Joint Rate-Setting Process for the Capitated Financial Alignment Model
(FAQs updated August 9, 2013)

This document describes a joint rate-setting process for Medicare-Medicaid capitated financial alignment model. Through this model, participating health plans are responsible for delivering an integrated set of services for Medicare-Medicaid enrollees. This initiative will test whether aligning Medicare and Medicaid financing can foster more person-centered models of care, achieve better outcomes, and lower costs through improvement.

Through this joint rate-setting process, Medicare and Medicaid will coordinate in setting payment levels and both payers will prospectively share in the savings achievable through the demonstrations.

Establishing baseline spending for the target population in the demonstration area.
Baseline spending is an estimate of what would have been spent in the payment year had the demonstration not existed. Baseline spending will be established prospectively on a year-by-year basis for each demonstration county. While the Medicaid methodology will vary state to state, the Medicare methodology will be consistent across all states participating in the capitated financial alignment model.

Medicaid:

- Responsible parties: The state and its actuaries will be responsible for providing data to support historical spending levels and utilization and cost trends for Medicaid services to CMS's contracted actuaries who, with guidance and input from CMS, will validate the data and projected baseline costs and trends in Medicaid (absent the demonstration).
- The historic spending will reflect costs for the services that will be included in capitation rates for the target population under the demonstration, and will incorporate data for the most recent years of prior experience available.
- The Medicaid baseline will take into account historic costs, and will include consideration of Medicaid managed care plan level payment (if the state currently serves Medicare-Medicaid enrollees through capitated managed care) as well as fee-for-service (FFS) costs.

Medicare:

- Responsible parties: CMS will calculate baseline spending (costs absent the demonstration).
- Given that the beneficiaries enrolled in demonstration plans will have come from both Medicare Advantage (MA) and FFS, demonstration baseline spending will be calculated based upon a weighted average of these populations' spending assumptions, proportional to the expected combination of enrolled dual eligible beneficiaries.
- CMS will develop an estimate of baseline costs for Medicare A and B services for each demonstration county.
    - For beneficiaries coming from Medicare FFS, the baseline costs will be calculated using the published Medicare standardized FFS county rates, which reflect historical costs of the Medicare FFS population. (Note: the standardized FFS county rates are calculated by CMS as part of the annual Medicare Advantage Rate Announcement and were released on April 1, 2013 for CY 2014.)
        - For each county, CMS will adjust the published FFS rates to fully incorporate the most current hospital wage index and physician geographic practice cost index during 2013 and 2014. (A similar adjustment in Medicare Advantage phases in as detailed in the 2014 Medicare Advantage Rate Announcement.)

    - In some states, CMS will also adjust the rates to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS (in the absence of the demonstration). The adjustment factor will be 1.25% in 2013.
  - For beneficiaries coming from MA, the baseline will reflect the estimated amounts that would have been factored into payments made to MA plans in which the beneficiaries would have been enrolled in the absence of the demonstration, including Part C rebates. Rebates will be calculated based on the county benchmarks that incorporate quality bonuses.
  - Each county baseline will be a weighted average of these FFS and MA county costs based on the expected proportion of enrollment from FFS and MA.
  - Amounts will be expressed as standardized rates (i.e. reflecting risk of an average 1.0 population).
- The Medicare Part D projected baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount for the payment year, which occurs in early August of each year. CMS will estimate an average monthly payment amount for the low-income cost sharing and Federal reinsurance subsidy amounts; these payments will be 100% cost reconciled after the payment year has ended.

Aggregate savings percentages under the demonstration.

- CMS assumes that the demonstrations can achieve overall savings through improved care management and administrative efficiencies. Initial modeling suggests potential changes in utilization patterns and a range of potential savings in each state. This work, plus input from states and others, will inform the selection of a savings percentage.
- Informed by the modeling, and with input from the state and others, CMS will establish a specific aggregate savings percentage for each year of the demonstration. The savings percentages will be specified in each state's MOU.
- Savings percentages may differ among states. For example, states with low historic Medicare spending, low utilization of institutional long-term care services, or a high penetration of Medicaid managed care may have lower savings potential than other states. However, we anticipate applying consistent percentages across states with comparable ranges of feasible savings. For example, in some states, we expect the savings percentages to be 1% in year 1, 3% in year 2, and 5% in year 3.

Applying aggregate savings percentage to components of the integrated rate.

- The aggregate savings percentages identified above would then be applied to the Medicare A/B and Medicaid components of the rate.
- By applying the savings percentages to the Medicare A/B and Medicaid components, both payers proportionally share in the contribution to the capitation rate and in the savings achieved through the demonstration regardless of underlying utilization patterns. That is, regardless of whether savings accrue from reducing hospitalizations (for which Medicare is primary) or reducing nursing facility placements (for which Medicaid is primary), both payers will benefit under the integrated approach.
- Savings percentages will not be applied to the Part D component of the rate.

Applying risk adjustment methodology to each component of the integrated rate.

- The Medicare A/B and Part D Direct Subsidy components of the rate will be risk adjusted based on the risk profile of each enrolled beneficiary in the demonstration. The existing CMS-HCC, CMS-HCC ESRD, and RxHCC risk adjustment models will be utilized for the demonstration for A/B and Part D, respectively.

- The Medicaid component will be risk adjusted or distributed into rating categories based on a methodology proposed by the state and agreed to by CMS. This may include the identification of various rate cells/cohorts of the population (e.g., by age or sex, nursing home level of care, care setting, etc.). We will allow these methodologies to vary from state to state, as they do among Medicaid managed care programs today, as long as the risk categories incent home and community based services over institutional placement, have clear operational rules and processes for assigning beneficiaries into a rate category that are compatible with an individual's risk level/profile, and are budget neutral across the Medicaid program as a whole after the application of savings percentages.

Applying quality withhold policy to Medicaid and Medicare A/B components of the integrated rate.

- To incent quality improvement, CMS and the state will withhold a portion of the capitation payments that participating health plans can earn back if they meet certain quality thresholds.
- CMS expects the threshold measures to be a combination of certain core quality measures (consistent across all demonstrations under the capitated financial alignment model), which will be a subset of a larger integrated quality reporting measurement set, and state-specified performance measures that are more specific to the target population of each demonstration. Each state will work with CMS to develop the state-specific performance measures that will be used for the purposes of the quality withhold.
- In year 1, encounter reporting and other process measures will be utilized as the basis for the 1% withhold. The quality withhold will be of increasing amounts (2% in year 2 and 3% in year 3) and will be based on performance in the core demonstration and state-specified measures. (Note: Part D payments will not be subject to a quality withhold.)

Making payments to participating health plans for each component of the integrated rate.

- CMS will make separate payments to the participating health plans for the Medicare A/B and Part D components of the rate.
- The state will make a payment to the participating health plans for the Medicaid component of the rate.

Paying participating health plans relative to quality withhold requirements.

- CMS and the state will assess plan performance according to the specified quality withhold measures in each given year and calculate final payments to each plan.

Capitated Financial Alignment Model Financing and Payment FAQs

Payments to Participating Plans

How will rates under the demonstration be different than those currently paid under Medicare Advantage?

Unlike Medicare Advantage, participating plans will not submit bids. Instead, CMS and the state will jointly develop capitation rates for Medicare A/B, Part D, and Medicaid services.

CMS will develop payment rates for Medicare A and B services using baseline estimates of what Medicare would have spent on behalf of the enrollees absent the demonstration. To the extent that enrollees are entering the demonstration from both the Medicare FFS and Medicare Advantage programs, the Medicare A/B baseline spending will include both Medicare FFS and Medicare Advantage components based on the patterns of enrollment.

How are Medicare Fee-for-Service (FFS) standardized county rates developed?

When calculating demonstration rates, CMS will incorporate the standardized county FFS rates that are calculated each year by the CMS Office of the Actuary (OACT) to the extent that FFS beneficiaries are expected to enroll in the demonstration. These standardized county FFS rates reflect projected FFS United States per capita costs (USPCC), adjusted to reflect the historic relationship between the county's FFS per capita costs and the USPCC. CMS calculates these geographic adjustments based on historical FFS claims data. The USPCC includes expenditures for Parts A and B services and the associated bad debt payment, DSH payments, amounts related to direct and indirect medical education, and federal administrative costs. The USPCC and the standardized county FFS rates exclude hospice services, which are reimbursed through Medicare fee-for-service for all Medicare beneficiaries. CMS excludes direct GME and the operating component of IME payments in establishing standardized county FFS rates. CMS also calculates a separate statewide rate for beneficiaries with end stage renal disease.

CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

Why is CMS using standardized rates rather than historical expenditures for the target population in each demonstration state?

Standardized county rates reflect the average cost experience for each county, standardized by (divided by) the average risk score in a county. By starting with a standardized county rate, CMS can then risk adjust each standardized county rate at the enrollee level, ensuring that the Medicare A/B payment level appropriately reflects the expected Medicare costs of the Medicare-Medicaid population. In addition, by using the standardized rates, CMS is able to leverage an established and tested payment methodology.

Will there be plan-specific rates?

For the Medicare component of the payment, base rates will be developed at a county level using standardized FFS county rates and Medicare Advantage benchmarks. For the projected number of beneficiaries coming from Medicare Advantage, the baseline will include plan-specific assumptions regarding bids, quality bonus payment-adjusted benchmarks, and rebate amounts for each county. Although the Medicare rates will not vary from plan to plan, the Medicare rates will be risk adjusted for each enrollee when the Medicare payment is calculated and, hence, actual payment may differ. States have discretion, subject to CMS approval, for developing the Medicaid component of the payment and may choose to develop rates on a county, regional, or statewide basis, and to customize Medicaid risk adjustment methods.

Will payment be tied to quality under the demonstrations?

To incent quality, CMS and the state will withhold a portion of the capitation payments that participating plans can earn back if they meet certain quality thresholds. These threshold measures will be a combination of certain core quality measures (consistent across all the demonstrations) and state-specific measures tailored to the particular demonstration.

How is Part D being paid for under the demonstration?

Participating plans will not submit bids for Part D. Instead, the Medicare Part D projected baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount, which is derived each year from the competitive Part D bidding process. For contract year 2014, that amount is $75.88. CMS will estimate an average monthly payment amount for the low-income cost sharing and Federal reinsurance subsidy amounts; these payments will be 100% cost reconciled after the payment year has ended, as occurs with Part D plans today. CMS does not expect this change in payment approach to have any material financial impact for beneficiaries in or out of the demonstration. As the demonstration progresses, CMS and its Office of the Actuary will be closely monitoring any impacts on the Part D market.

How will the rates be risk-adjusted?

The Medicare A/B and Part D direct subsidy components of the rate will be risk-adjusted based on the risk profile of each enrollee in the demonstration. The existing CMS-HCC, CMS-HCC ESRD, and RxHCC risk adjustment models will be utilized to calculate risk scores for paying demonstration plans for A/B and D, respectively.

The Medicaid component of the rate will be adjusted according to methodologies proposed by the states, subject to CMS approval. CMS may allow different states to use different methods, as long as they incentivize community alternatives to institutional placement, have clear operational rules and processes for assigning beneficiaries into a rate category that are compatible with an individual's risk level/profile, and are budget neutral across the Medicaid program as a whole after the application of savings percentages.

How does the coding intensity adjustment used in Medicare Advantage apply in the demonstrations?

CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service (FFS) Medicare programs. The adjustment for 2014 is 4.91%. At the start of each demonstration,

the majority of new enrollees will come from Medicare FFS, and risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the plan themselves. Generally, at the start of each demonstration, CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis. For the first full calendar year that follows the phase-in period for the demonstration, CMS will apply the prevailing Medicare Advantage coding intensity adjustment for all enrollees, unless special circumstances apply (e.g., if the enrollment phase-in would lead to a significant increase in enrollment from FFS after October 1.)

How will savings be determined?

CMS expects that each approved demonstration can achieve overall savings through improved care management and administrative efficiencies. Savings opportunities will vary by state depending on a number of factors, including historical utilization rates, current managed care penetration for both Medicare and Medicaid, and ratio of institutional to community based services, among others. Analytic work plus input from states and others will inform the selection of a savings percentage. We describe the major drivers of savings under "General Issues" below.

Does sequestration impact payment to demonstration plans?

Under sequestration, for services beginning April 1, 2013, Medicare payments to providers for individual services under Medicare Parts A and B, and non-exempt portions of capitated payments to Part C Medicare Advantage Plans and Part D Medicare Prescription Drug Plans are reduced by 2%. These reductions are also applied to Medicare components of the integrated rate. Therefore, under the capitated financial alignment model CMS will reduce non-exempt portions of the Medicare Part A and B fee-for-service and Medicare Advantage components, and the Medicare Part D component of the integrated rate, by 2%. (The exempt portions include the low-income cost sharing and reinsurance payments for Part D.)

Does the Health Insurance Providers Fee apply to demonstration plans?

If a plan participating in the capitated financial alignment model is a "covered entity" under Section 9010(a) of the Affordable Care Act which establishes the annual Health Insurance Providers Fee, that plan is subject to the fee for its revenue under the demonstration. The demonstration, in and of itself, provides no exemptions from this fee. Exemptions already specified in the law continue to apply.

Will the new Medicare Advantage medical loss ratio (MLR) regulations apply for plans in the demonstrations?

Application of MLR rules depend on the terms of the specific demonstration. In demonstrations that include a minimum MLR, the allowable costs will include both Medicare and Medicaid covered services, plus costs for care coordination and quality improvement.

Payments to Providers

What are CMS' expectations on payment rates to providers?

CMS does not project any changes to the amounts paid to service providers under the demonstrations compared to rates in fee-for-service today, and we assume that savings achieved through these demonstrations are from better health outcomes, coordination of care, and opportunities to live in the community. We do expect, however, that health plans and providers will use these demonstrations as opportunities to implement innovative payment arrangements to reward quality and value rather than volume of services.

Some states require that health plans in Medicaid managed care pay certain rates to certain providers, and we are allowing some state discretion on regulating payment rates for services traditionally covered only by Medicaid. However, federal law forbids CMS from direct involvement in establishing contract terms between providers and Medicare Advantage plans, and we are following that prohibition in the demonstrations as well.

What are the federal requirements for health plan payment to in-network providers?

Providers that contract with plans will establish payment parameters in those contracts. Participating plans are expected to pay the contracted rate to in-network providers and not further deduct any cost-sharing amounts from this payment. The contracted rate is established between the participating plan and the provider, and not prescribed by CMS, consistent with CMS policy for Medicare Advantage plan-provider contracts.

What are the federal requirements for health plan payment to out-of-network providers?

Participating plans must cover emergent or urgent services provided by out-of-network providers, and may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, CMS will follow Medicare Advantage policy, under which participating plans will be required to pay non-contracting providers at least the lesser of the provider's charges or the Medicare FFS rate, regardless of the setting and type of care for authorized out-of-network services. Payment rates must include capital IME and DSH as applicable.

Will providers receive Medicare bad-debt payments for serving beneficiaries under the capitated model?

Provider payments associated with Medicare bad debt are included in the standardized FFS county rates and Medicare Advantage capitation rates used to determine the Medicare baseline estimates for the demonstration capitation rates. In some states, CMS is further adjusting the Medicare baseline amounts to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS. As a result, providers will not bill Medicare separately for bad debt under the demonstration. This is consistent with current CMS policy under which Medicare FFS does not reimburse facilities for bad debts associated with Medicare Advantage plan enrollees as the plan payment constitutes payment in full; providers' cost reports detailing bad debt can only include those debts from FFS enrollees.

Will Medicare graduate medical education (GME) payments be impacted?

Nothing about the Medicare GME payments will change as a result of the capitated financial alignment model. Medicare provides direct (DGME) and indirect (IME) payments to teaching hospitals for approved GME programs. Because both types of GME payments are calculated using fixed approaches regardless of whether Medicare beneficiaries are in FFS or Medicare Advantage, hospitals will continue to receive all GME payments (DGME and IME) payments in the same manner in which they receive those payments today. Beneficiaries in the demonstrations will count toward a hospital's GME payments in the same way as other beneficiaries in Medicare managed care. As a result, Medicare baselines used to determine capitation rates will generally not include amounts related to DGME or operating IME payments.

How will Medicare disproportionate share hospital (DSH) payments work under the demonstration?

As with Medicare bad debt payment, provider payments associated with Medicare DSH are included in the standardized FFS county rates and Medicare Advantage capitation used to determine the Medicare baseline spending under the demonstration. Providers will not separately claim DSH payments for beneficiaries in the demonstration. Beneficiaries in the demonstrations will count toward a hospital's qualification for DSH payments in the same way as other beneficiaries in Medicare managed care.

General Issues

Where will the savings come from in the demonstrations?

We assume that we can achieve lower costs over time through improvement, including better care coordination to reduce the utilization of certain types of high-cost services. CMS does not assume any savings from reducing payment rates to providers or reducing access to services. Indeed, we assume that spending on some types of services will increase under the demonstrations.

Each demonstration exists in a different context, with different target populations, managed care penetration, and underlying costs and utilization patterns today. In general, though, we assume the following:

- **Reductions in inpatient hospital utilization** – Approximately 60-70% of projected savings come from fewer hospital admissions, driven most significantly (approximately 35-50%) by reductions in admissions for ambulatory care sensitive conditions (e.g., dehydration, hypertension) and other potentially avoidable admissions and readmissions (approximately 15-30%).

- **Reductions in ER use** – Approximately 1-5% of projected savings come from fewer ER visits, particularly those visits related to ambulatory care sensitive conditions.

- **Reductions in NF/SNF** – Approximately 15-25% of projected savings come from reduced use of long term nursing facility services and post-acute skilled nursing facility services. However, these assumptions are particularly sensitive to the state context. For example, we assume much smaller reductions in nursing facility use if the state has already established (or is concurrently implementing) a broader capitated managed LTC program to avoid "double-counting" reductions that are attributable to the implementation of managed LTC even in the absence of the demonstration.

- In addition to the savings from reduced inpatient, ER, and skilled nursing facility services, there are also savings for the physician/provider services and follow-up services that would have been associated with those reduced services.

- **Increases in primary care, outpatient services, behavioral health services, and HCBS –** Higher spending on these services partially offsets the savings above.

What is the evidence base for assuming that service utilization patterns would change under the demonstrations?

There is a significant body of published research on interventions that help to reduce hospitalizations, ER use, and nursing facility placement. While there are few programs in operation today that mirror the new demonstrations, the closest ones consistently show reductions in potentially avoidable admissions. A bibliography is available at this link:
http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcessBiblio.pdf

Does CMS expect the demonstration financing approach to work in all states?

For states interested in pursuing the demonstration, there are a number of programmatic, policy and financial issues to consider. State-specific factors may contribute to the financing approach under the capitated model being more or less challenging for a particular state. The existing health plan market, proportion of the demonstration population in Medicare Advantage, demonstration population size, and the state's current Medicare costs, among other factors, may play a role in state and stakeholder considerations on whether rates meeting the demonstration requirements will support a sustainable, viable demonstration with high-quality health plans. While CMS does not expect the demonstration to be the right fit in all states, CMS remains committed to working with all states on efforts to improve integration and quality of care for Medicare-Medicaid enrollees.

What should stakeholders consider when comparing the Medicare component of the demonstration rate with Medicare claims experience in individual states?

The following are factors to consider when analyzing the Medicare component of the demonstration rates in comparison to Medicare claims experience:

- Hospice: For enrollees electing Medicare hospice services, to the extent such individuals remain demonstration-eligible, hospice services will be reimbursed via Medicare FFS and the health plan would no longer receive the applicable Medicare A/B payment for that enrollee. Thus, when examining historical claims/expenditure data it is important to consider whether hospice expenditures are included, as those are expenditures for which plans would not be responsible.

- Beneficiaries with ESRD: A separate ESRD Medicare A/B baseline rate applies to beneficiaries with ESRD. For enrollees with ESRD in the dialysis and transplant status phases, the Medicare A/B baseline will be the ESRD state rate; for enrollees in the functioning graft status phase, the Medicare A/B baseline will be the Medicare Advantage 3-star county benchmark for the applicable county. Therefore, when examining historical claims/expenditure data it is important to consider whether ESRD beneficiaries are included in the FFS claims data; to the extent that

baseline FFS data includes beneficiaries with ESRD, the applicable payment rates for these subsets of beneficiaries should be considered.

- Indirect Medical Education (IME): Historical Medicare cost data may include payments for IME. Per MIPPA requirements, CMS is phasing out operating IME as part of the Medicare rate book, and therefore operating IME is not factored into the Medicare portion of the demonstration rate. Under the demonstrations, direct payments to teaching hospitals for IME continue in the same manner today.

- Trend: Recent historically low Medicare cost and utilization experience has resulted in lower trends used by CMS to project payment rates. Trends used in projecting forward historical expenditure/claims experience should be compared to the trends CMS uses to update rates.

- Sequestration: To the extent a comparison is made between expenditures and projected payments under the demonstrations, both sets of analyses should treat adjustments (such as payment reductions resulting from sequestration) in the same manner – that is, either include or exclude such adjustments in both expenditure and revenue analyses.