Hospice Payment Webinar Transcript

February 26, 2020

0:06
Hello, my name is Mark Atalla and on behalf of Sibel Ozcelik and all of us on the VBID model team, thank you for joining our discussion today of the 2021 hospice capitation payment rate methodology. Today the CMS Office of the Actuary, or OACT, will present the payment methodology and base rate that have been developed over the past number of months in support of the Model. The slides from the presentation will be available on the model website in the coming days.

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Additionally, please submit your questions by typing your questions in the questions panel or after the webinar by emailing VBID@cms.hhs.gov. Additionally, for planning purposes for plan actuaries, we are looking to provide additional time to submit your application to the portal and we'll have more information next week on our model website.

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With that, at this time, I'd like to introduce our presenters, Richard Coyle and Jennifer Lazio from the Office of the Actuary for the presentation. Thank you Rich. Thank you Mark. And as Mark said, I'm Richard Coyle.

1:12
I'm with CMS' Office of the Actuary or OACT and I will be providing an overview of the key components and assumptions used in the development of the proposed calendar year 2021 VBID hospice capitation rates. The Office of the Actuary works closely with our colleagues in CMMI and other CMS components to develop the proposed capitation rates.

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While much of the structure of the capitation rates and payment processes are in place, there are still some assumptions we finalized. I will highlight some of these outstanding items which are also described in the actual methodology technical paper to be posted on our website. We also encourage you to ask questions after today's formal presentation and then follow-up to today's meeting.

1:59
So today we will discuss basically four things. First we will talk about the hospice capitation rate development and payment structure. We'll then present an overview of the data book supporting the rate development. This is something that will also be posted on the website. We'll then discuss the model timeline and finally provide an opportunity to ask questions of the proposed rating methodology.

2:26
So first, we'll talk about the current fee-for-service Medicare hospice benefit.

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What you see here is a slide that presents, this is information that's been published in recent regulations. And you see in the description that there's essentially four types of hospice payments in the fee-for-service program today and basically five payment levels. That is Routine Home

Care, which is obviously the most common type of payment, is split into two different payment ranges.

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One is for the first 60 days of a hospice episode and the second payment is for 61 and later. Next we have continuous Home Care coverage and that's paid basically on an hourly basis. And what's listed here is the 24-hour rate

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Next, we have In-patient Respite Care and finally General Inpatient care. As you can see the Routine Home care dominates the percent of coverage or the number of days with over 98% and next is General In-patient care. Another thing that's worth mentioning is that the payment rates for fiscal year 2018, and for that matter 2019, were somewhat different than what was recently announced for 2020, particularly for the Continuous home care, Inpatient Respite care and General In-patient care. It was a significant increase in the payment rates, which was based on a study of actual cost and a very modest increase in Routine Home Care, which is just due the general inflation.

4:21
So what's represented here is the experience period that we use to develop the ratings, 2016 to 2018, and what this represents is calendar year experience and it only includes episodes that began during the calendar year. So for instance in 2016, this experience does not include any hospice episodes that began prior to January 1st, 2016.

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And you can see we have three counts, and three columns of counts. The first is beneficiary counts, which is the number of unique beneficiaries who received hospice service during the calendar year. Next is stay count, which is the number of episodes for those beneficiaries.

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It's slightly higher because some beneficiaries actually had more than one episode of care during the calendar year. The final column stay month count is basically the number of member months of hospice coverage. The last four columns represent the average per beneficiary per month cost. The first column, hospice fee-for-service payment per beneficiary is the cost for the direct hospice coverage itself. That is the coverages that were listed on the prior slide. You can see it averages about 3500-3600 a month for the episode month or stay count month.

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The next two columns represent the spending for non-hospice care. That is other fee for service benefits.

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The first of those two columns is the other spending that was incurred during the hospice episode and the next column is the spending that occurred during the month, but after a live discharged from a hospice episode. So if you sum the three payment fields, the last column on the right shows the aggregate per beneficiary per month spending was for each of those years, which you know ranges from around $3,900 to about $4,000 dollars per month.

6:32
And continuing with this, representing those same types of episodes, we have the service days per beneficiary per month. As you can see in the third column here, it averages to about 20

service days per member per month, or per beneficiary per month, and again, similar to what we saw in slide four, those are dominated by the Routine Home Care.

7:00
Now we're going to turn to the actual development of the rates and how we took this information and used it to develop the capitation rates for Calendar Year 2021. Okay, so just as a high-level overview, we felt it was worth thought to compare it to the current Medicare Advantage payment structure and there's a lot of similarities. First of all, we're using base experience for multiple years. Now the Medicare Advantage rates, generally.

7:30
Use five years of experience. For Hospice we're using three years. We did look at using additional years, but we found that experience prior to 2015 was dissimilar to the other three years. So we felt that three years was the reasonable basis for the experience. We're also developing localized rates through the use of what we call an average Geographic adjustment. Again, with the Medicare Advantage rate book the rates are typically at the county

8:00
Level. The rates we're developing for this model at our core base statistical area, formerly known as a metropolitan statistical area, and that's a good metric for measuring geography, largely because the wage index for hospice, is that the CBSA level. So again, that's another similarity and of course, we will trend the base experience to the contract year for 2021.

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Now a key difference between this model and Medicare Advantage is that the payment rates will not be risk-adjusted, as we'll talk about in a minute. They'll be other adjustments but there's no risk adjustment. Partly, the main reason we're not risk adjusting is, in looking at the experience,

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There was not that much variation between different risk characteristics of beneficiaries to really warrant that. Another reason we did this is just administratively and to for the understandability of the model. It's much more straightforward to not develop a complex risk model. Also, it's worth pointing out that the payments we've developed our budget neutral relative to the current state that is basically pre-model. Obviously there's a key difference that the rates today are paid on a per diem or a per hour basis. We're making a monthly capitation payment.

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But you know, we're certainly developing those in a way that's budget neutral.

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And as I mentioned we're only including hospice stays that began in the calendar year in the experience development which models the way that the program will work in 2021. That is for this for the plans that participate in this, they will only be responsible for the management of hospice episodes that begin calendar year 2021. Any episodes that begin in to 2021 will remain within the fee-for-service program.

10:08
So building upon that, as was mentioned and shown in slide number five, the cost for including both direct hospice spending and fee-for-service spending either encourage or in the hospice episode or after the enrollment for the month also mentioned that we're using, you know calendar year 2016 to 2018 data.

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What's important to note here though was that we repriced that experience to fiscal year 2020 and we saw that there was a dramatic change in some of the payment levels because we believe 2020 it's going to be more representative of e the costs incurred during the model year 2021, there's historical periods. So we felt like this was an important addition to the development of the rates.

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And of course, we're trending the cost from that base period to the contract year 2021 using our typical actual training approach.

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So far we've talked about more or less an aggregate or a national rate. There are going to be two adjustments applied to actual payments. The first is an area factor and I mentioned before that it's going to be an average Geographic adjustment applied at a CBSA-level and we're going to we're going to walk through that a little bit, second adjustment.

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The second adjustment is what we're calling a monthly rating factor and that's to reflect that primarily duration one.

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That is the month that a beneficiary first enrolls in hospice, is unique compared to the other months, partly because on average you could only be enrolled for half of a month as opposed to month to month later where you could have been enrolled the whole month but also as you analyze the data, you'll see that there's a lot of very short stays or intermediate stays that have unique characteristics that should be reflected in the rating. Moving forward to the next slide, this is kind of an overview of what we just talked about. I wanted to drill in on item number two the monthly rating factor I just mentioned

12:33
As I said for month one, there's really three different tiers of rates. For episodes or coverage that lasts one to six days in that first month, we're going to have one set of rates. For coverage 7 to 15 days in that first month, it's going to be the second set of rates. And for those that last 16 days or more in that first month, they'll be a third set of rates and then the fourth set of rates will be four months to and later. This is kind of a schematic of what we just talked about. Not going to walk through it, but I believe it would be a good reference as you go through this material and study it more in depth.

13:19
And the first bullet point on here, to kind of transition from where sponsors are today, Medicare Advantage organizations for hospice coverage. As you know, when you have a beneficiary in hospice, after the first month of coverage, you were paid any Medicare Advantage rebate payment and you're also paid any subsidies or payments for the part D coverage prescription drugs. Of course, we're going to be paying you an additional capitation

13:55
Rate on top of what you're currently being paid. So nothing is being taken away. We're only going to add additional payments to cover the additional exposure that you have. Should have mentioned it before but similar to the Medicare Advantage rates, we will build claims processing cost into the capitation rates and will also be publishing a county-by-county rate book, although

the rates, like I said, will largely be developed by core based statistical areas. And that will be released in April this year.

14:34
So the next two slides present a lot of detail in terms of the data and assumptions used in the developing the rates and I apologize if it's a little much of this point. Again the slides will be available for you work through it. But this first slide illustrates the development of the hospice portion of the rate and on slide 14

15:04
This is the fee-for-service payment portion of the payment and then the bottom two sections are consolidated. So going back to slide 13, the hospice payment, you can see in row A. This is actually the data that comes off of our claim records.

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What we talked about earlier how the experience is developed and this represents the actual per-member per-month spending, relative to the stay months that are at the top of this exhibit. It's on a post sequestration basis so it reflects the haircut for sequestration. It reflects all the subtleties and payments whether it's quality adjustments and payments due to quality bonuses and service intensity add-on and other unique adjustments to the hospice program. So that's the actual cost under reflects everything.

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Item B is what we use for the modeling, which is a little more simplistic. It's basically tied into the number of service days that we talked about and the location of the beneficiary and other factors are a little more obvious.

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Because our modeling is based on B, we want to relate it to the more detailed and so line C illustrates what the difference is between our modeling and what's actually in the clean records. You can see it's very close, but there is a slight difference. So for instance, it's what we're calling a true-up adjustment for calendar year 2016 is about nine basis points higher than the actual payments. It’s about nine basis points higher than what our modeling is. So we're going to hold on to that true-up adjustment and add that into the payments as we go through this illustration.

17:03
So we have this adjustment that we're going to make. Go on the line D. That represents the service days that we had reflected on slide six, but repriced to the fiscal year 2020 per diems. Again, I think everyone would realize that it's important to reprice just because of the dramatic shift in the payment levels.

17:32
And then we have a placeholder here in row E for the claim completion adjustment. We expect there to be a minor adjustment there. But as of this moment, we do not have that calculated. I mean it’s just your typical actual completion factor.

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So going down the row F that is essentially the trended values to 2020 fiscal year basis reflecting this to up true-upped adjustment and a 1.0 claim completion factor. And that is essentially what we're saying the national rate would be in 2020 on a post sequestration basis.

18:14
We're going to talk about in a little bit a data book which shows details and you will see those numbers right there in the data book, in terms of how we're looking at the cost at a local level. This is the national number, but you'll see the corresponding local levels. At the risk of missing some key facts, I'm going to fast forward from item F to item K. Essentially what we're doing there is going from a fiscal year 2020 basis.

18:43
To a calendar year 2021 basis, we're applying a trend factor in item H and we are also providing in line J what we call an aggregate cap adjustment because the claims data does not reflect some outlier adjustments that are made to the claims experience.

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So whereas line F is more or less what we're using for the modeling line K. It is really the basis for 2021 payments although it is on a post sequestration basis.

19:22
I apologize. I can take questions at this point because I am sure they would be tons of them. If you know you have any questions you have on this, please submit them near the end. So that's where we are. 2021 hospice payment on a pre-sequestration basis. Moving forward to slide 14, the trending on fee-for-service is much more straightforward. We start in column L.

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We start in column L, or row L with the actual per member per month spending is for those beneficiaries for coverage both during the hospice episode and any post discharge spending for that month. And then we trend it in row M to 2021 and these are based on the trend factors

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We just released in the 2021 advance notice. So you can see where the trend from 2016 to 2020 is about 20% and then it's about 14% from 2018 to 2021. That yields row N which is the trended non hospice spending in calendar year 2021. So we combine what's in row N to the last item on the prior slide row K and that's in line O. And that's the spending for both related and unrelated 2021 on a post sequestration basis.

20:52
Going down the line R, which is on a pre sequestration basis. So basically divided by .98 and we're also adding loading in for the administrative cost and that's basically our national hospice capitation rate $4,409 dollars in calendar year 2021. That's the anchor rate that everything else will be developed over.

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And again, I apologize. We went through a lot here. I do suggest that those of you who have an interest, I suspect many of you do, to go through the technical paper that we are publishing in conjunction with this. Much of the detail of this development is explained there and additional information. Hopefully you would find and agree with that this is a reasonable approach and the relevant factors have been taken into consideration.

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And this is just an overview what we just talked about. We can move forward.

22:03
Okay, so kind of taking a step back. We just talked about the national capitation rate of $4,409. That's in the bottom right of this table here. National number. We also talked about different payment rating factors for the different durations, four different ones. Days one through six for month one, 7 through 15 for month one, 16 and greater per month one and month two.

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Okay. So the last column on the right shows what those payment rates are for each of those different breakdowns. It ranges from $1,764 for the shortest duration month one payments to $5,291 for the 16 days and longer in month 1. It's interesting to point out that the column to the left of that shows how we came up with those factors.

23:03
And those are relative to the month two rate. We've developed these all to be on a budget neutral basis to the $4,409. So we developed the month two rates to say it needs to be $5,187 based on the distribution of stay months to come back to national average. Then working off of that, we developed what these monthly payment rates were for the different month one durations so that each of those payments were equitable and reasonably matched with what the expected costs were.

23:33
So that each of those payments were equitable and reasonably matched with the expected cost were.

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So that's how we can develop the rates off of, basically, the month two composite rate. Another thing that will be of interest to many of you is the average monthly service day column, which is the third column in here. So for instance, you can see for month one where they stay up to six days of coverage on average, there's about three days of hospice coverage there whereas on the other end for months two and later, there's been an average of 26 days of coverage for hospice.

24:08
So again, you can take the gross monthly base rate divided by the average monthly service days to see what the per diem payment is for each of those different rating cells.

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The next couple slides summarize what we've already talked about but we feel like it's worth it to really make this point clear. That if you look at the graphic at the top of this, in the darker blue, is what plans are currently being paid in today's world for a beneficiary who enrolls in hospice in the first month. That is, they get the basic A/B capitation rate, the MA rebate amount as applicable, the Monthly prescription drug amount if applicable and that's not going to change.

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You know, when you participate in this program what you're going to get is that additional payment which is a monthly hospice capitation rate, and, as we just talked about, that's going to range depending upon the days and months at the bottom of this chart.

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The next slide will show comparable payments for durations two [months] and later in hospice. And again, currently current payments are the MA rebate amount and the prescription drug payment. There is no A/B capitation payment today and that's going to remain, but what you will

be getting is the monthly hospice capitation rate, which is tied to the base rate of $5,187. Although remember these amounts are preliminary.

25:49
Although remember, these amounts are preliminary and likely will change in what we publish in April.

25:54
And this is just a graphic to more or less document what we talked about for the AGA adjustment. Effectively, the AGA adjustment, for each of those three years in the historical period, we're looking at what the per member per month costs are for that CBSA level divided by the national level. Similar to what we're doing with the Medicare Advantage rate book.

26:23
So now we're going to turn it over to the data books that we're going to publish in conjunction with this webinar material.

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And I'm just going to talk about one slide of this data book. I've actually hidden many of the rows on this. Basically what the data book is, it shows for every CBSA and there's over 500 combinations of CBSA and states and it shows for three different groups.

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You look in column E, as in Edward. You know, we have, all months, meaning, you know, a combination of month one and month two and later. And we separately break it out for month one and month two. And you can see we have it by state CBSA, CBSA code. We describe what the CBSA is if you scroll over.

27:40
Okay, so in columns F, G, and H, for the all beneficiaries, those are figures that were previously displayed on slide 6. Then if you go down to the next section, you can see we have it broken out between month one and month two and later. And again, we're only showing Fresno, California. Here is a CBSA. But if you un-hid all the rows in this data book, you can see each and every CBSA and what the values are.

28:09
So F through H is a beneficiary counts. If you go to columns I through L, that shows the per-member per-month values in each of the years and those tie. I believe those tie to the chart on slide 13.

28:34
Let's see. Row A. And again we gave the national number in that table on slide 13, you can look at it for each CBSA. Same thing with column M, as in Mary, the service days.

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N through W will show you the actual service days for each of these different groupings. That is the Routine Home Care days, the In-patient Respite days, General impatient, etc. And we have it broken up by fiscal year.

29:18
Remember these results are on a calendar year basis but embedded in the claims are experience paid under two fiscal years because the fiscal year changes on October 1st. But again, what you'll

be able to do in going through this is you'll be able to look and see for each CBSA what is the distribution of average days by the different types of payments. And again, this is something that we believe is useful for assessing the rate adequacy and variability. Continuing on this data book to columns X through Z.

29:56
These are the fully developed rates for calendar year 2020 and these correspond to row F in the in the chart on page 13. Actually, they correspond to row F and on slide 14. Continuing over, please, columns AC and AD show the wage index for each CBSA. Column, AC is actual published wage index. AD is more or less an effective wage index. That is the wage index only applies to about 68% of the payments.

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And so you will see AD is an effective wage index impact on the rate.

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And then finally in columns AE and AF, this will show what the AGA is for each of the CBSA's, separate for month one and month two and later. And we have Fresno California listed here because in the data dictionary Fresno, California is the illustration. And you'll be able to see effectively how you come up with that rate, which is just the… For instance, I believe it is columns E, the relationship of the Fresno California value and column Z, relative to what it is for all counties. And it's a simple relationship. But as you can see it's built up through all the components. All the service days and the rating variables, etc.

31:46
So again, this is a whole lot to digest. I highly encourage you once this becomes, once this is posted to work through it. And we think that you'll know, you'll have a better appreciation for the methodology and approach for developing the rates once you go through this data book.

32:08
Okay, turning back to the presentation. We're on the home stretch here. So apologies for putting so much out at you. Okay. So now turning to some of the changes in benefits. There are some hospice specific supplemental benefits that are available to the model.

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These are treated similarly to other supplemental benefits as our guidance indicates. In our draft bid instructions that we released for 2021, the second bullet point there illustrates that the certifying actuary has the discretion of including or excluding the supplemental hospice benefits from the pricing and that Medicare Advantage bid pricing tool.

33:02
And that last bullet point there is basically from the Request for Applications, in which we provide some examples of hospice specific supplemental benefits. So I suggest that you refer to the RFA to understand what the options are for supplemental benefits.

33:23
And then another thing that’s worth pointing out from the bid price perspective is if you participate in the model, similar to today's practice, you will exclude the projection and the actual experience for the hospice benefit from the bid pricing tool. It has no effect on the bids, has no effect on the experience you'll be reporting, so it's pretty much status quo from that perspective.

33:49
That said, we have added a new PDP category 19c for the hospice VBID. And there's two applications of this. One is if you're providing supplemental benefits to reduce the two hospice co-payment categories. That is for prescription drugs and for Inpatient Respite Care, you would include that in item 19c. And, as we just discussed, any hospice specific supplemental benefits, would also be reflected in this bid price control category. Next slide please.

34:29
So with this I'm going to turn it back to my CMMI colleagues to talk about the RFA and additional steps. Sure. Thanks Rich. So the hospice benefit RFA is available currently on the VBID model website. So as many actuaries may know, and others, the 2021 VBID RFA is not yet posted.

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Plans should, in order to review what is allowed in 2020, probably is a good start for plans. The one tele-network is the one flexibility. We are not testing in 2021 or looking based on Executive Order guidance.

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We're looking at additional flexibilities to include for 2021, but plans, in terms of focusing on what you can do for 2021 should as a baseline look at 2020. One change, also from 2020 is actuaries will not need to submit a mock BPT from the financial projections. We're asking more for a pro forma. That will come, that will be released along with the 2021 RFA. We're hopeful in the coming days.

35:59
So with that, we mentioned earlier, and one question that we've gotten, is to clarify the application timeline. And so the application portal for all parts of VBID. Well when we release the VBID RFA, the portal will be live. And then at that time we'll announce any additional time that we can give plans around submitting applications.

We are cognizant, you know, around, in terms of timeline. And so we appreciate. If we could get or give additional time, we're aiming towards doing that, and so we'll clarify that. Hopefully next week.

36:53
Next slide. Right. So what we'll have is really things for April. In terms of the county level rate book we're aiming to hopefully have a portal ready and submission by April for everything but will confirm that with the VBID RFA release.

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Plans will still have till May 1st after the rate book is available to finalize your participation in the hospice benefit component portion of the model. After that, pretty shortly thereafter, you'll receive provisional approval from us to make your bid on June 1st as per usual. So that's our timeline. Next slide. That should be it.

37:56
So thank you. So first, thanks to Rich and Jennifer from OACT. We appreciate everything our OACT colleagues at done in support of the model. It's been great. And thank you for walking through this Rich in such a detailed way. We have some questions so we'll pause and then come back shortly. Thank you.

39:09
So we're looking through the questions right now. This is Sibel Ozcelik. And we received the question around what the admin load factor is. Rich? Yes. So for those of you familiar with the Medicare Advantage rate book, we built into the rates the cost of claims processing. That is the cost for Medicare Advantage contractors.

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And so the administrative load that we're proposing to build into the hospice rates parallels that. And it's the same factors that we would build into the Medicare Advantage rate book.

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And then we have another question around how GIP is factored into the rate.

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So as we talked about and is illustrated in the data book that you will soon be able to look at, the rates are essentially built up by looking at the average number service days by benefit type. For instance, Routine Home Care versus General In-patient Care, etc. And the corresponding rates and wage index and so forth. So to the extent that a given area has more or less General Inpatient Days than the national average that would be directly reflected in the rates. Again it we believe that it's a fair way of doing it. We also believe that the rating methodology is very transparent. So we encourage you to go to through methodology in detail.

40:37
So we received a question around whether the anchor rate includes, you know, the service intensity add on and professional claims for hospice beneficiaries for example . So is that part of the true up? Yes, it is. Absolutely. Yes. So as mentioned on slide 13, we're effectively starting with actual payments that include all these components and that's what we're trending off of.

41:03
That's why we're developing the true up adjustment because the subsequent modeling does not directly reflect those things, but we believe that there are important to reflect and they are represented in the final rates. We had a question around why are there different eight hospice AGAs for month one versus months two and on?

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And again, we will refer you to the data book, but I think when you look at the experience, you will see that there's some pretty dramatic differences in practice patterns for month one versus month two for specific geographic areas. Generally, what you find is that there is a higher proportion of routine Home Care days in durations two and later than in duration one and the can be a lot more variation in the other. Other types of coverage in duration one. And the different AGAs, you know, is the best way to reflect the true variation for the different CBSA's.

42:12
So we have a question around, sort of, are there any anomalies and, sort of, in the rate setting process for Puerto Rico? Yes. So as I mentioned that the rates were set using fee-for-service paid experience for hospice and non-hospice claims related to a hospice claim for both MA enrollees and fee-for-service beneficiaries who elected hospice. These rates which had been repriced using the rebased per diem rates for calendar year 2020 for the different coverage types accurately aligned payments with cost. We've taken a close review of the Puerto Rico experience proposed rates and did not uncover any issues or anomalies.

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And then we have a question around, sort of, is there any greater risk for smaller plans?

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Not necessarily. The hospice benefit is comprised of a lot of relatively low-cost services. So there was less variation in the cost of care than in general health care delivery. This is shown statistically in the credibility section of the methodology paper.

43:17
So we received two more process questions. One is around, sort of, when will the slide deck, recording, the data book, and the payment methodology paper be made available. We just want to clarify that the slide deck, the payment methodology paper, and the data book will be made available this week. It'll be posted on the VBID model website.

43:39
And then we have another question around, sort of, when are we holding additional office hours and we're planning on holding office hours in March. And to aid in that we would like you guys to, you know, submit your questions to us VBID mailbox, which again is VBID@cms.hhs.gov, which is shown here on the slide.

43:59
And then a third question is, you know, what about the March 16th deadline. Are we maintaining that or not? And so, as Mark has mentioned earlier, you know, we are looking for a date in April to provide additional time for plans to submit their applications alongside the general VBID RFA application response as well. And then plans will have up until May 1st the finalized their applications after they've submitted their initial application.

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So we just received the question around whether there's a need for any sort of risk mitigation program.

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Thank you. And so CMS reviewed the need for a mitigation program and found the variation of fee-for-service payments by state month would be relatively low. And that's because the majority of the fee-for-service payments, about 92%, are comprised of per diems with relatively small range of values.

45:16
And then we received a question around, you know, why is there no risk adjustment? And as I mentioned, beneficiary specific risk adjustment will not be applied to the rates, as we're counting for variation to the area factor using that hospice AGA and a monthly rating factor.

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So we found that the area factor monthly rating accounts for the mix of services and they also account for different distributions by terminal condition that's implicitly reflected in the rates. So we feel like between those two factors, we've reflected, you know, the appropriate variation in cost by geography and that application risk adjustment is really not necessary.

46:11
We also believe that including a risk adjustment model would make the model inherently more difficult to understand and to administer. And we feel like all parties would benefit from more transparency in the in the payments and rate methodology.

46:30
So we have a, again, a more process question. Is the hospice benefit component open only to current participants in the VBID model or is it open to all eligible Medicare Advantage organizations nationwide? To clarify, as it's written in the hospice benefit component RFA, which was posted in December, you know, the VBID model, inclusive of the hospice benefit component, is open to all eligible Medicare Advantage organizations and eligibility criteria is in the RFA itself, which is again on the VBID model website.

47:05
We're just going to go on pause for a minute to look and review questions.

48:17
So we have a question around, sort of, how the sequestration is applied to the rates that were just shown. Yes, great question. And sorry. I didn't make this clear that, as you know today, Medicare Advantage rates, the rate book, and business so forth are developed growths of sequestration. And then at time of payment the 2% sequestration cut is applied. The approach here is similar that the rates are intended to be. Growths of sequestration and that at the time of payment, sequestration will be applied. I apologize that some of the adjustments were showing in tables or the slides 13 and 14 ae a little bit confusing. We did our best to try to clarify where things were pre and post sequestration. But, you know, the simplest way of think about it is actual claims that are being, paid which is the basis of this

49:17
Development, are after sequestration and then we went through a series of adjustments to put those, the hospice and the fee-for-service payments on pre sequestration basis for purposes of the great publication.

49:57
So we received a question around, sort of, clarity around the month one payment. The attendee asked us to provide an example, sort of, what happens. If someone has a three-day stay up versus a five-day versus a 30-day stay. How does that factor in with the one-month rating factor?

50:19
A great question and I appreciate the opportunity to clarify that. So I mean, as was illustrated on one of the slides. I believe it may have been around 15 or 16. There was, you know, the rates are very much correlated.

50:38
Are very much correlated with the average length of stay. So for instance if a beneficiary has a stay of between one and six days and that is slide 16.

50:50
So between 1 and 1 in 6 days, there's an average length of stay of 3.28 days. And the national rate of 1,764 directly reflects that. If the beneficiary, you know, if that same beneficiary or a different beneficiary was enrolled in month one for 16 days or more. Let's say 20 days. Then the rate goes up considerably the 5,291. You know, we feel like you know, of course we could have developed fewer or less ranges for that first month. We felt like this hit a sweet spot because, you know, each of these on average, each of these rating cells, you know is appropriate for the range.

51:37
We found that if we had fewer than three, it was more difficult to, you know, match the actual costs with the projected cost with the payments. And if you get beyond three ranges, it's just administratively seemed to be too complex. So we feel like this this was a good balance between complexity and accuracy in the rates. And Sibel, I'll ask you, do you think more needs to be clarified here in terms of how those payments work?

52:08
No, I think that's spot-on. So again, so it's days in month one. So if your month one experience, again was 60 days or more, you get the highest rate and then four months two and on you would get the month two plus rate that's shown here. So the $5,187. And again, this is this is sort of the gross monthly base rate. It'll be sequestered.

52:31
So the 2% cut, but then it'll be adjusted based on the hospice AGA depending on sort of the geographical mix and sort of those historical experiences. It'll most likely be adjusted up or if it's closer to the national experience it all remains the same. Yes. Yes, and so just to give another example, let's suppose some beneficiary enrolls in hospice on the 17th of a month and it's a 30-day month. So they're in there for 14 days.

53:01
Let's say that first month, we would be paid based on the rate 3320 and then if they're still enrolled in hospice the first of the next month then they would get, be paid based on the $5,187 that second month. And then any subsequent month, they would be paid based on the $5,187.

53:21
Yeah, and in the first month, the plan would receive the full A/B risk-adjusted capitated payment plus the hospice capitation payment for month one consistent with current law plus, any rebate dollars as well as if it's a MA PDP to receive the prescription drug payment as well. And then we got a question. If a patient is on for 45 days, is there any sort of pro-ration? We just want to clarify that no, you would get the, if there's a full month. If you have a month two experience whether that's one day or 30 days you get that full month two rate.

54:19
Here's another question for you, Rich. We have a question about work. Someone asked where can we find additional information about how to incorporate VBID pricing into the bid? Okay good question. So I believe within the last couple weeks

54:33
We released drafted pricing instructions and forms for calendar year 2021 and it's clarified in there that treatment of hospice. And I do not believe VBID hospice was necessarily mentioned, but, you know, the bottom line is that this should not be included in the development of the bid. It can be included in the supplemental benefit pricing, but there's no change in the development of the bid whether you're in the demo or not or the model or not in terms of hospice coverage. You're not bidding on the hospice. You're being paid these capitation rates and there's no effect on the bid.

55:37
Great. Thank you for attending today's presentation. We hope you enjoyed this webinar covering the 2021 hospice capitation payment rate actuarial methodology. The presentation slides and recording will be made available as the model team mentioned as always. If you have questions

or need guidance, please contact the VBID Model Team via email at VBID@cms.hhs.gov. Have a great afternoon everyone.