# Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model

## *Overview of Calendar Year (CY) 2023 Request for Applications (RFAs), Hospice Benefit Component Payment Methodology, and Application Process*

*March 10, 2022*

*Center for Medicare & Medicaid Innovation*
*Centers for Medicare & Medicaid Services*

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# Agenda

- CMS Introductions
- Overview of Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model
- What's New for CY 2023?
- CY 2023 Hospice Benefit Component Payment Methodology
- CY 2023 Application Timeline & Process
- CMS Technical Assistance and Applicant Resources
- Question and Answer Session

# Presenters

- Laura McWright, Deputy Director, Seamless Care Models Group
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# Overview of VBID Model Design

# CMS Innovation Center Statute

The CMS Innovation Center was established by section 1115A of the Social Security Act.

> *"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles."*

Three scenarios for success outlined in the Statute:

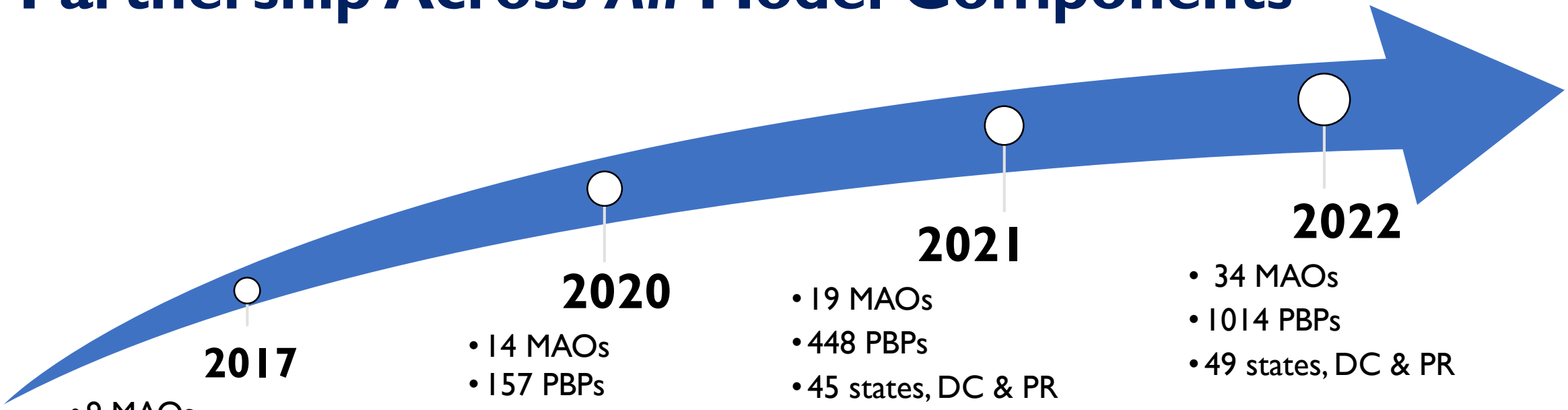
- Quality improves and costs are neutral
- Quality neutral and costs are reduced
- Quality improves and costs are reduced (best case scenario)

If a model meets one of these three criteria and other statutory prerequisites, the Statute allows the Secretary to expand the duration and scope of a model through rulemaking.

# VBID Model Overview

- Testing a broad array of complementary Medicare Advantage (MA) health plan innovations through the VBID Model
- Designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries and improve the coordination and efficiency of health care service delivery
- Eligible MA Organizations (MAOs) and their plan benefit packages (PBPs) in all 50 states and territories may apply for the Model's health plan innovations annually
- Model began on January 1, 2017 and is currently set to be tested through 2024

# Significant Growth in Model Adoption and Partnership Across *All* Model Components



**2017**
- 9 MAOs
- 45 PBPs
- 3 States

**2020**
- 14 MAOs
- 157 PBPs
- 30 states and 1 territory

**2021**
- 19 MAOs
- 448 PBPs
- 45 states, DC & PR

**2022**
- 34 MAOs
- 1014 PBPs
- 49 states, DC & PR

# VBID Model Strategy within CMMI Portfolio

- Juxtaposed against a rapidly growing and diversifying MA Program, VBID is the ***only*** Part C Innovation Center Model
- VBID offers a unique opportunity to learn about approaches to increase use of high-value services and/or benefits that are customized to enrollees with greatest needs or have suboptimal take-up
- VBID's ability to target by socioeconomic status (SES), coupled with the flexibility to design health-related social needs (HRSN) solutions, will allow for greater and more meaningful insight into how underserved populations access and gain from MA benefits and Rewards and Incentives (RI) programs

**As the only CMMI Innovation Model directly focused on MA, the VBID Model is a critical lever to shape the trajectory of health equity within the rapidly growing and diverse MA market.**

# CY 2023 VBID Model Components

## Tests Complementary MA Health Plan Innovations

| Targeted Benefits by Condition, Socioeconomic Status (SES), or both | MA and Part D Rewards and Incentives (RI) Programs | Wellness and Health Care Planning (WHP) | Hospice Benefit Component | New and Existing Technologies |
|---|---|---|---|---|
| Tests the impact of targeted, reduced or eliminated cost-sharing (including for Part D drugs) or additional supplemental benefits based on enrollees:<br>a. Chronic Condition(s)<br>b. SES<br>c. Both (a) and (b) | Tests how R&I programs that more closely reflect the expected benefit of the health-related service or activity, within an annual limit, may impact enrollee decision-making about their health in more meaningful ways | Tests the impact of timely, coordinated approaches to wellness and health care planning, including advance care planning | Tests how including the Medicare hospice benefit in an enrollee's MA coverage impacts financial accountability and care coordination across the care continuum | Tests the impact of allowing MAOs to cover new and existing FDA-approved technology not currently covered by the Medicare program |

# What's New for CY 2023?

# Summary of Key Updates

- In concert with the CMS Innovation Center Strategy Refresh, VBID is continuing to evolve with an **expanded focus on health equity** that leverages Model flexibilities
- In alignment with the Innovation Center's vision for a health system that achieves equitable outcomes through high-quality, affordable and person-centered care, key updates to VBID include:

- Addition of the voluntary Health Equity Incubation Program
- Focusing of benefits and RI programs to those uniquely authorized by the Model
- Additional guidance on defining high-value providers
- Removal of the Cash or Monetary Rebates Component
- Incorporation of a health equity plan requirement and qualitative and quantitative network adequacy standards in VBID's Hospice Benefit Component

# Addition of the Voluntary VBID Health Equity Incubation Program

## Health Equity Incubation Program Overview

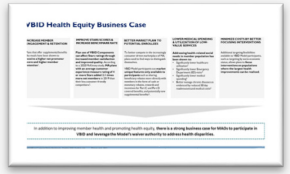
The **Health Equity Incubation Program** will serve as the central pillar of planned learning activities with the goal of:

- Encouraging innovation in most promising focus areas;
- Optimizing design and implementation best practices; and
- Building evidence base for **quality improvement and medical savings** related to social needs interventions.
- Inform new directions in MA program

## Upcoming Sessions and Technical Assistance

**Initial VBID Business Case Session**
*September 2021 – December 2021*

Engage MAOs in **"Health Equity Incubation Sessions"** in the form of webinar and follow-up 1-on-1s that focus on **VBID health equity business case**




**Technical Assistance**
*January 2022 – December 2022*

During **Health Equity Incubation Sessions**, the VBID Team will engage MAOs in health equity focused technical assistance (TA) and leverage use cases and case studies tailored to **the most promising focus areas** (e.g., food and nutrition).

The VBID Team will host joint events with relevant federal partners (e.g., Million Hearts) highlighting best practices for leveraging VBID Components to address health equity in **the most promising focus areas.**

**Learning and Performance Feedback**
*2023 and onwards*

In the long-term, the VBID Team plans to create a true learning network, where plans can tackle common challenges around health equity. An essential part of this learning network will be tailored feedback based on plan data.

# Focusing of Benefits and RI Programs to Those Uniquely Authorized by the VBID Model

| Category | Options Available Under MA* | Options Available Under VBID |
|---|---|---|
| **Benefit Targeting** | • **Special Supplemental Benefits for the Chronically Ill (SSBCI):** Allows MAOs to provide chronically ill enrollees (as defined in § 422.102(f)(1)(i)(A) using three specific criteria) with both non-primarily and primarily health-related supplemental benefits that have a reasonable expectation of improving or maintaining the health or overall condition of the chronically ill enrollee.<br>❖ While CMS may provide a list of chronic conditions, MA plans may consider other chronic conditions not identified on this list if the chronic condition is life threatening or significantly limits the overall health or function of the enrollee<br>❖ Targeting by low-income subsidy (LIS) or dual status alone is NOT allowed but 422.102(f)(2)(iii) permits MA plans to consider social determinants to help identify chronically ill enrollees whose health or overall function could reasonably be expected to improve or maintained with the SSBCI. **MA plans may not use social determinants of health as the sole basis for determining eligibility.**<br>• **Uniformity Flexibility (UF):** Allows MAOs to target enrollees for healthcare services that are medically related to the patient's health status or disease state (e.g., reduced cost sharing of eye exams for diabetics) if the benefit is offered uniformly to all individuals with the same qualifying condition. Supplemental benefits must be primarily health related (§ 422.100(d)(2)(ii))<br>• **NOTE:** Part D reductions in cost sharing are **not** permitted under SSBCI or UF | Allows MAOs to provide enrollees with LIS/dual status or chronic condition(s) (or both) with:<br>• Non-primarily health related supplemental benefits (allowed under SSBCI, but not UF)<br>• Reductions in cost sharing for Part D drugs<br>• New and existing technologies or FDA-approved medical devices as a mandatory supplemental benefit |
| **RI Programs** | • Part C RI must reflect the cost/value of the health related activity and not the expected benefit<br>• Part D RI only for Real Time Benefit Tool (RTBT) | • RI limit that is tied to the value of the expected impact on enrollee behavior or the expected benefit, within an annual limit<br>• Part D RI outside of RTBT |
| **Hospice** | • Available to MA enrollees through Original Medicare | • MA plans participating in the Hospice Benefit Component generally cover ALL of their Medicare benefits, including hospice care. Can also offer transitional concurrent care and hospice supplemental benefits |

**See 85 FR 33802 and 42 CFR 422.102(f)(1)(i)(B) for other requirements.*

# Additional Guidance on Defining High-Value Providers

- CMS recognizes the importance of providers who demonstrate high value through culturally competent care and increased continuity of care for enrollees in underserved areas.
- To that end, CMS includes further guidance about what constitutes a high-value provider for inclusion in the Model, including providers who:
  - Predominantly serve underserved populations (e.g., a majority of enrollees living in areas identified by the CDC/ATSDR Social Vulnerability Index or the Area Deprivation Index) or dual-eligible enrollees;
  - Provide care through Area Agency on Aging, Aging and Disability Resource Center, or Center for Independent Living; and
  - Qualify as Essential Community Providers (ECPs) under 45 CFR 156.23516 e.g., Federally Qualified Health Centers.

# Removal of the Cash or Monetary Rebates Component

- After careful consideration, CMS is removing the Cash or Monetary Rebates component of VBID Model for CY 2023 Model year and future years due to potential negative impacts on enrollee eligibility for means-tested benefits based on receipt of cash benefits under the Model
  - MAOs may offer a range or combination of primarily health related and non-primarily health related benefits that address the medical and social needs of enrollees who receive LIS and/or other underserved populations
- CMS recommends MAOs:

  (1) provide these benefits together as part of a holistic benefit design; and

  (2) seek input from enrollees in structuring their benefit designs, e.g. enrollee advisory committees.
- CMS available to answer questions and provide technical assistance on any interventions being considered for inclusion in VBID Model

# Hospice Benefit Component: Updates to Network Design Standards

All participating MAOs with PBPs that have participated in the Model Component for at least one year and are applying to participate for a second year ("mature-year PBPs") must meet two new network adequacy requirements:

1. Participating MAOs must form a network of hospice providers so that enrollees have access to a minimum number of hospice providers (MNP) in every county within the service area of their mature-year PBPs; and
2. Participating MAOs must describe their comprehensive strategy for forming a network of Medicare hospice providers to ensure that enrollees receive a set of timely, comprehensive, and high-quality services aligned with enrollee preferences in a culturally-sensitive and equitable fashion.

# Advancing Health Equity through the Hospice Benefit Component

- Each participating MAO must describe a detailed strategy for advancing health equity as part of its approach to the Hospice Benefit Component.
- This strategy must include, but is not limited to, identifying, addressing, and monitoring any potential inequities in access, outcomes, and/or enrollee experience of care as it relates to the MAOs' palliative care strategies and to their coverage and coordination of the Medicare hospice benefit.
- We welcome Model participant and other stakeholder feedback on the role of the Hospice Benefit Component in advancing health equity.

# CY 2023 Hospice Benefit Component Payment Methodology

# Hospice Model Actuarial Considerations

- Hospice Model Component Payment Design
- Hospice Capitation Rate Development & Payment Structure
- Proposed Changes to Capitation Rate Development for CY 2023
- Appendix

# Model Component Payment Design

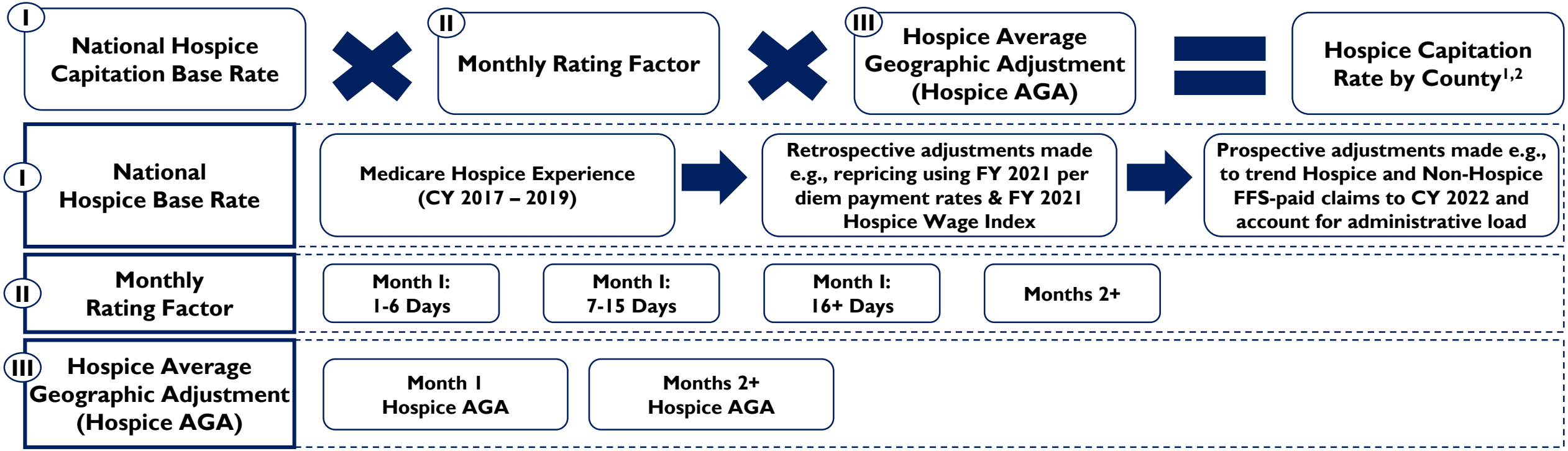
**Basic Benefit Capitation Rate**[1] *("A/B capitation rate")* + **Monthly Hospice Capitation Rate** + **Beneficiary Rebate Amount** + **Monthly Prescription Drug Payment** *(if any)*

Under the Model Component, for all MA enrollees who elect hospice care:

- For the first month of hospice coverage ("Month 1"), participating MA Organizations (MAOs) will receive a risk-adjusted A/B capitation payment,[1] the MA rebate amount, monthly prescription drug payment (if offering prescription drug coverage) and a hospice capitation payment
  - Month 1 hospice capitation payments will be made in a lump-sum on a quarterly basis
- For hospice stays that occur in a second calendar month and on ("Months 2+"), participating MAOs will receive a monthly hospice capitation payment, the MA rebate amount, and monthly prescription drug payment (if offering prescription drug coverage) prospectively

[1]Risk-adjusted and consistent with current law; only paid during Month 1 if as of the first of the month, an enrollee is not under hospice election status

# Overview of the Hospice Capitation Rate Development, CY 2022




[1] Current law sequestration will be applied as applicable.

[2] For Month 1 only, a days-in-month adjustment is applied to each county rate.

# National Average Values - Year-1 Rates, CY2022

| | Hospice Enrollment in Month 1 | Average Monthly Service Days | Distribution of Stay Months | Monthly Rating Factor[1] | Gross Monthly Base Rate |
|---|---|---|---|---|---|
| Month 1 | 1-6 Days | 3.28 | 16.11% | **0.340** | $1,827.78 |
| | 7-15 Days | 10.49 | 11.74% | **0.640** | $3,440.53 |
| | 16+ Days | 22.65 | 11.23% | **1.003** | $5,391.96 |
| Month 1 Composite[2] | | 11.01 | 39.09% | 0.621 | $3,336.56 |
| Month 2+ | | 26.25 | 60.91% | **1.000** | $5,375.83 |
| CY 2022 Composite National Hospice Capitation Rate[3] | | 20.30 | 100.00% | 0.852 | $4,578.69 |

[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.

# National Average Values - Year-2 Rates, CY2022

| | Hospice Enrollment in Month 1 | Average Monthly Service Days | Distribution of Stay Months | Monthly Rating Factor[1] | Gross Monthly Base Rate |
|---|---|---|---|---|---|
| Month 1 | 1-6 Days | 3.28 | 11.42% | **0.349** | $1,827.11 |
| | 7-15 Days | 10.49 | 8.32% | **0.657** | $3,439.57 |
| | 16+ Days | 22.65 | 7.96% | **1.030** | $5,392.33 |
| Month 1 Composite[2] | | 11.01 | 27.70% | 0.637 | $3,336.10 |
| Month 2+ | | 26.98 | 72.30% | **1.000** | $5,235.27 |
| CY 2022 Composite National Hospice Capitation Rate[3] | | 22.56 | 100.00% | 0.900 | $4,709.21 |

[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-2 rates.

# Hospice Average Geographic Adjustment

The Hospice Average Geographic Adjustment (AGA):

- Accounts for regional variation in claims at the core-based statistical area (CBSA) level
- Calculated using the average of repriced per capita claim cost for each of the three experience years
- Has a separate value for Month 1 and Month 2+ because of the differences in utilization of services and length of stay by CBSAs
  - Month 1 Hospice AGA is adjusted to account for the difference in Month 1 rating tier distribution between the CBSA and national distribution ("Month 1 Tier Adjustment")
  - Month 2+ Hospice AGA is adjusted to recognize the impact by CBSA of the Hospice Provider Inpatient and Aggregate Caps

# Excerpt from CY 2022 Hospice Capitation Payment Ratebook

| SSA Code | State | County Name | CBSA-State Identifier | Indicator of Year 1 or Year 2 Rate | CY 2022 Payment Rates | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Month 1 Days 1-6 | Month 1 Days 7-15 | Month 1 Days 16+ | Month 2+ |
| 06140 | CO | Delta | 99906-CO | Year 1 Rate | 1,675.01 | 3,152.95 | 4,941.27 | 5,148.33 |
| 06150 | CO | Denver | 19740-CO | Year 2 Rate | 1,731.03 | 3,258.70 | 5,108.76 | 5,045.56 |
| 06160 | CO | Dolores | 99906-CO | Year 1 Rate | 1,675.01 | 3,152.95 | 4,941.27 | 5,148.33 |
| 06170 | CO | Douglas | 19740-CO | Year 2 Rate | 1,731.03 | 3,258.70 | 5,108.76 | 5,045.56 |
| 06180 | CO | Eagle | 99906-CO | Year 1 Rate | 1,675.01 | 3,152.95 | 4,941.27 | 5,148.33 |
| 06190 | CO | Elbert | 19740-CO | Year 2 Rate | 1,731.03 | 3,258.70 | 5,108.76 | 5,045.56 |
| 06200 | CO | El Paso | 17820-CO | Year 2 Rate | 1,725.47 | 3,248.23 | 5,092.35 | 4,989.74 |

# Proposed Rating Changes for CY 2023

Key rating changes proposed in the CY 2023 Preliminary Hospice Capitation Payment Rate Actuarial memorandum (March 1, 2022):

- Advance experience period one year to CY 2018 – CY 2020
- Month 2+ rates in counties not represented in CY 2022 VBID Hospice Benefit Component to be based on first-year hospice experience only. Month 2+ rates for continuing counties include carryover claims from all prior years.
- Base repricing of claims on FY 2022 per diem rates and hospice wage index from CMS-1754-F (*see Appendix*)
- Revised labor shares from FY 2022 final hospice regulation, CMS-1754-F (*Table 1 in preliminary actuarial memorandum*)

# Proposed Rating Changes for CY 2023 (continued)

- Updated actuarial assumptions for:
  - Hospice claim trend (*Table 2 in preliminary actuarial memorandum*)
  - Non-hospice claim trend (*Table 3 in preliminary actuarial memorandum*)
  - Hospice aggregate and inpatient caps
  - Administrative expense load
  - Claim completion factors
  - Hospice service mix adjustment (*Table 4 in preliminary actuarial memorandum*)

# Labor Shares of Hospice Payments

| Description | FY 2021 Labor Shares | FY 2022 Labor Shares |
|---|---|---|
| Routine Home Care (Days 1-60) | 68.71% | 66.00% |
| Routine Home Care (Days 61+) | 68.71% | 66.00% |
| Continuous Home Care | 68.71% | 75.20% |
| Inpatient Respite Care | 54.13% | 61.00% |
| General Inpatient Care | 64.01% | 63.50% |

# Service Intensity Trends, 2018 – 2020

| Calendar Year | Service Days Per Stay Month (a) | Weighted Per Diem FY22 (g) | Composite (a * g) | Trend to 2020 adjusted |
|---|---|---|---|---|
| 2018 | 22.80 | $188.97 | $4,308.44 | 0.37% |
| 2019 | 23.05 | $187.32 | $4,317.75 | 0.15% |
| 2020 | 23.00 | $184.85 | $4,251.56 | 1.71% |
| 2020 (adj.) | 23.27 | $185.83 | $4,324.26 | n/a |

# CY 2023 Application Timeline & Process

# Next Steps for MAOs

1. Reach out to CMS for technical assistance at VBID@cms.hhs.gov
2. Review release of hospice-specific county-level rate book in **mid-April 2022**
3. Submit your application via the Qualtrics Portal to CMS by **April 15, 2022**
4. Receive provisional approval in **Mid-May 2022**
5. Submit MA Bids, due **June 6, 2022**
6. Execute contract addenda for Model participation in **September 2022**

# CY2023 Application Materials & Resources

The below materials are available for download via a ZIP file on the Model webpage and within the Qualtrics application:

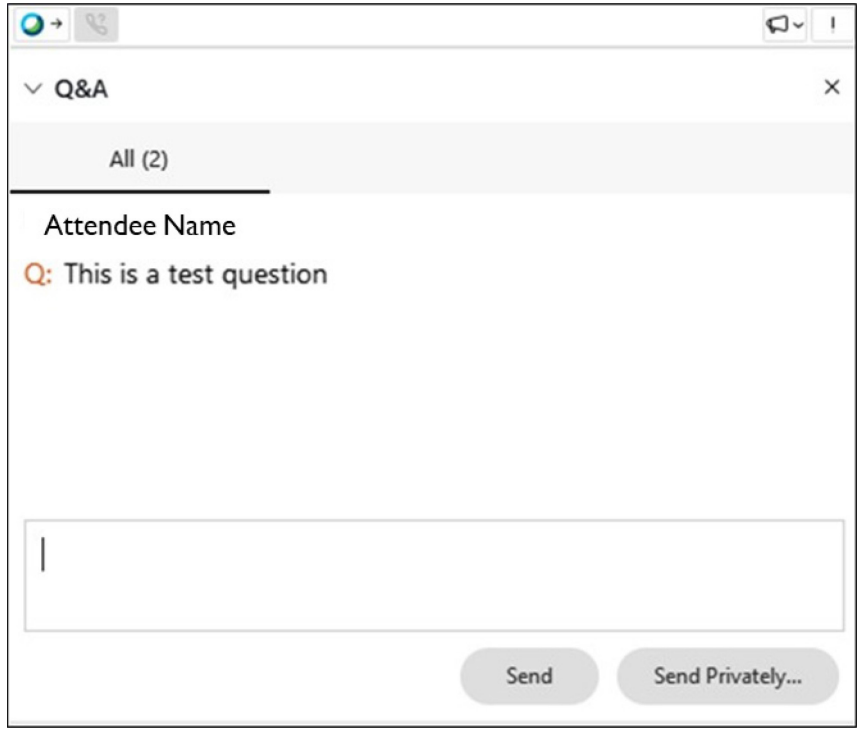
| Material | Description |
|---|---|
| **PDF of Application Questions** | Template to aid MAOs in preparing applications |
| **Supplemental Application Instructions** | Helpful tips and application reminders |
| **Financial Application FAQ Document** | Additional clarifications to the actuarial requirements for MAOs submitting VBID Model applications |
| **Required Application Summary Spreadsheet** | All MAOs are required to fill out and submit via the Qualtrics application or directly to VBID@cms.hhs.gov an Excel file that includes the proposed VBID contracts, PBPs, plan types, SNP types (if applicable), enrollment projections that are applicable to each proposed Model Component |
| **Required Net Savings Template** | All applicants are required to fill out and submit via the Qualtrics application or directly to VBID@cms.hhs.gov an excel file that outlines the projected costs PMPM for Medicare with and without VBID interventions. |
| **Required Financial Projections Template** | All applicants are required to fill out and submit via the Qualtrics application or directly to VBID@cms.hhs.gov a PDF that outlines the projected costs for each VBID Model Component, as well as projected net savings to Medicare over the course of the Model |
| **Part D Supplemental File** | *ONLY* MAOs proposing to reduce cost-sharing for covered Part D drugs are required to fill out and submit via the Qualtrics application or to VBID@cms.hhs.gov. |

# Tips for a Seamless Application Submission

- **Find all resources on the VBID Model website:** https://innovation.cms.gov/initiatives/vbid, including the Request for Applications, Application link, and materials.
- **Submit ONE application per Parent Organization:**
  Each MAO needs to complete one application inclusive of all the Model Components, contracts, and PBPs that they to are proposing to include in the VBID Model.
- **Review the Qualtrics application tips:**
  Toward the beginning of the Application, you will be asked to select the various Model Components that you propose to implement in CY 2023. These selections will dictate the questions that appear throughout the rest of the Application, so please be sure to select all Model Components that are applicable to your proposed VBID program. Information that you type into the Application is saved automatically.
- **Please reach out to the VBID team with questions:** CMS is available for meetings throughout the application process. To request a meeting with the VBID Model Team, please email VBID@cms.hhs.gov. To aid in expedited scheduling, please provide requested times.

# How to Submit Questions

- Questions can be submitted through the WebEx Q&A panel.
  - Select "Q&A" followed by "All Panelists."
- The VBID Model Team will review submitted questions and provide answers. Some questions may require additional research, and a reply will be shared via email.



# Thank you for joining us.

# Please email us with any questions at: VBID@cms.hhs.gov

# Appendix: Overview of VBID Model Components

# Value-Based Insurance Design – Chronic Condition and/or Socioeconomic Status

- To test the impact of value-based insurance design, MAOs may propose reduced cost-sharing and/or additional supplemental benefits, including non-primarily health-related supplemental benefits, for targeted enrollees
- MAOs may propose reducing cost-sharing for Part C items and services and covered Part D drugs
  - For example, based on chronic condition(s) and/or low-income subsidy status (LIS), MAOs may propose generic drug(s) with $0 cost-sharing or elimination of co-pays for primary and specialty care visits
- MAOs may propose additional conditions for eligibility
  - For example, a conditional requirement may be participation in a disease state management program or seeing a high-value provider
- MAOs may also propose providing additional "non-primarily health-related" supplemental benefits
  - MAOs may choose how narrowly to provide these "non-primarily health related" supplemental benefits, including to all enrollees with a chronic condition or to a more defined subset of targeted enrollees (e.g., enrollees who qualify for LIS)

# Rewards and Incentives (RI) Programs

- Provides higher-value MA RI Programs than currently available under MA and tests how MAOs may improve uptake and utilization of RI through flexibilities to:
  - Set a value that reflects the benefit of the service, rather than just its cost
  - Provide a higher allowed annual aggregate amount per enrollee (up to $600);
  - Provide the RI Program to targeted enrollees (e.g., specific to participation in a disease management or transition of care program); and
  - Have a RI program associated with the Part D benefit.

# Part D RI Programs

- Permits MAOs to propose Part D RI programs that, in connection with medication use, focus on promoting improved health, medication adherence, and the efficient use of health care resources
- Goal is to reward and incentivize enrollees' medication adherence to their drug therapy regimen. RI programs may promote:
  - Participation in a disease state management program;
  - Engagement in medication therapy management with pharmacists and/or providers;
  - Receipt of preventive health services, such as vaccines; and
  - Active engagement with their plans in understanding their medications, including clinically-equivalent alternatives that may be more cost-accessible.

# Wellness and Health Care Planning (WHP)

- As a condition of receiving any program waiver granted in connection with this Model, MAOs must implement a strategy in 2022 regarding the delivery of timely WHP services, including advance care planning (ACP) services, to all enrollees in all of the PBPs included in the Model
- Broader strategies include, but are not limited to:
  - MAO WHP infrastructure investments (e.g., digital platforms to support ACPs);
  - Provider initiatives around WHP education; and
  - Member focused initiatives (e.g., providing information on how enrollees can access WHP services in the Evidence of Coverage)
- In addition to a broad strategy, MAOs participating in the Model may also have a targeted strategy for their VBID enrollees to receive WHP

# Hospice Benefit Component Design

This Model Component aims to enable a seamless care continuum that improves quality and timely access to palliative and hospice care in a way that fully respects beneficiaries and caregivers.

1. Maintains the full scope of the current Medicare hospice benefit

2. Focuses on improved access to palliative care

3. Enables transitional concurrent care for enrollees

4. Introduces additional hospice-specific supplemental benefits

5. Promotes care transparency and quality through actionable, meaningful measures

6. Maintains broad choice and improves access to hospice

7. Utilizes a budget neutral payment approach to facilitate all of the above aims

# New & Existing Technologies

- Allows MAOs to propose to cover new technologies that are FDA approved and that do not fit into an existing benefit category for **targeted populations** (chronic conditions and/or LIS status) that would receive the highest value from the new technology
- MAOs permitted to provide coverage for:
  (a) FDA approved medical device or new technology that has a Medicare coverage determination (either national or local) where the MA plan seeks to cover it for an indication that differs from the Medicare coverage determination and the MA plan demonstrates the device can be medically reasonable and necessary for the other indication; and
  (b) For new technologies that do not fit into an existing benefit category.

# Appendix: Hospice Actuarial Materials

# Fee-For-Service (FFS) Medicare Hospice Per Diem Rates

| Code | Description | FY 2021 | FY 2022 |
|---|---|---|---|
| | | Payment Rate* | Payment Rate** |
| 651 | Routine Home Care (RHC) (Days 1 – 60) | $199.25 | $203.40 |
| 651 | RHC (Days 61+) | $157.49 | $160.74 |
| 652 | Continuous Home Care (CHC)<br>Full Rate = 24 hours of care | $1,432.41<br>($59.68/hourly rate) | $1,462.52<br>($60.94/hourly rate) |
| 655 | Inpatient Respite Care (IRC) | $461.09 | $473.75 |
| 656 | General Inpatient Care (GIP) | $1,045.66 | $1,068.28 |

**Notes:** Hospices that do not report quality data receive a 2 percentage point reduction in their annual payment update. The base hospice experience includes impact of Service Intensity Add-on (SIA). Out-of-network hospice care must be reimbursed at FFS rates.

*Rate before sequestration: Medicare Program. FY 2021 Hospice Wage Index and Payment Rate Update. (CMS-1733-F).
https://www.federalregister.gov/documents/2020/08/04/2020-16991/medicare-program-fy-2021-hospice-wage-index-and-payment-rate-update
**Rate before sequestration: Medicare Program. FY 2022 Hospice Wage Index and Payment Rate Update. (CMS-1754-F).
https://www.govinfo.gov/content/pkg/FR-2021-08-04/pdf/2021-16311.pdf

# Hospice Supplemental Benefits

- Treatment similar to other supplemental benefits, but targeted to hospice enrollees only
- Certifying actuary has discretion to include or exclude the hospice membership from both mandatory supplemental and optional supplemental benefits where applicable
- Examples of hospice supplemental benefits include:
  - Coverage of primarily and non-primarily health-related services and items such as adult day care services, home and bathroom safety devices and modifications, support for caregivers of enrollees, over-the-counter (OTC) benefits, meals, transportation, coverage of utilities, room and board, personal care items and service animal expenses
  - Reductions in cost sharing, as applicable, for hospice drugs and biologicals and/or inpatient respite care
  - Reductions in cost sharing for specific transitional concurrent care drugs

# Bid and Bid Pricing Tool (BPT) Considerations

- Hospice capitation payments and claims for hospice and non-hospice A/B benefits for beneficiaries while in hospice status should be excluded from the MA BPT, similar to non-VBID plans
- See PBP Category 19c – Hospice VBID
  - Beneficiary liability for cost-sharing for hospice care *(could be eliminated under Model)*
    - Prescription drug coinsurance of 5%, with maximum of $5 per script received when receiving continuous or routine home care
    - 5% coinsurance for payment made by Medicare for IRC
  - Hospice supplemental benefits

# CY 2022 VBID Hospice Materials on CMS.gov

- CY 2022 VBID-Hospice Supplemental File for CBSA Descriptions (March 2021)
- CY 2022 Final Hospice Benefit Component Data Book for Year-1 Rates
- CY 2022 Final Hospice Benefit Component Data Book for Year-2 Rates
- CY 2022 Final Hospice Capitation Payment Ratebook
- CY 2022 Final Hospice Capitation Payment Rate Actuarial Methodology

# CY 2022 Hospice Benefit Component Data Books

- Tabs *Summary 20XX* include historical claim, utilization, and cost and per capita costs repriced to FY 2021 and trended to CY 2022
- Tab *Hospice AGA Summary* illustrates development of Average Geographic Adjustment (AGA) for both Month 1 and Months 2+ rates
- Tabs *Data Dictionary- 20xx Summary* and *Data Dictionary - Hospice AGA* provide description of fields included in respective tabs
- Tab *Sample Calc – Hospice AGA* illustrates the development of the AGA factors for a specified CBSA
- Tab *DGME, IME, and KAC factor* includes the CBSA-level carveout factors