Calendar Year 2024
Final Hospice Capitation Payment Rate Actuarial Methodology

Value-Based Insurance Design Model: Incorporation of the Medicare Hospice Benefit into Medicare Advantage

Table of Contents

1. Background and General Information

Beginning in calendar year (CY) 2021, within the Value-Based Insurance Design (VBID) Model's Hospice Benefit Component, the Centers for Medicare & Medicaid Services (CMS) has been testing the impact on quality and program expenditures of incorporating the Medicare Part A hospice benefit into the Medicare Advantage (MA) program with the goal of creating a seamless continuum of care in the MA program for Part A and Part B services. In voluntarily participating in this Model component, MA Organizations (MAOs) are incorporating the Medicare hospice benefit into MA-covered services while offering comprehensive palliative care services outside the hospice benefit for enrollees with serious illness. In addition, participating MAOs are able to provide individualized, clinically appropriate transitional concurrent care services through in-network providers and to offer hospice-specific supplemental benefits.

On February 17, 2023, CMS released for comment the CY 2024 preliminary payment rate actuarial methodology for the Hospice Benefit Component of the Model. In response, CMS received one comment letter. Comments relevant to the payment rate actuarial methodology are addressed later in this document (section 5).

After consideration of all responses, CMS is finalizing the CY 2024 hospice payment rate actuarial methodology, as described in this updated methodology paper. The updates reflect CMS' continued commitment to maintaining the full Medicare hospice benefit while providing MAOs with the flexibility to develop and implement innovative approaches to serious illness care. CMS expects that uptake of the Hospice Benefit Component will result in improvements in financial accountability and timely access to high-quality palliative and hospice care for Medicare beneficiaries, and the agency is looking forward to continuing to work with stakeholders to achieve the shared goals of transforming and improving serious illness care for those beneficiaries. Comments or questions regarding the payment rate actuarial methodology of the Hospice Benefit Component may be sent by email to VBID@cms.hhs.gov.

1.1. Executive Summary of the CY 2024 Hospice Capitation Payment Rate Actuarial Methodology

This paper describes the actuarial methodology for the hospice capitation payment rate paid to MAOs that participate in the voluntary Hospice Benefit Component of the Model. Included in the document are the following: (i) a review of the key changes from the CY 2023 final methodology (section 1.2); (ii) the current payment structure of the fee-for-service (FFS) Medicare hospice benefit (section 1.3); and (iii) detailed technical specifications regarding payments made under the Hospice Benefit Component of the Model, including the rate determination process for the CY 2024 national monthly hospice capitation rate and applied rating factors (sections 2–4).

Payment Structure of the Hospice Benefit Component

Participating MAOs will be paid in accordance with current law for their enrollees who do not elect hospice. For their enrollees who elect hospice under 42 CFR 418.24, participating MAOs will be paid per the following payment structure:

- For the first month of hospice election ("Month 1"), the basic benefit capitation rate (also known as the "A/B capitation rate") will be paid only if, as of the first of the month, an enrollee is not under hospice election status consistent with 42 CFR 422.320(c).
- For all calendar months in which an enrollee elects hospice care, including the first month of hospice election, a participating MAO will receive the following:
    - A monthly hospice capitation rate;
    - Consistent with 42 CFR 422.320(c)(2), the beneficiary rebate amount as described in 42 CFR 422.304(a); and
    - Consistent with 42 CFR 422.320(c), the monthly prescription drug payment as described in 42 CFR 423.315 (if any).

Hospice Capitation Rate Development

For CY 2024, CMS developed two national monthly hospice capitation rates and corresponding sets of payment rates. The development of the first national monthly hospice rate and corresponding set of payment rates includes hospice stays that begin in each of the base calendar years used in the tabulations. These tabulations mimic the first year Model experience that MAOs with Plan Benefit Packages (PBPs) that offer the Hospice Benefit Component for the first time in CY 2024 will encounter in CY 2024—that is, the impact of not having carryover hospice stays from prior years. In essence, hospice stays that spanned calendar years are excluded to align the base data with the expected rating period duration. These values and rates will be referred to in this document as "year-1 rates."

The development of the second national monthly hospice rate and corresponding set of payment rates includes hospice stays that begin in each of the base experience calendar years or in prior years. These tabulations mimic the second and third year Model experience that MAOs with PBPs that offer the Hospice Benefit Component in CY 2023 and CY 2024 will encounter in CY 2024. These values and rates will be referred to as "mature-year rates."

Unless specified otherwise, the narrative and data contained in this report pertain to the year-1 rates, and references to years pertain to calendar, not fiscal, years.

The determination process for the CY 2024 rates[1] is described in section 2. These rates reflect FFS-paid hospice experience for care associated with the terminal condition and related conditions during a hospice stay ("hospice FFS payments") and FFS-paid non-hospice experience ("non-hospice FFS payments"). The latter experience consists of two parts: (i) FFS-paid non-hospice care furnished by non-hospice providers during a hospice stay; and (ii) other FFS-paid non-hospice care provided after a hospice stay ends (including, in the event of a live discharge, non-hospice care provided on the last day of the stay and through the end of the calendar month that the stay ends) for all Medicare beneficiaries who elected hospice (both those enrolled in Original Medicare and those enrolled in the MA program).

[1] These rates represent actual hospice FFS payments for hospice care and services; the term "hospice stay" refers to the overall period between an election and discharge, which may include multiple 90-day or 60-day periods.

CMS followed a standard rate development process, which consisted of three parts: (i) as described in section 2.3, base data appropriate to the population and benefits being priced (for example, use of 3 years of complete data for hospice and non-hospice FFS-paid Part A and Part B claims from CY 2019 to CY 2021); (ii) as described in sections 2.4a through 2.4d, retrospective adjustments to the base data to allow for known changes that have taken place since the base data were incurred (for example, taking into account repricing to reflect fiscal year (FY) 2023 per diem payment rates and the FY 2023 Hospice Wage Index); and (iii) as described in section 2.5, prospective adjustments for changes that are anticipated to occur between the base data incurred period and the period being priced (for example, trending hospice and non-hospice FFS-paid claims to CY 2024).

The national monthly hospice capitation rates will be adjusted by two rating factors: an "area factor," as described in section 3, and a "monthly rating factor," as described in section 4. The national monthly hospice capitation rate will be adjusted for each county by a hospice-specific average geographic adjustment similar to the MA average geographic adjustment (area factor) to result in an adjusted monthly hospice capitation rate. Of note, beneficiary-specific risk adjustment will not be applied to the hospice capitation rate payment.[2] Additionally, to better reflect the first month beneficiary experience in hospice, the national monthly hospice capitation rate will be adjusted by a monthly rating factor for the first month only, as described in section 4. The hospice capitation rate paid for the first month will vary based on the number of days of hospice benefit occurring in the first calendar month of a hospice stay in a three-tiered structure (days 1–6, 7–15, 16+).

The Month 1 rating factors used in development of the year-1 rates are the same as the 2023 rates: (i) 0.3400 for 1–6 days; (ii) 0.6400 for 7–15 days; and (iii) 1.0030 for 16+ days. The key parameters and values for the year-1 rates are summarized in table 1a. The rates are shown in the last column gross of sequestration.

Table 1a. National Average Values for 2024 Capitation Rates, Year-1 Rates

	Hospice Enrollment in Month 1	Average Monthly Service Days	Distribution of Stay Months	Monthly Rating Factor[1]	2024 Gross Monthly Base Rate
Month 1	1–6 Days	3.24	17.26%	**0.3400**	$1,927.64
	7–15 Days	10.49	11.95%	**0.6400**	$3,628.50
	16+ Days	22.68	11.09%	**1.0030**	$5,686.55
Month 1 Composite[2]		10.74	40.30%	0.6115	$3,466.74
Month 2+		26.12	59.70%	**1.0000**	$5,669.54
CY 2024 Composite National Hospice Capitation Rate[3]		19.92	100.00%	0.8434	$4,781.70

[1] Bold numbers are the monthly rating factors used.
[2] Values are based on the distribution of stay months.
[3] This amount represents the national hospice capitation base rate for year-1 rates.

[2] CMS reviewed the need for a risk mitigation program and found the variation in FFS payments by stay month to be relatively low (see section 3.2 on credibility) because the majority of the FFS payments (approximately 92 percent) consist of per diem rates with a small range of values.

The Month 1 rating factors used in development of the mature-year rates are as follows: (i) 0.3507 for 1–6 days; (ii) 0.6602 for 7–15 days; and (iii) 1.0347 for 16+ days. These rating factors yield Month 1 rates that are equal to the Month 1 rates developed for year-1. The key parameters and values for the mature-year rates are summarized in table 1b. Again, the rates are shown in the last column gross of sequestration.

Table 1b. National Average Values for 2024 Capitation Rates, Mature-year Rates

	Hospice Enrollment in Month 1	Average Monthly Service Days	Distribution of Stay Months	Monthly Rating Factor[1]	2024 Gross Monthly Base Rate
Month 1	1–6 Days	3.24	11.04%	**0.3507**	$1,927.39
	7–15 Days	10.49	7.65%	**0.6602**	$3,628.35
	16+ Days	22.68	7.10%	**1.0347**	$5,686.55
Month 1 Composite[2]		10.74	25.78%	0.6308	$3,466.59
Month 2+		27.23	74.22%	**1.0000**	$5,495.84
CY 2024 Composite National Hospice Capitation Rate[3]		22.98	100.00%	0.9048	$4,972.65

[1] Bold numbers are the monthly rating factors used.
[2] Values are based on the distribution of stay months.
[3] This amount represents the national hospice capitation base rate for mature-year rates.

First month hospice capitation payments will be made to participating MAOs in a lump sum retrospectively on a quarterly basis for all enrollees who have a first calendar month hospice experience. Consistent with current law, as applicable, the A/B capitation rate, beneficiary rebate amount, and monthly prescription drug payment will be paid prospectively for Month 1. For any future calendar month experience, a participating MAO will prospectively receive a flat hospice capitation rate, the beneficiary rebate amount, and the monthly prescription drug payment, if applicable, for an enrollee who continues under hospice care. For Months 2+, the monthly rating factor is 1.00, and the base rate gross of sequestration is $5,669.54 for year-1 rates and $5,495.84 for mature-year rates.

Overall, the hospice capitation rates are projected to be budget neutral; that is, for CY 2024, the total CY 2024 capitation amounts are projected to equal the aggregate estimated CY 2024 Medicare FFS payments, plus an administrative load. In other words, no discounts are applied to estimated CY 2024 Medicare FFS payments.

1.2. Key Changes from the CY 2023 Final Actuarial Methodology

On March 1, 2023, CMS released a memorandum titled *CY 2024 Preliminary Hospice Capitation Payment Rate Actuarial Methodology for the Hospice Benefit Component of the MA VBID Model*. Within the document is a section titled "Key Preliminary Updates from the CY 2023 Final Actuarial Methodology," which includes proposed changes to the data, as well as the methodology to be used in the development of the CY 2024 rates. Summarized below are the provisions from this section that are reflected in the final CY 2024 hospice rates.

- CMS plans to use mature-year Model experience in counties where the Hospice Benefit Component was offered in CY 2023 and to use year-1 Model experience in counties where the component will be offered for the first time in CY 2024. This method will still result in one

ratebook for the Hospice Benefit Component; however, rates will be independently developed to reflect year-1 and mature-year rates depending on whether a plan benefit package (PBP) participated in a county offering the Hospice Benefit Component in CY 2023.

- The rates continue to be based on a 3-year experience period in the base data. For the CY 2024 rates, the experience period consists of CY 2019 through CY 2021.
- For CY 2024, CMS has repriced the CYs 2019–2021 historical hospice FFS-paid claims experience to CY 2023. The repricing of these claims uses the FY 2023 per diem payment rates for the four prospectively determined rate categories of hospice care—routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP)—and the FY 2023 Hospice Wage Index. Also, consistent with the 2023 rates, the repricing will be based on the provider CBSA for IRC and GIP and on the place of residence for RHC and CHC. Repricing for CHC will be based on CHC units and the published FY 2023 hourly rate for CHC
- Consistent with the CY 2023 MA capitation rates, the tabulation of non-hospice claims excludes direct graduate medical education (DGME), indirect medical education (IME), and kidney acquisition costs (KACs). The DGME, IME, and KAC exclusion represents a sum of the three carve-out factors incorporated in the CY 2024 MA ratebook[3], tabulated at the CBSA level and applied against non-hospice claim expenditures. The consolidated carve-out factors are included in the "Hospice AGA Summary" tab of the published databook for the CY 2024 Hospice Benefit Component, which can be found on the VBID Model website.
- As stated in the FY 2023 Hospice Wage Index and Payment Rate Update Final Rule (CMS-1773-F),[4] there were no changes in the mapping of counties to CBSAs from FY 2021 to FY 2023. Accordingly, the development of the CY 2024 VBID hospice rates at the CBSA level will be based on the same county-to-CBSA mappings as were the CY 2023 VBID hospice rates
- Based on 2019 Medicare cost report data, the hospice labor shares were updated for FY 2022 and remain at the same level for FY 2023. These labor shares, which are included in table 2, are used the tabulation of the CY 2024 VBID hospice rates.

Table 2. Labor Shares of Hospice Payments, FY 2022 and FY 2023

Description	Labor Shares
Routine Home Care (Days 1–60)	66.00%
Routine Home Care (Days 61+)	66.00%
Continuous Home Care	75.20%
Inpatient Respite Care	61.00%
General Inpatient Care	63.50%

[3] CMS. 2024 Medicare Advantage ratebook and Prescription Drug rate information; Rate Calculation Data; tab risk2024. Retrieved from https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/ratebooks-and-supporting-data/655541402/2024

[4] CMS. Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (CMS-1773-F). Retrieved from https://www.cms.gov/medicaremedicare-fee-service-paymenthospicehospice-regulations-and-notices/cms-1773-f

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1.3. Background: Payment Structure of the Current FFS Medicare Hospice Benefit

Hospice care is a holistic, comprehensive approach to treatment that recognizes that the impending death of an individual with terminal illness warrants a change in focus from curative care to palliative care for symptom management and relief of pain. Palliative care is at the core of hospice philosophy and care practices, and it is a critical component of the Medicare hospice benefit, with the goal of helping terminally ill individuals remain primarily in the home environment and continue life with minimal disruption to normal activities.[5] A hospice facility uses an interdisciplinary approach to deliver medical, social, nursing, emotional, psychological, and spiritual services through a collaboration of professionals and other caregivers in an effort to make the beneficiary as physically and emotionally comfortable as possible. This beneficiary and family/caregiver-centered care for those who are terminally ill is supported through a per diem payment that allows for the provision of a bundle of comprehensive services.

42 CFR part 418, subpart G provides for a per diem payment—based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected it)—in one of four levels of care: RHC, CHC, GIP, or IRC. This per diem payment is to include all of the hospice services and items needed for the palliation and management of a beneficiary's terminal condition, as required by section 1861(dd)(1) of the Social Security Act (the Act). These four levels of hospice care are distinguished by the intensity and location of the services provided.

A CMS review of claims over a recent 10-year period shows that RHC, which is the basic level of care under the hospice benefit, remains the highest utilized level of care, accounting for an average of 97.6 percent of total hospice days; GIP accounts for 1.7 percent of total hospice days, CHC for 0.4 percent, and IRC for 0.3 percent.[6] If, in the judgment of the hospice interdisciplinary team, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for GIP, a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital, and its purpose is to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to his or her home and continue to receive RHC. Limited, short-term, intermittent IRC is also available because of the absence, or need for relief, of the family or other caregivers. Additionally, CHC can be provided during a period of crisis in which continuous care is required to achieve palliation or management of acute medical symptoms so that the individual can remain at home. For any given patient, the type of care can vary throughout the hospice stay as his or her needs change.

CMS has noted on multiple occasions that there has been little change in the hospice payment structure since the benefit's inception. Today, this original per diem payment structure remains largely the same, with some adjustments. A couple of these modifications are noted below:

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[5] Proposed Rule CMS-1714-P. "CMS FY 2021 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Retrieved from https://www.federalregister.gov/documents/2021/04/25/2021-08143/medicare-program-fy-2021-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting

[6] Final Rule CMS-1714-F. "Medicare Program; FY 2021 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Retrieved from https://www.govinfo.gov/content/pkg/FR-2021-08-06/pdf/2021-16583.pdf

- Beginning January 1, 2019, using the hospice payment reform authority under section 1814(i)(6) of the Act, Medicare changed how it pays for RHC. There are now two RHC base payment rates: a higher rate for days 1 to 60 and a lower rate for days 61 and beyond. Medicare also makes additional payments for registered nurse and social worker visits that are provided during the last 7 days of life, and these payments are made above and beyond the RHC per diem amount.
- Using the hospice payment reform authority under section 1814(i)(6) of the Act and under section III.A.3 of the FY 2023 hospice final rule "Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update" (CMS-1733-F), Medicare rebased the FY 2022 per diem payment rates for CHC, IRC, and GIP and reduced RHC payment amounts for FY 2022 in order to maintain overall budget neutrality. This rebasing was done to adequately cover the costs of providing higher-intensity levels of care—given that the costs of providing CHC, IRC, and GIP have been significantly higher than their payment rates. The FY 2023 payment rates were developed using a methodology consistent with that for FY 2022. The FY 2022 and FY 2023 per diem payment rates are highlighted in table 3.

Table 3. Hospice Average Costs Per Day versus Gross Per Diem Payment Rates in FY 2022 and FY 2023[7]

Code	Description	FY 2022 Per Diem Payment Rates	FY 2023 Per Diem Payment Rates
651	Routine Home Care (Days 1–60)	$203.40	$211.34
651	Routine Home Care (Days 61+)	$160.74	$167.00
652	Continuous Home Care Full Rate = 24 hours of care	$1,462.52/ $60.94 (hourly rate)	$1,522.04/ $63.42 (hourly rate)
655	Inpatient Respite Care	$473.75	$492.10
656	General Inpatient Care	$1,068.28	$1,110.76

Further, to ensure that hospice care does not exceed the cost of conventional care, there are two annual limits to hospice payments: the inpatient cap and the aggregate cap. The hospice inpatient cap limits the total number of Medicare inpatient days (for both general inpatient and inpatient respite care) to no more than 20 percent of a hospice's total Medicare hospice days. Any excess reimbursement must be refunded by the hospice. The hospice aggregate cap limits the total aggregate payments that any individual hospice can receive in a cap year to an allowable amount, based on an annual per beneficiary cap amount and the number of beneficiaries served. Any actual Medicare payments in excess of the aggregate cap must be refunded by the hospice. CMS found that the inpatient cap repayment represents about 0.01 percent of hospice claims and that the aggregate cap repayment constitutes about 1 percent of claims.

While hospice care is a covered Medicare Part A benefit, the MA program—formerly known as Medicare+Choice—does not include risk or financial accountability for providing the Medicare

[7] Final Rule CMS-1754-F. "Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Retrieved from https://www.govinfo.gov/content/pkg/FR-2021-08-04/pdf/2021-16311.pdf
and CMS-1773-F "Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Retrieved from https://www.govinfo.gov/content/pkg/FR-2022-07-29/pdf/2022-16214.pdf

hospice benefit as part of MA plan obligations.[8] Specifically, the Balanced Budget Act of 1997 (BBA) provided that, should an individual enrolled in a Medicare+Choice program elect to receive hospice care from a particular hospice program, payment for that hospice care would be made to the hospice program by the Secretary of Health and Human Services (HHS), while payment for services not related to the individual's terminal illness and related conditions may be made by the Secretary of HHS to the Medicare+Choice organization or to the provider or supplier of the service.[9] As codified at 42 CFR 422.320(c)(2) and (3), during the time that the hospice election is in effect, CMS' monthly capitation payment to the MAO is reduced to the sum of (i) an amount equal to the beneficiary rebate for the MA plan, as described in 42 CFR 422.304(a)(3), or a zero amount for plans with no beneficiary rebate, as described in 42 CFR 422.304(a)(2); and (ii) the amount of the monthly prescription drug payment, as described in 42 CFR 423.315 (if any). The A/B capitation rate will be paid only if, as of the first of the month, an enrollee is not under hospice election status.

2. Rate Determination Process for the CY 2024 Hospice Capitation Rates under the Model

2.1. Introduction

This section describes the process used to develop the national hospice capitation rates for CY 2024. In developing these rates, CMS considered the following policy objectives:

- To the extent possible, maintain a simple, transparent, and clear payment structure and cost-neutral rates so that, for CY 2024, the aggregate 2024 capitation equals the aggregate estimated 2024 Medicare FFS payment (plus an administrative load);
- Continue to ensure the accuracy of rates to the extent possible while moving from a granular four-level per diem FFS payment structure, which automatically adjusts for length of stay and service intensity, to a monthly capitation rate, with capitation offering opportunities for improved quality management;
- Primarily measure accuracy on an aggregate basis by CBSA;
- To the extent possible and appropriate, develop rates consistent with the process by which MA benchmarks are prepared, following actuarial guidance and practices in developing the rates; and
- Align payment structure with policy objectives to (i) promote hospice enrollment early enough in the disease trajectory to allow delivery of the range of services necessary to promote comfort while also discouraging very short stays, when an enrollee with a terminal illness has little time to benefit from hospice services and after significant costs with acute medical care have often been incurred; and (ii) reduce the financial incentive surrounding very long stays that is present

[8] Section 1852(a) of the Act carves hospice out of the services that MA plans must cover. See also H.R. 2015. Balanced Budget Act of 1997 (BBA). Retrieved from https://www.congress.gov/105/plaws/publ33/PLAW-105publ33.pdf

[9] The specific statutory provisions that were added by the BBA and that address this issue include section 1852(a), which provides that MA plans do not cover hospice, and section 1853(h)(2), which provides the payment rules for hospice services offered to MA enrollees.

in the current FFS payment system,[10] to help ensure appropriate access to, and utilization of, the Medicare hospice benefit under the Model.

The basic rating structure under the Model is similar to the MA approach for setting benchmarks:

$$Monthly\ Capitation\ Payment\ =\ National\ Base\ Rate\ \times\ Area\ Factor\ \times\ Monthly\ Factor$$

As further described in sections 3 and 4, the rating structure under the Hospice Benefit Component has just two rating factors: (i) the area factor—to account for all regional variation in claims to the extent possible; and (ii) the monthly rating factor—to better match capitation with the durational claim pattern. Under the Model component, the rating structure, which is detailed in this payment methodology, is as follows:

$$Capitation\ Rate_{\ CBSA,\ Month\ 1} = (National\ Rate)\ \times (Month\ 1\ Factor\ for\ Covered\ Days\ in\ Month\ 1)\ \times (Hospice\ Average\ Geographic\ Adjustment)_{\ CBSA,\ Month\ 1}$$

$$Capitation\ Rate_{\ CBSA,\ Month\ 2+} = (National\ Rate)\ \times\ (Month\ 2^{+}\ Factor)\ \times (Hospice\ Average\ Geographic\ Adjustment)_{\ CBSA,\ Month\ 2+}$$

CMS considered other rating factors,[11] but analysis showed that either they were not significant, after accounting for the area factor and monthly rating factor, or they were administratively too complex to implement. The area factor and monthly rating factor account for the following, all of which persist over years by area:

- Claim unit cost differences (for example, labor cost differences that vary by CBSA).
- Mix of services (for example, more use of intense hospice services such as CHC, GIP, and IRC and spending for non-hospice FFS-paid care).
- Mix of condition categories that are persistent in the experience (for example, in comparison to the national average, New York has a much higher proportion of beneficiaries who elect hospice with cancer conditions, and New Jersey has a much higher proportion of beneficiaries who elect hospice with dementia conditions).
- Stay month mix (that is, short, mid, and long stays in Month 1), in which the stay month reflects the calendar month of coverage for a beneficiary enrolled in Medicare.

[10] Medicare Payment Advisory Commission (MedPAC). *Report to the Congress: Medicare Payment Policy*. Chapter 10: "Hospice Services." March 2023. Retrieved from https://www.medpac.gov/wp-content/uploads/2023/03/Ch10_Mar23_MedPAC_Report_To_Congress_SEC.pdf

[11] The other rating factors identified as drivers of hospice and non-hospice FFS payments include (i) discharge status of hospice beneficiaries—that is, continue status (for those who continue from one month to the next), death status, or discharge status (for those who have a live discharge); (ii) terminal condition of a hospice beneficiary; (iii) aged versus disabled status; and (iv) dual versus non-dual status.

In aggregate, of the FFS payments related to a hospice experience, 92.0 percent are for hospice FFS-paid claims, and 8.0 percent are for non-hospice FFS-paid claims. RHC represents the vast majority of all per diem amounts (91.3 percent) for hospice claims.

2.2. Process for Developing Rates

CMS followed a standard rate development process, which consisted of three parts:

- Base data appropriate to the population and benefits being priced.
- Retrospective adjustments to the base data to allow for known changes that have taken place since the base data were incurred.
- Prospective adjustments for changes that are anticipated to occur between the base data incurred period and the period being priced.

Table 4a provides an illustrative[12] development of the CY 2024 composite national hospice capitation rate for the year-1 rates. The CY 2024 rate prior to hospice provider caps is $4,781.70, which is 1.6 percent higher than the corresponding value of $4,707.51 for CY 2023.

Table 4a. 2024 National Hospice Capitation Composite Rate Development, Year-1 Rates

		2019	2020	2021
	Stay Months	3,458,829	3,552,769	3,543,988
CY 2024 Hospice FFS Payments				
(a)	Actual Net Per Member Per Month (PMPM)	$3,759.95	$3,832.95	$3,929.24
(b)	Calculated Using Service Days & Historical Per Diem Rates	$3,716.10	$3,777.99	$3,888.70
(c) = (a) / (b)	True-up Adjustment	1.0118	1.0145	1.0104
(d)	Calculated Using Service Days and FY 2023 Per Diem Rates (Gross)	$4,202.92	$4,084.06	$4,067.30
(e)	Claim Completion Adjustment	1.0001	1.0012	1.0024
(f) = (d) x (c) x (e)	Calculated FY 2023 x True-up x Claim Completion	$4,252.94	$4,148.44	$4,119.57
(g)	Per Diem Trend from FY 2023 to CY 2024	1.0387	1.0398	1.0411
(h)	Service Day Utilization and Mix Change	0.9807	0.9956	1.0000
(i) = (f) x (g) x (h)	CY 2024 Hospice FFS Payment (Gross)	$4,332.08	$4,294.69	$4,288.80
CY 2024 Non-Hospice FFS Payments				
(j)	Actual Net PMPM	$353.62	$366.38	$381.98
(k)	Claim Completion Adjustment	1.0191	1.0190	1.0185
(l)	Non-ESRD PMPM USPCC Trend to CY 2024	1.2545	1.3084	1.1822
(m)	Sequestration Gross Up	0.9800	0.9933	1.0000
(n) = (j) x (k) x (l) / (m)	CY 2024 Non-Hospice FFS Payments (Gross)	$461.33	$491.79	$459.93
CY 2024 Hospice FFS Payments + Non-Hospice FFS Payments				
(o) = (i) + (n)	CY 2024 Hospice + Non-Hospice FFS Payments	$4,793.41	$4,786.48	$4,748.73
(p)	Straight Average[1]			$4,776.21
Top Side Adjustments				
(q)	Administrative Load Factor			1.00115
(r) = (p) x (q)	CY 2024 National Composite Gross Capitation Rate (prior to Provider Cap Adjustment)			$4,781.70

[1] Calculated as the simple average of CYs 2019–2021, consistent with the approach used in the MA ratebook development.

[12] The actual rate development for the most part was done at a beneficiary level. Tables 4a and 4b show the rate development at an aggregate level.

Table 4b provides an illustrative development of the CY 2024 composite national hospice capitation rate for the mature-year rates. The CY 2024 rate prior to hospice provider caps is $4,972.65, which is 3.98 percent higher than the corresponding value for the year-1 rates.

Table 4b. 2024 National Hospice Capitation Composite Rate Development, Mature-year Rates

		2019	2020	2021
	Stay Months	5,283,105	5,553,941	5,543,970
CY 2024 Hospice FFS Payments				
(a)	Actual Net Per Member Per Month (PMPM)	$3,949.11	$4,035.17	$4,149.59
(b)	Calculated Using Service Days & Historical Per Diem Rates	$3,913.03	$4,000.02	$4,120.29
(c) = (a) / (b)	True-up Adjustment	1.0092	1.0088	1.0071
(d)	Calculated Using Service Days and FY 2023 Per Diem Rates (Gross)	$4,402.90	$4,334.78	$4,315.30
(e)	Claim Completion Adjustment	1.0001	1.0012	1.0024
(f) = (d) x (c) x (e)	Calculated FY 2023 x True-up x Claim Completion	$4,443.94	$4,378.12	$4,356.42
(g)	Per Diem Trend from FY 2023 to CY 2024	1.0363	1.0374	1.0386
(h)	Service Day Utilization and Mix Change	0.9807	0.9956	1.0000
(i) = (f) x (g) x (h)	CY 2024 Hospice FFS Payment (Gross)	$4,516.36	$4,521.67	$4,524.53
CY 2024 Non-Hospice FFS Payments				
(j)	Actual Net PMPM	$331.26	$344.87	$368.07
(k)	Claim Completion Adjustment	1.0191	1.0190	1.0185
(l)	Non-ESRD PMPM USPCC Trend to CY 2024	1.255	1.308	1.182
(m)	Sequestration Gross Up	0.98	0.99	1.00
(n) = (j) x (k) x (l) / (m)	CY 2024 Non-Hospice FFS Payments (Gross)	$432.15	$462.92	$443.18
CY 2024 Hospice FFS Payments + Non-Hospice FFS Payments				
(o) = (i) + (n)	CY 2024 Hospice + Non-Hospice FFS Payments	$4,948.51	$4,984.59	$4,967.71
(p)	Straight Average[1]			$4,966.94
Top Side Adjustments				
(q)	Administrative Load Factor			1.00115
(r) = (p) x (q)	CY 2024 National Composite Gross Capitation Rate (prior to Provider Cap Adjustment)			$4,972.65

[1] Calculated as the simple average of CYs 2019–2021, consistent with the approach used in the MA ratebook development.

2.3. Base Data

The base data reflect 3 years of complete data for Part A and Part B claims from CY 2019 to CY 2021 (that is, 100 percent of Medicare final action hospice FFS-paid and non-hospice FFS-paid claims, as defined in section 1, for beneficiaries enrolled in the FFS program or in an MA plan). Because the Medicare hospice benefit does not cover Part D benefits, these were excluded in the national hospice capitation rate. It is important to note that the base data, which are derived from paid claims, reflect a net of the 2-percent sequestration reduction and do not include the hospice provider inpatient and aggregate caps.

To emulate the first year experience of MAOs newly offering the Hospice Benefit Component in CY 2024, the base data supporting the year-1 rates use only those hospice benefit periods that begin in each of the calendar years.

The base data supporting the mature-year rates consist of claims incurred during the historical period, including benefit periods that started during any previous year.

2.4. Retrospective Adjustments

As described in greater detail below, CMS made three retrospective adjustments:

- Repricing of the hospice FFS-paid claims using the FY 2023 per diem payment rates for RHC, CHC, IRC, and GIP levels of care and the FY 2023 Hospice Wage Index (see section 2.4a).
- Recognizing the impact of the hospice provider inpatient and aggregate caps, which are not included in the claims data (see section 2.4c).
- Making an adjustment to the CY 2021 experience for estimated beneficiary-level claims that were incurred but not reflected in the base experience and for claims paid outside the claim system (see section 2.4d).

2.4a. Repricing

CMS performed three steps to reprice the CYs 2019–2021 historical hospice FFS-paid claims experience to FY 2023:

Step 1: CMS repriced the data using the 2023 per diem payment rates by type of service (RHC days 1–60, RHC days 61+, CHC, GIP, and IRC) multiplied by a FY 2023 Hospice Wage Index adjustment and by the number of service days by stay month for each beneficiary within the base data. The 2023 Hospice Wage Index was based on the beneficiary's CBSA listed within CMS data.

Step 2: In addition to services covered by the standard per diem payment rates, CMS considered other features that were not accounted for in those rates, including service intensity add-ons, physician services covered under the hospice benefit but not offered by a hospice provider, and the fact that some hospice providers receive lower per diem payment rates for not reporting quality data.[13] To account for these features, CMS performed a second repricing, identical to the first except using per diem rates and wage indices specific to the incurred time period and the beneficiary's CBSA. The actual paid amount in the base data was then compared to this calculated paid amount to develop a true-up adjustment factor.

Step 3: CMS multiplied the calculated 2023 claims from Step 1 with the adjustment factor from Step 2 to recognize the features that were not accounted for in the FY 2023 per diem payment rates.

[13] This adjustment factor also accounts for situations in which the hospice provider is in a CBSA that is different from the beneficiary's CBSA listed in the CMS data. Based on analysis of the beneficiary's CBSA and the provider location, approximately 4 percent of 2019 payments were to providers in States that were different from the beneficiary's location.

2.4b. Service Day Utilization and Intensity Adjustment

Using a methodology similar to that described in section 2.4b of the CY 2023 Final Actuarial Methodology, CMS studied the 2018–2021 mature-year experience for average number of service days and weighted per diem amounts, based on FY 2023 per diem rates.

The experience and trends are summarized in Table 5. For purposes of analysis, the service days in column a, and the weighted per diem amounts in column g, were multiplied by each other to arrive at a composite value in column h.

The resulting annual trends in the composite values are -1.50 percent for 2019-2020 and -0.44 percent 2020-2021. The negative trends are driven by annual reductions in distribution of services with relatively high per diem rates: inpatient respite care (IRC), general inpatient care (GIP), and continuous home care (CHC). The resulting trends proposed for the 2024 rates, from base year 2019 and 2020 to 2021 are

- CY 2019 – CY 2021: -1.94 percent [(1 - .0150) * (1- 0.044) – 1]
- CY 2020 – CY 2021: -0.44 percent

Finally, consistent with the VBID hospice actuarial methodology for the CY 2022 and CY 2023 rates, no additional trend for changes in service mix will be applied from 2021 to 2024.

Table 5. Service Day Utilization and Intensity Adjustment, Mature-year Rates

Period	Service Days Per Stay Month (a)	Mix of Service Days: RHC 1–60 (b)	RHC 61+ (c)	IRC (d)	GIP (e)	CHC (f)	Weighted Per Diem (g)	Composite (h) = a * g
FY 2023 Per Diem		$211.34	$167.00	$492.10	$1,110.76	$1,522.04		
Service days and weighted per diem								
	Value	***Distr.***	***Distr.***	***Distr.***	***Distr.***	***Distr.***	***Value***	***Value***
CY 2018	22.80	32.09%	66.17%	0.33%	1.23%	0.18%	$196.35	$4,476.75
CY 2019	23.04	31.27%	67.11%	0.33%	1.12%	0.16%	$194.66	$4,484.95
CY 2020	22.99	30.44%	68.25%	0.20%	0.98%	0.13%	$192.16	$4,417.71
CY 2021	22.95	30.69%	68.02%	0.26%	0.95%	0.09%	$191.66	$4,398.49
Annual trend / difference								
	Trend	***Diff.***	***Diff.***	***Diff.***	***Diff.***	***Diff.***	***Trend***	***Trend***
2018–2019	1.05%	-0.82%	0.94%	0.00%	-0.11%	-0.02%	-0.86%	0.18%
2019–2020	-0.22%	-0.83%	1.14%	-0.13%	-0.14%	-0.03%	-1.29%	-1.50%
2020–2021	-0.17%	0.25%	-0.23%	0.06%	-0.03%	-0.04%	-0.26%	-0.44%
Annual trend / difference								
CY 2019 experience (change in composite value from 2019 to 2021)								-1.93%
CY 2020 experience (change in composite value from 2020 to 2021)								-0.44%
CY 2021 experience								0.00%

2.4c. Recognition of the Hospice Provider Inpatient and Aggregate Caps[14]

As noted in sections 1.3 and 2.3, any actual Medicare payments made to a hospice provider in excess of the inpatient cap and the aggregate cap must be refunded; these amounts were not reflected in the base data (that is, within the 100 percent of Medicare final action hospice claims for beneficiaries enrolled in the FFS program or in an MA plan). Below is a description of the two provider cap adjustments. The combined impact of both caps on the final rates for CY 2024 was a 0.9-percent reduction, weighted by stay months.

Hospice Provider Inpatient Cap

The hospice provider inpatient cap excess reimbursements for 2019–2021 were relatively small ($1.6 million total) compared to the total hospice payment. However, these amounts were limited to seven hospice providers during that 3-year period, with three hospice providers responsible for 99.3 percent ($1.6 million total) of the overpayment. CMS reduced the hospice FFS-paid claims in the three CBSAs that showed year-over-year consistency both in reimbursement amounts and

[14] A detailed description is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

in the identity of providers that had these recoveries. Table 6 shows the reductions by CBSA by year.

Table 6. Hospice Provider Inpatient Cap Experience Adjustment (Mature-year Rates)

CBSA	CBSA Description	2019	2020	2021	Total
22744–FL	Fort Lauderdale–Pompano Beach–Deerfield Beach, FL	$101,532	$17,627	$0	$119,159
25060–MS	Gulfport–Biloxi–Pascagoula, MS	$0	$414,104	$340,685	$754,789
32820–TN–MS–AR	Memphis, TN–MS–AR	$722,365	$0	$0	$722,365
Total		$823,897	$431,731	$340,685	$1,596,313

Hospice Provider Aggregate Cap

Consistent with the approach used with the 2021, 2022 and 2023 hospice capitation rates, the hospice provider aggregate caps were calculated using the most recent payment data under the proportional approach at a provider level. Next, CMS allocated any calculated overpayment to beneficiaries using that provider based on hospice FFS payments by beneficiary. This approach allowed the allocation of the overpayments to beneficiary CBSAs. CMS calculated the overpayments as a percentage of hospice FFS-paid claims for Month 2+ and applied that reduction to all experience years for the given CBSA. This calculation is based on mature year experience supporting the mature-year rates, and it is appropriate for both mature-year and year-1 rates since the ratio of hospice claims to total claims is about the same for both cohorts.

The resulting hospice provider aggregate cap adjustment factors were inconsistent with the factors used in the 2021 – 2023 hospice capitation rates. Our analysis revealed that the source payment data contained anomalies that could not be fully addressed. Given the issues with the updated provider cap adjustments, we used the 2023 hospice provider aggregate cap adjustment factors in the development of the 2024 hospice capitation rates. Table 7 summarizes the distribution of CBSA count by the percentage of the hospice provider aggregate cap reduction to the Month 2+ hospice average geographic adjustment (AGA) (see section 3 for details on the hospice AGA). On an aggregate basis, the reduction is approximately 0.9 percent of hospice FFS payments (0.8 percent of total payments).

Table 7. Distribution of Hospice Provider Aggregate Cap Reductions to Month 2+ Hospice AGAs

Month 2+ Reduction	Count of CBSAs
<1%	432
1–3%	40
3–5%	6
>5%	4

2.4d. Claim Completion

To develop the hospice claim completion factors, CMS used historical experience consistent with the process used to develop claim completion factors for the MA program. Table 8 shows the claim completion multiplicative factors for both hospice and non-hospice FFS-paid claims for 2019–2021.

Table 8. Claim Completion Multiplicative Factors

Claim Type	2019	2020	2021
Hospice FFS-paid claims	1.0001	1.0012	1.0024
Non-hospice FFS-paid claims	1.0191	1.0190	1.0185

The multiplicative factors listed in table 8 account for outstanding claims from the National Claims History (NCH) base experience and provider reimbursements made outside the NCH, including cost report settlements, but these factors do not include hospice cap settlements.

2.5. Prospective Adjustments

Table 9 provides a high-level summary of prospective adjustments and respective assumptions.

Table 9. Summary of Prospective Adjustments and Respective Assumptions

Prospective Adjustment	Note	Assumption
Hospice FFS Payment		
2023 to 2024 Per Diem Change	Projection of Market Basket Update Offset by Multifactor Productivity Adjustment.	FY 2023 to FY 2024, 2.8%; FY 2024 to FY 2025, 3.1%
2023 to 2024 Hospice Wage Index Change by CBSA	No Change	0%
Change in Utilization and Mix of Services from 2021 to 2024	No Change	1.000
Non-Hospice FFS Payment		
2019 to 2024	FFS USPCC—Non-ESRD Growth Rate from the MA 2024 Announcement	1.2546
2020 to 2024		1.3085
2021 to 2024		1.1822
Other		
Administrative Expense Load	Claims Processing Cost Load	0.1150%
Sequestration	Base data are net of sequestration. Repricing of hospice FFS-paid base data used per diem gross of sequestration, and therefore no adjustment was applied for sequestration. The sequestration multiplier applied to Medicare payments was 0.98 for claims paid April 2013 through March 2020, and 1.00 for claims paid April 2020 through March 2022. Corresponding to these adjustments, FFS-paid non-hospice base data were divided by the following factors to result in data that are gross of sequestration: (i) CY 2019 claims: 0.9800, (ii) 2020 claims: 0.9933, and (iii) 2021 claims: 1.0000.	

Per Diem Trend from FY 2023 to CY 2024

After repricing the base data to 2023, CMS made an adjustment to the hospice FFS-paid claims to reflect an estimated increase in per diem payment rates from FY 2023 to FY 2024 (for the period January 1, 2024 to September 30, 2024) and from FY 2023 to FY 2024 (for the period October 1, 2024 to December 31, 2024). An annual trend of 2.8 percent for FY 2023 to FY 2024 and of

3.1 percent for FY 2024 to FY 2024 was applied, based on the CMS projection of the inpatient hospital market basket offset by the legislated multifactor productivity adjustment.

Trending Non-Hospice FFS-Paid Claims from the Experience Period to 2024

The FFS USPCC—non-ESRD trends that were presented in the CY 2024 Rate Announcement were used to trend the non-hospice FFS-paid claims from the 2019, 2020, and 2021 base data to CY 2024.[15] Table 10 shows the trend rates by year.

Table 10. USPCC—Non-ESRD Trends

Calendar Year	Trend
2019 to 2020	-4.12%
2020 to 2021	10.68%
2021 to 2022	3.95%
2022 to 2023	8.85%
2023 to 2024	4.48%

Administrative Expense

The national hospice capitation rate includes the same administrative load, or clams processing costs, as a percentage of benefits as the MA ratebook. Table 11 demonstrates the development of the total hospice administrative load of 0.001093.

Table 11. Administrative Expense[16]

	Hospice FFS Payment	Non-Hospice FFS Payment		Total
Claims Processing Costs as Fraction of Benefits, FY 2022.	Part A	Part A	Part B	
	0.001094	0.001094	0.002801	0.001150
Claims for Beneficiaries in Hospice Status as Percentage of Total for Mature Year Rates, 2019–2021	92.08%	4.62%	3.30%	100.00%

Sequestration

Consistent with MA capitation rates, the final hospice capitation rates under the Hospice Benefit Component are presented gross of sequestration in the CY 2024 hospice capitation ratebook for the Model (that is, without the application of the 2-percent sequestration reduction). The following bullets describe how CMS handles sequestration in the rate development process:

- *Hospice FFS-Paid Claims:* CMS repriced the 2019–2021 experience using FY 2023 per diem payment rates by CBSA (see "Repricing" under section 2.4a). The per diem rates reflect the

[15] CMS. "Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies." March 31, 2023. Retrieved from https://www.cms.gov/files/document/2024-announcement-pdf.pdf

[16] CMS. "Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies." March 31, 2023. Retrieved from https://www.cms.gov/files/document/2024-announcement-pdf.pdf

values in tables 1 and 2 of "Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update" (CMS-1773-F).[17] This repricing resulted in an estimate of 2023 claims gross of sequestration.

- *Non-Hospice FFS-Paid Claims:* CMS used 2019–2021 non-hospice FFS-paid claims, which reflect the paid amount, net of sequestration. The projected non-hospice claims are divided by the applicable sequestration adjustment illustrated in table 8 to result in amounts that are gross of sequestration, consistent with the hospice claims.

3. Area Factor

3.1. Background and Development of the Area Factor

FFS-paid hospice per diem payment rates vary by CBSA,[18] with the variation driven by the Hospice Wage Index. This Index is based on the CMS inpatient prospective payment system (IPPS) Hospital Wage Index, which measures the relative difference in hourly wages for certain health care professionals across areas based on an annual survey of hospitals. The Hospice Wage Index measures the difference in labor cost by CBSA. In total, there are 462 CBSAs in the FY 2023 Hospice Wage Index, the same number as for FY 2022.

The Hospice Wage Index is applied to only the labor portion of the per diem payment rates, which varies by hospice service type. In aggregate, the labor portion accounts for about 68 percent of the hospice per diem rates. The non-hospice FFS-paid services are reimbursed using the prevailing area-specific CMS fee schedules. CMS developed 498 CBSA-State areas and then combined several of the smaller CBSAs for credibility purposes. The result was a final list of 482 areas (referred to as CBSAs in this document) for the area factor development.

The MA average geographic adjustment (AGA) is the area factor used to develop county-level benchmarks for enrollees in non-hospice status. The AGA reflects county variation in claim costs due to the cost of services under FFS Medicare, as well as variation in the utilization of comprehensive medical services. Table 12 shows the range of the Hospice Wage Index and the approximate range of the impact on the per diem payment rates for FY 2021 and FY 2023; the data in this table demonstrate why an area factor is needed.

Table 12. Hospice Wage Index and Per Diem Ranges

	Hospice Wage Index		Approximate Per Diem Range	
	FY 2021	FY 2023	FY 2021	FY 2023
Lowest	0.3727	0.3422	0.5866	0.5665
Highest	1.8807	1.9418	1.5804	1.6206

CMS considered several approaches for the area factor, including the following:

- Splitting an area factor for hospice FFS payment and non-hospice FFS payment, whereby hospice FFS-paid claims were adjusted by the Hospice Wage Index and non-hospice FFS-paid

[17] CMS. Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (CMS-1773-F). Retrieved from https://www.cms.gov/medicaremedicare-fee-service-paymenthospicehospice-regulations-and-notices/cms-1773-f

[18] CBSAs are collections of counties within States; in 48 CBSAs, they are collections of counties that cross State lines.

claims were adjusted by the MA AGA. There were several CBSAs with significant mismatches with regard to the 2021 hospice FFS-paid claims, and there was a weak correlation between (i) the MA AGA and the non-hospice FFS-paid claims by CBSA—due to the difference in the mix of services for comprehensive medical care, which the AGA is based on—and (ii) the non-hospice FFS-paid services used by hospice beneficiaries.

- Creating a three-part area factor for hospice FFS-paid claims to adjust for (i) the Hospice Wage Index area factor; (ii) the service intensity factor (that is, the mix of service days by area weighted by their relative per diem payment rate compared to the national average mix of services); and (iii) the relative length of stay by stay month. The three-part area factor was a good fit and showed correlation with hospice FFS-paid claims in combination with the non-hospice FFS-paid claims, which were adjusted using the AGA, but there was still a mismatch. As expected, the greatest variation occurred within CBSAs with 2,000 or fewer beneficiaries.

The approach that best accounted for all regional variation in claims was emulating the MA AGA, which is the ratio of the area-specific spending to the national average (referred to as the "hospice average geographic adjustment" or "hospice AGA" under the Model).

The general formula is as follows:

$$Hospice\ AGA_{\ CBSA} = \frac{Historical\ Claim\ Cost\ PMPM_{\ CBSA}}{Historical\ Claim\ Cost\ PMPM_{\ National}}$$

There are separate hospice AGAs for Month 1 and Month 2+ because of the differences in utilization of services and length of stay by CBSA. This distinction is captured in the following general formula:

$$Hospice\ AGA_{\ CBSA,\ Month} = \frac{Historical\ Claim\ Cost\ PMPM_{\ CBSA,\ Month}}{Historical\ Claim\ Cost\ PMPM_{\ National,\ Month}}$$

The 2024 hospice AGA is calculated using the 2024 projected cost for each of the 3 experience years. This calculation is represented by the following general formula:

$$Adjusted\ Hospice\ AGA_{CBSA,Year,Month} = \frac{2024\ Hospice\ AGA_{CBSA,Year,Month\ 1}}{Month\ 1\ Hospice\ AGA\ Tier\ Adjustment_{National,Year,Month}}$$

The Month 1 hospice AGA is adjusted to account for the difference in the mix of stay months by rating tier between the CBSA and the national distribution. The factor used to account for this difference is termed the "Month 1 Hospice AGA Tier Adjustment" (see section 4 for more detail). The formula for Month 1 is shown below:

$$Adjusted\ Hospice\ AGA_{CBSA,Year,Month\ 1} = \frac{Hospce\ AGA_{CBSA,Year,Month\ 1}}{Month\ 1\ Hospice\ Tier\ Adjustment_{CBSA,Year}}$$

The Month 2+ hospice AGA is adjusted to recognize the impact by CBSA of the hospice provider inpatient and aggregate caps (see section 2.4 c for more detail). The formula for Month 2+ is shown below:

$$Adjusted\ Hospice\ AGA_{CBSA,Year,Month\ 2+} = 2024\ Hospice\ AGA_{CBSA,Year,Month\ 2+} \times Hospice\ Provider\ Cap\ Adjustment_{CBSA}$$

The 2024 hospice AGA is the average of the three yearly hospice AGAs:

$$2024\ \text{Hospice AGA}_{CBSA,Month} = \text{Average}\ (2024\ \text{Hospice AGA}_{CBSA,2019,Month}, 2024\ \text{Hospice AGA}_{CBSA,2020,Month}, 2024\ \text{Hospice AGA}_{CBSA,2021,Month})$$

3.2. Credibility for the Core-Based Statistical Area (CBSA)-Level Experience

Consistent with the credibility standard used in the 2023 rates, the full credibility threshold in 2024 VBID hospice rates was set at 230 stay months. Please refer to section 3.2 of the 2023 VBID Hospice Actuarial Memorandum for demonstration of the full credibility threshold.

Partial Credibility

Consistent with methodology used in development of the 2023 rate, CMS used two approaches to address CBSAs with insufficient stay months to be 100 percent credible. The first was to combine low-volume CBSAs with adjacent CBSAs that have a similar Hospice Wage Index and similar historical utilization and cost. The second was specific to low-volume CBSAs without adjacent CBSAs—Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands. For these four areas, CMS used a partial credibility approach. For CBSAs with a Hospice Wage Index (the Virgin Islands and Guam), we credibility weighted the year-by-year tier-mix-adjusted Month 1[19] and Month 2+ hospice AGAs with the Hospice Wage Index area factor for the CBSA. The 2024 hospice AGA for these two CBSAs is the average of the credibility-adjusted factors. Since American Samoa and the Northern Mariana Islands do not have a Hospice Wage Index, any historical experience (there was none for the Northern Mariana Islands) was credibility weighted with the national Hospice Wage Index area factor, which is 1.000.

4. Monthly Rating Factor

4.1. Background and Development of the Monthly Rating Factor

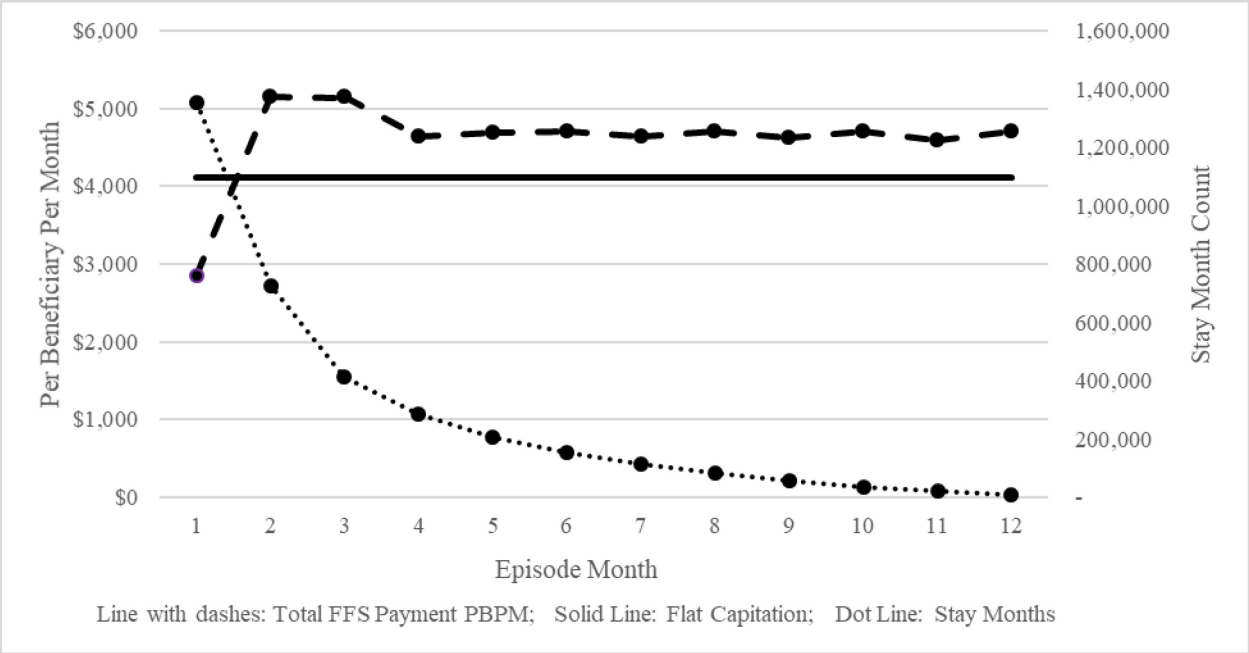
This section describes the monthly rating factor, which is applied to the base rate to adjust the capitation payment for the stay month. The purpose of the monthly rating factor is to create the best possible fit of monthly capitation payments to historical claims within the objectives for the Model.

The following chart shows why the monthly rating factor is needed. The dotted line shows the FFS payment pattern by stay month for CY 2019 for stays that started in 2019; Month 1 is low, driven by the average mid-month entry and the large number of short stays, while Months 2 and 3 are

[19] For details on the Month 1 tier adjustment, see section 4.2.

higher due to the higher per diem rate for RHC days 1–60 and the relatively level FFS payment for Months 4+. The purpose of the monthly rating factor is to improve the match of the hospice capitation rate line with the FFS payment line.

Stay Months and FFS Payments by Stay Month (CY 2018 First Year Data)



This chart also highlights the following:

- The dashed line shows the concentration of stay months in the first few months (39 percent of the total stay months occur in the first month and 72 percent in the first 3 months).
- The solid line is a "flat" capitation, which represents the average stay month FFS payment over all months and serves as a reference. A flat capitation would significantly overpay relative to the FFS per diem payment methodology in Month 1 and would underpay in Months 2 and 3.

In recognition of the variation in FFS payments across months within a hospice election period, CMS developed a methodology to determine the Month 1 capitation payment based on the actual days that a beneficiary is enrolled in hospice in Month 1.

For the first month only, the monthly hospice capitation rate that will be paid will have an adjustment (that is, the monthly rating factor) applied to better reflect actual beneficiary experience (in combination with the area factor discussed in section 3). The hospice capitation rate paid for the first month will vary based on the number of days of hospice benefit that occur in the first calendar month of a hospice stay, split into three tiers, as shown in table 13:

Table 13. Month 1 Rating Factors, Year-1 Rates

Days in Month 1	Monthly Rating Factor	Gross Monthly Base Rate[1]
1–6 Days	0.340	$1,927.64
7–15 Days	0.640	$3,628.50
16+ Days	1.003	$5,686.55

[1] Gross of sequestration

The day count is equal to the hospice discharge date (or the last day of the month if there is no discharge) minus the enrollment date plus one. If there is more than one stay month in Month 1, the days in hospice will be added together to determine rate tier.

First month payments will be made in a lump sum retrospectively to participating MAOs on a quarterly basis for all enrollees who have first-calendar-month hospice experience.

For Months 2+, the monthly rating factor is 1.00, and the base rate is $5,669.54 (gross of sequestration).

4.2. Month 1 Tier Adjustment

The rating tier factors shown in table 13 were developed using the national distribution of days in 2021. A difference in the distribution of Month 1 stay months by rate tier between the national and CBSA distributions would result in the appropriate rate not being produced by the Month 1 hospice AGA. To address this issue, CMS developed a Month 1 tier adjustment. Table 14 provides an example of how the Month 1 tier adjustment was calculated.

Table 14. Example of Month 1 Tier Factor Calculation for CBSA 48424—West Palm Beach–Boca Raton–Boynton Beach

Rate Tier: Days in Month 1	Monthly Rating Factor	National Distribution of 2021 Month 1 Stay Months	CBSA 48424 Distribution of 2021 Stay Months
1–6 Days	0.340	42.69%	50.03%
7–15 Days	0.640	29.45%	27.77%
16+ Days	1.003	27.86%	22.21%
Stay Month Weighted Composite Factor (Month 1 Tier Distribution Factor)		0.6131	0.5405
Month 1 Hospice AGA Tier Adjustment (CBSA Month 1 Tier Distribution Factor/National Month 1 Tier Distribution Factor)			0.9306

The following formula is used to develop the Month 1 tier distribution factors:

$$Month\ 1\ Tier\ Distribution\ Factor_{CBSA,Year} = \begin{bmatrix} 0.340 \\ 0.640 \\ 1.003 \end{bmatrix} x \begin{bmatrix} Tier\ 1\ stay\ month\ \% \\ Tier\ 2\ stay\ month\ \% \\ Tier\ 3\ stay\ month\ \% \end{bmatrix}_{CBSA,Year}$$

The Month 1 tier adjustment is calculated as follows:

$$Month\ 1\ Hospice\ AGA\ Tier\ Adjustment_{CBSA,\ Year} = \frac{Month\ 1\ Tier\ Distribution\ Factor_{CBSA,\ Year}}{Month\ 1\ Tier\ Distribution\ Factor_{National,\ Year}}$$

The final adjusted Month 1 hospice AGA is calculated in the following way:

$$Adjusted\ Hospice\ AGA_{CBSA,\ Year,\ Month\ 1} = \frac{Hospce\ AGA_{CBSA,\ Year,\ Month\ 1}}{Month\ 1\ Hospice\ AGA\ Tier\ Adjustment_{CBSA,\ Year}}$$

4.3. Operational Rules

CMS built the operational rules of the "CY 2024 Request for Applications" for the Hospice Benefit Component (outlined in section 2.7 of the CY 2024 Request for Applications) into the final pricing of Model payments. These operational rules include the following:

- *No more than one hospice capitation will be paid for an enrollee for a given month.* In the historical hospice experience, there are situations in which a beneficiary dis-enrolls and re-enrolls in the same month. For purposes of pricing, CMS concatenated these stay months in calculating the capitation rates.
- *For Month 1 (that is, the first month in which a hospice election occurs), the sum of the days that a beneficiary is enrolled in that month will be used to determine which Month 1 tier rate will be paid.* For purposes of pricing, CMS reviewed the live discharges and re-enrollments within Month 1 and concatenated these stay months in attributing the correct Month 1 tier.

5. Stakeholder Comments

In response to our request for comments on the Calendar Year 2024 Preliminary Hospice Capitation Payment Rate Actuarial Methodology for the Hospice Benefit Component of the VBID Model, published on February 17, 2023, CMS received one comment letter from an MAO. The following are the two comments pertaining to the rates for the Hospice Benefit Component and our corresponding response.

Comment: The commenter noted that the proposed administrative load in the 2024 Hospice Benefit Component capitation rates is just over 0.1 percent. The commenter also stated that MAOs must solely assume the administrative burden of ensuring that a member's care is compliant with the rules of the Hospice Benefit Component and that if the Model Component is made to be permanent, additional funding in the range of 8 to 10 percent of claims should be built into the capitation rates.

Response: Thank you for your comment. The administrative load built into the Hospice Benefit Component capitation rates is consistent with the loading included in the MA ratebooks. We intend to continue to use the same approach for development of administrative loading for the Hospice Benefit Component's capitation rates as the MA ratebooks.

Comment: CMS should consider including funding for fraud, waste, and abuse enforcement and administrative implementation into the VBID Hospice Benefit Component capitation rates.

Response: Thank you for your comment. CMS believes that the payment made to participating MAOs is adequate for participating MAOs to implement strategies outlined in the CY 2024 RFA and accompanying technical guidance to reduce fraud, waste, and abuse.