Calendar Year 2022 VBID Hospice Benefit Component – Payment Design

March 17, 2021

Nate Hoffman:
Welcome and thank you for joining the Calendar Year 2022 Hospice Benefit Component Payment Methodology Webinar. Throughout today's presentation, 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. Please note that some inquiries might require additional research. The VBID Model Team will investigate these inquiries and will reply via email afterwards. At this time, I will turn today's presentation over to Laurie McWright, the Deputy Director for CMMI's Seamless Care Models Group. Laurie?

Laurie McWright:
Thank you so much, Nate. And I'd like to welcome everyone to our webinar today. Before we get started, there is the famous, infamous disclaimer: any information that we're sharing today is for general information and education and should not be construed otherwise. Next slide. So today's webinar, I'm excited about, we are able to talk today about the proposed Calendar Year 2022 Proposed Hospice Benefit Component Payment methodology. And in order to give it its due, I would like to introduce Richard Coyle, the lead actuary from CMS' Office of the Actuary.

[00:01:52] He has actually been with us in CMMI since the beginning of the development of the hospice payment methodology, and so we are definitely grateful for his time and expertise today. And just reflecting for a moment, we're here thinking about year two of the hospice benefit component, we went live in January and excited to get to that point. And so with that, I would ask Rich to tell us what he has in store on the agenda. Thank you.

Richard Coyle:
Thank you, Laurie and good afternoon. So as you can see, this is the agenda and the items we're looking to cover today. First, we're going to start with the payment design and policy objectives of the VBID Hospice Model. Next, we'll talk about rate development and payment structure; first in general terms, and related to the calendar year 2021 rates, and then we'll talk about those changes to the rates for 2022. We'll then cover hospice supplemental benefits and bids. And then I'll turn it back over to Laurie to discuss the timeline and to host a question-and-answer session. Next slide.

[00:03:13] So this is an overview of the Model Component and Payment Design. The graphic at the top, you can see that there's four boxes and three of them are darker blue. The three that are darker blue are the payments that plans would receive had they not been participating in the VBID hospice model. And that is the A/B capitation rate, the beneficiary rebate that the plan bids below the benchmark, and the Part D drug. Part D as in dog, Part D isn't all drug payment if they offer drug coverage. The fourth box shaded in lighter blue represents the payment that would be made under this Model.

[00:03:56] For the hospice capitation rate. So when we talk about first month hospice coverage, what we're referring to is when a beneficiary first enters hospice status after the first of the month; so the second of the month or later. In such cases, outside the Model, the payments would be, like I said, limited to the three boxes shaded in darker blue. What we're adding to this model is a capitation payment for the month, for the hospice benefits, and we'll talk a lot more about that in a moment. It is worth mentioning that the payments currently will be made on a lump sum basis.

[00:04:39] On a quarterly basis. That is just a month-long payment, it's an administrative issue, and it basically happens outside the system. So going to the second month rate, and that represents a case where a beneficiary is in hospice status as of the first of the month. We call that a month two rate. And that situation, as you're probably familiar, there is no basic benefit payment; no A/B capitation payment rate, so that would not be applied. The plans would continue to receive the beneficiary rebate and the Part B payment as applicable.

[00:05:18] And then they would also be the monthly hospice capitation rate. Next slide. So taking a step back, here are some of the policy objectives of the development of the capitation rates. Of course we like to create a clear and transparent payment structure, and I believe that we've hit the mark there. We would also want to align the payment structure with the model goals. For example, to allow flexibility of offering palliative care before someone would enter hospice status. Also of course, we want to insure that the rates are budget neutral.

[00:06:00] Relative to an alternative, which would typically be paid to the fee-for-service program. We also want to develop the rates consistent with the Medicare Advantage rate book. And there's a couple things we want to mention there. First of all, we use multiple years of base experience for both the hospice model and the Medicare Advantage rate book. We also develop geographic adjustments, in both models. And finally we trend the rates to the payment year, in a similar fashion. So at a high level, the rate development is very consistent between the Medicare Advantage rate book and the hospice model.

[00:06:40] And finally, we want to insure that the rates are accurate. Moving from the current per diem rates and are based on the four different tiers. To a monthly capitation rate. And of course, this is related to the third bullet point, to do this in an expected budget-neutral manner. Next slide. So the next two slides are going to talk about the payments in general, and the parameters in these slides is related to the 2021 rates, just because they're finalized, obviously, and widely available.

[00:07:21] And then we'll talk about some changes that we're proposing for 2022. So I know this is a busy slide, but let me kind of take it one line at a time. So the first row illustrates the three main components that build up to a hospice capitation rate. That is, first we have the national hospice capitation base rate, and we multiply that times the Rating Factor and then multiply that times the geographic adjustment and then that yields the rate. Please note that these rates are not risk adjusted. The published rate is what's paid, there is no beneficiary level risk adjustment.

[00:08:01] So moving down, the national hospice base rate, as you can see, that's developed based on experience from a historical period. So for the 2021 rates, we used a three-year period, 2016 to 2018. We then took that experience and we re-priced it to base it on the most recent published hospice rule. In 2021 rates, the most recent rule was the fiscal year 2020 rule. And we re-priced it using the per diem rates from the 2020 rule and also the wage index, reflected in that rule. And then finally we trend those from fiscal year 2020 basis to a calendar year 2021 basis.

[00:08:50] And obviously a similar approach will be applied for the 2022 rates, it's just all these years will be advanced by one. So that's the national hospice base rate. Next, we have what's called a monthly rating factor. And as you can see, there's four different coverage periods and the rates vary by each of these. There's three periods from month one and one period from month to and later. And as I mentioned, the month one reflects cases where the beneficiary enrolls in hospice after the first of the month. And month two applies when a beneficiary is in hospice status as of the first of the month.

[00:09:31] And then finally we have, and we'll talk more about this in a moment, and finally we have the hospice geographic adjustment, which is separate for months one and two, and we'll discuss that further as well. Next slide. So as described here, the monthly rating factor is applied so that we, in aggregate, the rates come back to what we call a composite national rate. And effectively what that composite national rate is, is an estimate of what the national cost would be under the fee-for-service model.

[00:10:13] And I'm going to walk through the different components of this table. So the first two columns in this table represent the coverage periods that I've just discussed. So for month one, we have coverage period of one to six days, and what that means is that if they have between one and six days of hospice coverage during that first month, this is the rate they would be paid. Now please note that the days do not necessarily have to be consecutive. So they could have two days, a break in service, and then say three more days, all within that month.

[00:10:48] And those would all be combined to determine the coverage period. We also have a seven to fifteen day coverage period in the first month. And sixteen days or more in that first month. So those are the first three coverage periods. And then the fourth coverage period is month two and later, which is represented in the third row, third box of this exhibit. Moving to the next column. Just for illustration purposes, the average monthly service days just shows kind of the development of the base experience, and what's the average number of days for each of these coverage periods.

[00:11:25] So for example, the one to six day coverage period on average, the beneficiaries were in hospice status 3.28 days. If you go down to month two and later, you can see that it's over 26 days of average hospice coverage for visits per month. So this column here is just for illustration, but it does help to kind of calibrate how the other coverage period matches up with average number days in a month. The next column is a distribution of stay months for the four different coverage periods, and these are used to calibrate the rates to come back to that composite national hospice capitation rate.

[00:12:13] Not going to get into much detail here, but you can see that in aggregate, month one represents 39 percent of the stay months, and months two and later represent 61 percent of the stay months. Next column, the monthly rating factor. This is basically relative scale of what the cost is for that coverage period relative to the overall coverage period. So for example, month one, one to six days, the monthly rating factor is .34, which is much less than the rating factor for, say, 16-plus days of 1.02.

[00:12:55] And you'll see how these apply in a moment. And then the last column is what we call the monthly base rate. And I would like to start with the month two plus value of $5,248, and this is what we call the national hospice capitation base rate that was referred to on a prior slide and this is the base rate we apply the rating factor against. So for example, to come up with the monthly, the gross monthly base rate, for month one, days one through six.

[00:13:25] We would multiply the $5,248 on national hospice capitation base rate. By the monthly rating factor of .34, and that would yield the $1,784. And finally I wanted to mention that if you weigh the different gross monthly base rates by the distribution of stay months, you will come up with the value in the bottom right of this table, $4,468, and that was or projection in 2021 of what the average per person per month hospice cost was in 2021. Next slide.

[00:14:12] So the third component of the rate I mentioned is the geographic adjustment, and this accounts for the variation in cost at what we call a core-based statistical area. And that's basically what also could be referred to as the metropolitan statistical area. Typically a collection of counties surrounding an urban area. In some cases it would actually be just one county though. And for areas that are not within an urban area, we combine those at a state level, and that would be like a rural CBSA for the state.

[00:14:53] Now for those of you familiar with the Medicare Advantage rate book, you probably realize that we develop rates at a county level. And the reason we didn't do that with the hospice program is, there's just not enough beneficiary stay months to have credible experience at the county level, and therefore we combine it at the CBSA level, and it works quite well. Next, the geographic adjustment is developed based on the historical experience that is re-priced for the latest payment parameters. So again, as I mentioned, for 2021 rates, we re-priced the historical experience from 2016 to 2018.

[00:15:40] To date, based on a fiscal year 2020 payment parameters and that would be both the per diem rate and the wage index. And then we tabulate information on a per beneficiary cost, per beneficiary level, per CBSA and develop a relative index and that's what the geographic index is. It's worth mentioning that this exercise is done separately for the month one rating tiers and month two. Because there is a different distribution of utilization and cost. For month one versus month two.

[00:16:18] And then there's two adjustments applied: one to month one and one to month two AGAs. The month one AGA adjustment is what we call a tier adjustment, a month one tier adjustment, and what this accounts for is that the distribution of stay months within a CBSA is different than the national distribution. And we make this adjustment so that the rates come to

that budget neutrality for each CBSA. In fact, it was based on a comment that we received early last year that we made this adjustment.

[00:16:52] So we're comfortable that this helps to retain that cost neutrality at a CBSA level. And then the adjustment that we apply to the month two rate is to account for the hospice provider inpatient caps and the aggregate caps. Next slide. And there's two additional adjustments that we applied to the 2021 rates. First is the credibility adjustment for both low-volume CBSAs and the territories. I can say for the low-volume CBSAs, and the mainland, it's very limited. In fact, there was only one CBSA that required this adjustment last year.

[00:17:36] And the other adjustment we have is to account for the trends in both service days and intensity to basically trend those forward from the experience period to the contract period. Next slide. And what we have here is an excerpt from the 2021 VBID Hospice Capitation Ratebook. These are actually the first eight rows in the table. And you can see the first three columns are county information, what we call a SSA code, or an identifier, the state and the county name. And then the last four columns are the rates for the four different coverage periods.

[00:18:23] Now if you notice, this is published at a county level because that's how the Medicare Advantage Ratebook is published. However, like I said, the rates are developed at a CBSA level. So if you go down to the fourth and fifth rows, Bibb and Blount Counties, they both fall within the Birmingham CBSA, and you can see that the rates are the same for those because they are CBSA-based rates. Next slide. So hopefully most of you are familiar with a memorandum we put out back on March 8th that describes our proposed changes for the 2022 hospice capitation rates.

[00:19:09] This was published on CMMI's website, or the Innovation Model website, and it was also broadcast through the HPMS system. So hopefully if you haven't seen it, you can go and find that memo, because it has some important information for the 2022 proposal. First thing that we propose is to advance experience one year. That is, in 2021, we used experience from 2016 to 2019. We're going to move that forward a year to 2017 to 2019. The next two items are from the fiscal year 2021 final hospice regulation.

[00:19:55] First of all, we're going to incorporate the CBSA definitions included in the reg. There were about 100 counties that had some sort of change from fiscal year 2020 to '21. Some counties moved from rural designation to urban. Some moved from urban to rural. Some changed CBSAs. So it was a fair number of changes in terms of volume, but honestly not a whole lot of change in terms of impact because they were mostly relatively small counties that were affected by this.

[00:20:32] The other provision from the 2021 rule we will adopt is to re-price based on the per diem rates in the rule and the wage index from the 2021 rule. The next bullet point's a little bit loaded, so bear with me on this one, but when we developed the rates for 2021, obviously the program was new. So everyone participating did not have any experience in a prior year. So when we developed the base experience, we did not include claims that were incurred prior to that year.

[00:21:08] So for example, when we tabulated the 2018 hospice experience, we did not include claims that began in 2017 or even earlier and carried over into 2018. We only included claims that commenced in 2018. Well, when you fast-forward to 2022 rates, some organizations will have been in the program for two years: both 2021 and 2022. So we wanted to reflect that in the development of the rates. So for these counties that were covered in 2021, we're developing in the rates, in the base period, we will include claims that were incurred in the year prior.

[00:21:52] So for example, back to 2018 experience, we will include claims that were incurred in 2017 and were continuing into 2018. Those claims will be included in the rates for the counties that are continuing. For the counties that are new to the Model that did not have coverage in 2021, we will, for 2022, we will use the same approach as last year, where we will not include carryover claims in the experience. It's worth mentioning that there's about 200 counties that were covered in 2021 which will have rates developed under what we're calling a year two approach for 2022.

[00:22:39] So please ask any questions about that if it's not entirely clear. And the last bullet point on this slide mentions that we're proposing to modify the month one tier factor for days 16 and later to 1.003, instead of 1.020, which was in the 2021 rates. And this change is being proposed because there was a change in the distribution of services between the two experience periods, and it's made to maintain budget neutrality. Next slide.

[00:23:22] So here's some additional changes we're proposing for 2022. We're proposing to include beneficiaries in End-Stage Renal Disease status in the tabulation of historical experience. They were not included in 2021. I will say, this isn't expected to have a meaningful impact on the results, but it is an appropriate inclusion because the rates we develop apply to both non-ESRD and ESRD beneficiaries. The next category of changes we're proposing has to do with the tabulation of non-hospice claims.

[00:23:58] And this is largely to follow what we do in the Medicare Advantage Ratebook. First, we're proposing to include what we call inpatient pass through payments. These are payments that are not associated with the specific claim or specific payment. Rather, they're cost report settlements that happen with facilities, and they include direct graduate medical education, organ acquisition costs, and other things such as bad debt. So again, that's consistent with the Medicare Advantage Ratebook.

[00:24:33] Also consistent with the Medicare Advantage Ratebook is the carve-out, the amounts, the hospital payments that are made directly by Medicare fee-for-service program. And that includes the graduate medical education, the kidney portion of the organ acquisition costs, and also indirect medical education expenses. And finally, we're going to adjust the typical trend in actuarial assumptions to advance them to reflect the most current projections and also to trend them to 2022.

[00:25:09] And so this includes trend rates for both hospice claims, updating the caps for aggregate and inpatient, revise the hospice service mix adjustment, update the administrative cost load, and to revise the claim completion factors. Next slide. So, now switching gears a little bit, talking about other supplemental benefits. So the hospice supplemental benefits are in broad

terms, similar to the non-hospice supplemental benefits. That is, you can buy down Medicare cost sharing or you can add additional services.

[00:25:55] But of course, these services would be limited to beneficiaries with a known hospice status. And consistent with the other plans, consistent with the non-VBID plans, the certifying actuary has discretion to either include or exclude the hospice membership when tabulating the per member per month cost of supplemental benefits, both mandatory and optional. And I suggest that you refer to the bid pricing tool instructions for more guidance on this option.

[00:26:33] And then finally listed here are some examples of hospice supplemental benefits. I will mention that you can go to the 2022 VBID Hospice Application to get a full list and other considerations for the development of supplemental benefits. Next slide. And then finally I was going to talk about the bid and bid pricing tool issues. So again, as with the non-VBID hospice plans, the experience for beneficiaries in hospice status, that is, the claim payments and enrollment, are not to be included in the development of the Medicare Advantage bid and benchmarks.

[00:27:21] And again, that's pretty widely known. And again, I would refer you to the bid pricing tool instructions for more guidance on this. And it's also worth pointing out that the plan benefit package category 19C applies to hospice VBID. And again, similar to other benefits, similar to the non-hospice VBID benefits, the supplemental benefits are broadly in two categories. One is for coverage producing cost-sharing for covered benefits. In the case of hospice, it's prescription drug coverage.

[00:28:01] For routine home care, for continuous home care, and also the five percent coinsurance for inpatient respite care. And then there's other non-coverage supplemental benefits. Again, similar to non-model benefits. Next slide. I'll now turn it back to Laurie so she can update on the applications and timelines.

LM:
Excellent. Thank you so much, Rich, really appreciate it. So on slide 16, we just had to draw a picture of the request for applicants, or RFA, and that's going to be your best tool in addition to the information that Rich has provided in preparing your applications for the VBID Model overall and to include the hospice benefit component. That is, deadline is April 16th. And here this slide shows how you can obviously access the RFA. The RFA contains a lot of different kinds of information that would be helpful.

[00:29:20] One thing I do want to actual highlight for you in this year's RFA for CY22 planning, we are actually soliciting specifically feedback on what kind of network adequacy requirements would be appropriate to include in CY23. As we announced in the beginning of the discussion on the hospice benefit component, that we envisioned going from a more open model where all hospices would be able to be included minus ones that have been excluded for specific reasons by Medicare.

[00:30:19] But otherwise, those would be all would be included for the first two years of the Model. And then we would move to an in-network model more specifically, where we would

develop a network design. And so that's a big deal in the sense that we really, really want to make sure that we get comments from a variety of stakeholders that are included and affected by the policy. And there are specifics in the RFA about the kinds of considerations and what we're thinking about things like the appropriate metric for measuring network access.

[00:31:15] Would it be like the minimum hospice provider ratio, is there something more appropriate. The service provider ratios, is it at the county or service area level. Thinking about quality of hospice providers. And how that should play into the adequacy standards. Very important, meaty kind of questions like that. Should there be consideration for sort of the, I guess the way I think of it is more like the ceiling or the floor.

[00:31:58] And thinking about the breadth of the access continuing forward for the last couple years of the Model. So very important that we get your feedback. On those issues. So make sure that you submit comments to the VBID Model email box on that. Why don't we go to the next slide, I believe there's an email address there. Yes. So I'm looking at next steps either for technical assistance or submitting comments, use the VBID@cms.hhs.gov mailbox. Very open to comments.

[00:32:49] And moving forward, we are also of course interested in any comments that you have on the proposed hospice benefit payment methodology. We will be releasing the hospice county ratebook and the hospice data book associated in April. Moving forward from there, the deadline, as I said, for the application for the model is April 16th. And that's submitted through the Qualtrics Portal. Just as a sort of big picture for those of you that didn't submit applications in the past, what we try to do is accept your applications in April, and then by mid-May, you would expect to receive a provisional approval.

[00:33:49] During that April 16 to mid-May timeframe, likely you'd hear from us related to any clarifying questions. If you have questions for us, obviously be in touch, and it's all scoped in terms of the timeline is what I call, the immovable object, when your MA bids are due from a statutory standpoint, the first Monday in June. So that's June 7th for this year. And so that's how we try to back out our application deadline and feedback to you all.

[00:34:29] In the interim, etc. And then of course, the bid season concludes with the submission and then the work begins for OACT colleagues, and it culminates in the contract signing in September. So that is just a quick overview of the sort of milestones coming in the next few months. So with that, I want to turn the webinar over to Sibel Ozcelik, and she is one of the value-based insurance design co-model leads, and she leads the hospice work for us. And how we were thinking would be helpful for the Q&A portion of this webinar is that we would start out, oh, thank you, next slide, thanks.

[00:35:31] That we would start out actually answering some questions that we thought were important ones to share with you all, that we actually received during last year's payment design webinar because it seemed like that would give just general information and look forward to all of your actual current questions and of course, if we don't get to everything today, then we'll, as we most often try to do, prioritize the questions so we get in the most often and then of course, resubmit through the VBID mailbox any that you didn't get answers to, or think about later.

[00:36:23] And if we see a theme of questions that seems appropriate to get out in an FAQ, we will use that medium as well. And so with that, I'm going to turn it over to Sibel to get us with the Q&A portion. Thank you.

Sibel Ozcelik:
Thanks so much, Laurie. And thanks everyone again for joining us this afternoon. So I'll go ahead and get started and ask this question for Rich. Where can I find (a), the slides, and or where can I find additional information about the payment methodology, both the one that you had referenced for 2021 and the memo that you had mentioned for 2022?

RC:
Yes. Thank you Sibel. Actually you can probably describe how to get to your website. I know what I would do is to go to cms.gov, choose the "Innovation Model" link. Type in either "VBID" or "Hospice" and it will send you to the VBID page. And on that site, you will find, I think three things of great interest of those interest in these rates. First is a payment methodology paper for 2021; it's called Capitation Rate Methodology Paper. The second thing is the data book that supports the rates, and it's a very useful spreadsheet that includes payment information at the CBSA level.

[00:37:58] For the three years development of the AGAs and examples; it's great way to really understand how the rates are developed. And then the third thing I would refer you to is the memorandum that was issued on March the 8th that has the proposed changes for 2022.

SO:
Thanks so much, Rich. And that's right, you can also go on the VBID Model main website if you Google that and search for that, it should come up right away. Here's another question that we had received last year. Rich, what is an administrative load?

RC:
Thank you. And so this is something that's carried over from the Medicare Advantage Ratebook. Per statute in the Medicare Advantage rates, we put in an administrative load to account for the cost of processing fee-for-service claims handled by the Medicare Advantage contractors. And those rates were developed and published in what we call the rate announcement. And those same factors that we use in Medicare Advantage Ratebook will be used in the hospice program in developing the VBID hospice rates. And so if you have any questions, I would refer you back to the Medicare Advantage Ratebook and you can see what those administrative factors are.

SO:
Thanks, Rich. And then we had received a question around, how was GIP, continuous or a general inpatient care, continuous home care, the service intensity add-on, FIA payments, how were all of those hospice payments included in the buildup of the hospice capitation rate?

RC:
So as I mentioned, we have an exercise where we re-price. So we essentially take the utilization for the experience period; for 2022, we're proposing 2017 to 2019. And we look at the service

days for each type of service, for each CBSA level. So for instance, it includes routine end care, includes general inpatient care, continuous home care, and respite care. And that's what we will use to re-price to the most recent hospice regulation using the per diem rates and the wage index.

[00:40:38] So all those utilization days are included, whether it's inpatient stays or not. And then again, as I mentioned, that's what forms the basis of the average geographic adjustment, or the geographic adjustment. And that's one of the reasons why we need a different AGA for month one versus months two and later because there tends to be more general inpatient days in the first month of care and there also tends to be more regional variation in that. And so because of that, there's a need to have two separate geographic adjustments.

[00:41:16] To account for the different mix in intensity of services. Both by coverage period and by geography.

SO:
Thank so much, Rich. And Laurie, I see a few questions in regards to whether the slides will be posted anywhere, or where will they be made available. Do you want to take that one?

LM:
Sure, absolutely. Thanks Sibel. So the slides will be shared and we will have them up on our VBID Model webpage. It always takes us a little while to have that happen, but within the next week or so, they will be posted.

SO:
Thanks, Laurie. And we envision we will also be posting the recording of the webinar along with the transcript, so you'll have lots of materials from this webinar to look back at next week. Laurie, here's another one for you. When is the deadline for comments on network adequacy standards, or network design?

LM:
Oh, that is a great question. So basically, we are in information gathering mode. And I think the way I sort of think about it is, to make sure that we're able to review all the amazing applications that we get in for next year and make sure we've got that taken care of but along the way, we're going to be soliciting that in a variety of ways. We would envision listening to stakeholders in groups, in one on ones, you tell us how you'd like to give us the feedback. But it's really important that we get that.

[00:43:20] And our goal would be to put the information on the network adequacy standards, requirements, the policy, in the CY23 RFA. And so we would likely lock down our listening sessions and feedback loop by the end of the summer, I would guess. I mean, we're always open to comment and feedback along the way. But most helpful, frankly, to have it in from now until the end of the summer so we can do our best to take into account as much feedback as we can on this important policy.

SO:

Thanks so much, Laurie. I think Rich, here's another question for you. Will the final rates be presented net of sequestration in the ratebook? What will that look like?

RC:
Thank you, Sibel. Actually the final rates will be presented gross to sequestration. That is, prior to the application of two percent sequestration reduction. And that's consistent with the Medicare Advantage rates.

SO:
And then I see a question in regards to, will sequential billing be required when submitted, claims to MAOs? And that's a question for the participating MA plans. Where plans will get paid whether it's sequential billing or not. But generally speaking, you'll still have to, sequential billing rules would still apply for hospice notice and claims submitted to your MAC. And then there's another question, and Laurie, if you want to take this one, and I can add on. But when will hospice providers know which plans are participating or not for 2022?

LM:
Oh yes, that is a good question. So I'll start us out and you definitely feel free to add in. So the process, the contracting process between the participating Medicare Advantage organizations and the hospice providers in the areas in which the MAOs are participating in those service areas, etc. And that is something that, by statute, we're not allowed, CMS is not allowed to be involved or interfere in that process.

[00:46:12] And so we have very clear expectations of our participating plans that they engage with all the hospice providers in their service areas. And even now when there's not an expectation of a network adequacy requirement or standard being met. So from that vantage point, we would anticipate that that there will be an MAO hospice provider discussion that we have that expectation of the MAOs, but I also think it's prudent for hospice providers to identify the Medicare Advantage organizations in their local areas.

[00:47:11] And contact them if they're interested in being a provider in the area for the hospice, for the MAOs. And Sibel, what I would love for you to add on anything, we have information to help connect the hospice providers in the area with their local MAOs. Would you want to talk a little bit about how to find that?

SO:
Thanks Laurie. And I love the last part that you added about sort of what hospice providers can do in preparation for 2022, because we just got that same exact question. But in terms of sort of where can hospices find information about plans, within the CMS website we do have plan contact information for all of the Medicare Advantage organizations generally. Within the VBID Model website specifically, on the Hospice Benefit Component webpages, you can see the list of participating plans that are participating for 2021.

[00:48:23] And then there's specific hospice points of contact within those plans. Both hospice network administrative contacts who I would encourage you all to reach out to. If you're

interested in talking to plans about sort of what their experience has been and potentially partnering with them in the future for 2022.

LM:
I was just thinking about, like, in the bigger picture there's all kinds of information available for hospices in the local areas of the participating plans, sort of partnership tool kits, all kinds of pieces that are available in addition to the connecting information that Sibel was talking about. So.

SO:
Yeah, yeah. And on the CMS.gov website, you can actually download the plan, MA plan directory and cross-reference against what county, what service area those plans have. To really identify those points of contact. And then to Laurie's point, we put out a lot, a lot, a lot of material, both technical and operational guidance, checklists, letters, webinars over the past few months about how to prepare, what to do, how billing and claims processing works, so I really encourage you all to check out those resources that we've put out.

[00:50:02] As you're thinking about 2022 and on. And that goes both for plans and for hospice providers and other interested stakeholders. And I see a few other questions coming in. So Rich, this was a question for you. Are the rates that you mentioned those that the insurance company will receive, or are these the rates that the hospice provider will receive?

RC:
Thank you Sibel, yes, these are the rates that the health plans will receive. Similar to the Medicare Advantage Ratebook where we pay for non-hospice benefits. This will represent the payments that we make to model participants for the hospice benefit. You could probably speak a little bit about how the payments to the plans will work or what flexibilities there are, but these are payments made directly to the plans.

SO:
That's right, so under the VBID Model, MAOs that have been approved to participate and offer the hospice benefit component will establish their payment arrangements with their in-network hospice providers. And as Laurie has shared we don't, as CMS don't interfere in that. It's up to the provider and the MAO to come up with their contracting arrangements and what not. For enrollees that utilize an out-of-network provider, a participating MAO or Medicare Advantage organization is required to cover those services and to make payments at the same amount that the hospice provider would receive from original Medicare.

[00:51:43] So fee-for-service for those covered hospice services, for plan year 2022. Let's see, what other questions do we have. And I see another question in regards to the plan payment report and the monthly membership report. And a specific question says, how will the payment adjustment for members moving to hospice mid-month be reflected on the plan payment summary? Will this adjustment only be on the PPS, or will this adjustment also be reflected on the MMR? So if you recall back when Rich was going over slide five.

[00:52:36] We had the month one payment and then the month two plus payment, meaning the monthly payments for months two and on of a hospice stay. The month one hospice capitation payments will be made in a lump sum retrospectively to the participating plans on a quarterly basis for those enrollees who have a first calendar month hospice experience, and that payment, and I know this is a little bit weedy, but that payment will be reflected at the contract level on the PPR or the plan payment report, and it won't show up on the MMR, which is the monthly membership report.

[00:53:15] And that said, CMS will provide beneficially level detail on the month one hospice capitation payments through a separate report that's made available to participating MAOs. For months two and on of the hospice stay, so meaning month two, month three, etc., participating MAO will prospectively receive the month two plus hospice capitation payment, the beneficiary rebate amount, the monthly prescription drug payment, as applicable, of course, for an enrollee who continues on hospice.

[00:53:44] And those payments will be seen on the MMR at the member level. So I hope that's helpful on that question.

LM:
Yes, Sibel, we have about three minutes left, so we may need to start prioritizing our questions, if we're getting, we're continuing to receive questions.

SO:
Yeah, so maybe we'll take one more. And that one, I'll bring it back to you, Rich. How is the hospice capitation rate adjusted to cover the cost of providing transitional curative treatments concurrent with the hospice levels of care?

RC:
Thank you, Sibel, I think I understand the question. So one thing I did not describe that is part of the process of developing the claim tabulations re-priced is, we take a look at what, prior to the re-pricing, we take a look at what the actual payments were for each beneficiary for the services rendered. And what it would be if you just applied the per diem rates. And the wage index. And often there is a difference. And the difference is typically attributed to these add-on payments. So what we do is, at the CDSA level, we will accumulate what the payments are using just the straight per diems and wage index.

[00:55:28] And what the actual payments are. And to the extent that they're different, we developed what's called a true-up factor. And the true-up factor accounts for these items that are basically add-ons to the fee schedule payments and that adjustment factor will carry forward to the re-pricing. So we are accounting for those, it's somewhat indirect, but we feel like it's an effective approach to account for all the payment streams, not just the base payments.

SO:
Yeah and the other thing that I would add on is that, as you might recall from slide five is, you're still getting an A/B capitation payment for the first month of hospice care, as long as if the beneficially has elected hospice after the first day of that calendar month, so you're getting the

A/B capitated payment plus the monthly hospice cap plus the rebate amount and the prescription drug payment as applicable. So you can braid those funds together to be able to fund that transitional concurring care. And I'll turn it back over to Laurie to close this out. Thanks.

LM:
Thank you so much, Sibel, and I want to thank Rich so much for joining us today. And presenting and answering so many important questions here. And thanks to our audience, we will look forward to your VBID Hospice Benefit Component applications. And of course, recall that we are happy to answer any questions in the interim and everyone stay well. Thank you.

END OF AUDIO FILE