in the agency process for the bid review and then after at the completion of that, we will finalize the Model approvals and then, and usually that's in August. And then we will be in a position to execute the contract agenda for Model participation in September. And then in later September as with all the plan announcements, we'll be announcing Model participation, etc., so very exciting, busy time.

[00:34:32] Okay, so I believe we're at the question-and-answer section, and I'm going to turn it over to my colleague Sibel Ozcelik, who will facilitate the Q&A session. For those that don't know who she is, she is the technical lead on the hospice component of the VBID Model but also a co-model lead on the overall Model. So, Sibel, I'm going to hand it over to you, thank you.

Sibel Ozcelik:
[00:35:07] Thanks so much, Laurie. I'm going to actually ask the first question to you. We just got a question: what is the deadline to submit the applications?

LM:
[00:35:18] So that for the VBID Model, including the hospice benefit component, would be April 16, so that's, I believe, this Friday at midnight or 11:59[pm], and I believe it's Pacific Standard Time. Sibel, do I have that right?

SO:
Yeah.

LM:
So it won't disadvantage anybody on the West Coast.

SO:
[00:35:44] Thanks, Laurie, that's exactly right. And then, Rich, I'm going to ask you the next question. Is uncompensated care part of the hospice DRG also carved out?

RC:
[00:36:00] So, thank you, Sibel, and the answer is no. Uncompensated care is included with the inpatient claim payments, and it is not carved out. And this is consistent with the development of the Medicare Advantage ratebook.

SO:
[00:36:19] Okay. And here's another question for you, Rich. Is year two meaning year two of participating in the VBID program, or does it mean year two of a member's hospice stay?

RC:
[00:36:34] It's the former. It pertains to the participation in the Model. But going back to what I referenced earlier, in the case of a plan who's in a particular county for the second year, beginning in 2022, they can have claims or episodes of care that began in 2021. And so the development of the rates represents that you can have experience that with episodes that began in the prior year. As opposed to a new county, new participant, you're not going to have any episodes that begin in the prior year. That's how the Model designed. If an individual started on hospice and they were in fee-for-service, they would remain in fee-for-service and would not be the responsibility of a new entrant into the program.

SO:
[00:37:28] Yeah, thanks, Rich. And we have a related question or a clarification question on that. Is year-one or year-two rates, the applicability is by county or by plan? So if by county, a county included in VBID in 2021 would have a year-two rate and all other counties not included in VBID in CY 2021 would have a year-one rate?

RC:
[00:37:58] How about if you take a crack at that, Sibel?

SO:
[00:38:02] So I think that that one is yes. If a VBID plan have participated in 2021 in a county, in 2022, they'll have a year-two rate in that county. If there was no VBID plan participating in that specific county, it'll have a year-one rate. And then I think -- let me look, the next question is when a doctor certifies a Medicare beneficiary as hospice, how long can the beneficiary be on hospice, one year?

[00:38:45] And I can take that one. So when a physician certifies somebody as -- or -- well hospice eligibility is determined on having terminal illness, and terminal illness means that the medical prognosis of that individual's life expectancy is six months or less. If that illness runs its normal course, and physicians will -- hospice providers will certify for election period. The first election period is a 90-day period and then afterwards, the physician will recertify that person as being terminally ill for another 90-day period. And an individual is able to have those two 90-day periods and then an unlimited number of 60-day periods.

[00:39:33] In fee-for-service Medicare, there are caps, or the hospice aggregate indication caps. Those don't apply under the VBID Model, but we will be closely monitoring to make sure that

there are no program integrity issues and that an individual and hospices of course does have terminal illness, for example.

[00:40:00] Let's see. I think we have one other question so far, and the question was what is the process and timing for payment? We have recently seen payments from month-two plus hospice beneficiaries going through MMRs but are unsure how month-one rates will be reflected in MMRs or PPR.

[00:40:26] I can go ahead and take that question as well. So the month-two plus payments are prospective and so they'll -- you'll receive them, and they'll be reflected at a member level in the monthly membership report or the MMR. The month-one payments are paid out retrospectively in a lump sum to participating MAOs on a quarterly basis for all enrollees who had that first-calendar-month hospice experience, and that will be reflected at a contract level on the PPR or the planned payment report. And it won't show up on your MMR because it is a retrospective lump sum payment that's made out.

[00:41:08] So we have a question on whether we can show the Qualtrics URL again. I'll go ahead and type that in the chat box for everyone. And then I see another question, for a year-two participant adding two new PDPs under the same age contract number, how should that be labeled under submission process prior to having a PBP number? So I think you're asking about the application materials on the spreadsheet. You can just put in the age number and then put a PBP number just put 000 with a note that says that you haven't yet received a PBP number for that plan, and then we'll work with you after your bid submission process and, of course provisional approval, to identify the PBP number.

[00:42:15] We'll just give a few more minutes for folks to ask their questions. And if there are no more questions end early. While we're waiting for that, I'll go ahead and pull up the Qualtrics link.

[00:42:51] So I got a follow-up question, whether the application is submitted via Qualtrics or via the HPMS application portal. You'll submit your application by April 16 using the Qualtrics link, and you'll be able to upload any additional supplemental files on Qualtrics directly. And then we'll review the applications, provide feedback, and then provide provisional approval by mid-May. And then afterwards, you will be able to -- in the PBP software and in your BPT, you would reflect as appropriate participation in the VBID Model, and you would respond to section I think 19T in the PBP regarding hospice. So I'm not seeing any other questions, and I'll pass it back to Laurie perhaps to close out?

LM:
[00:44:09] Okay, well thank you so much to our participants today. We appreciate your attention, definitely look forward to your applications. And a huge thanks to Rich Coyle and Sibel Ozcelik for answering many questions as well as a great presentation as always from Rich. And, Nate, I think we'll close out, thank you.

END OF AUDIO FILE