

Joint Rate-Setting Process for the Financial Alignment Initiative's Capitated Model

(Updated April 25, 2017)

This document describes the joint rate-setting process for the Center for Medicare and Medicaid Innovation's Financial Alignment Initiative capitated model.¹ Through this model, participating health plans called Medicare-Medicaid Plans, or MMPs, deliver an integrated set of services for Medicare-Medicaid enrollees. This initiative tests whether aligning Medicare and Medicaid financing can foster more person-centered models of care, achieve better outcomes, and lower costs.

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

This document summarizes the general rate-setting process that applies for all demonstrations, but additional demonstration-specific detail is available in the unique three-way contracts that are executed among each participating state, the Centers for Medicare & Medicaid Services (CMS), and the participating MMPs.²

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 is established prospectively on a year-by-year basis for each demonstration county. While the Medicaid methodology varies from state to state, the Medicare methodology is consistent across all states participating in the capitated model.

Medicaid:

- The state and its actuaries provide data to support historical spending levels, and utilization and cost trends for Medicaid services to CMS' actuaries who, with guidance and input from CMS, validate the data and projected baseline costs and trends in Medicaid (absent the demonstration).
- The historical spending reflects costs for the services included in capitation rates for the target population under the demonstration, and incorporates data for the most recent years of prior experience available.
- The Medicaid baseline cost projection takes into account historical costs, and includes 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.

¹ The Financial Alignment Initiative is a model test through the CMS Center for Medicare and Medicaid Innovation. More information about the Financial Alignment Initiative is available at <https://innovation.cms.gov/initiatives/Financial-Alignment/> and <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>

² Three-way contracts are available on the state-specific web pages at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>

Medicare Parts A and B:

- Beneficiaries enroll in the demonstrations from both Medicare Advantage (MA) and FFS. Therefore, Medicare A/B baseline spending is calculated based upon a weighted average of these populations' spending assumptions, proportional to the expected or actual combination of enrolled dual eligible beneficiaries.
 - For beneficiaries with Medicare FFS ("Original Medicare"), CMS calculates baseline costs using the published Medicare standardized FFS county rates, which reflect historical costs of the Medicare FFS population. The standardized FFS county rates are released with the annual Medicare Advantage Rate Announcement, updated annually each April for the following calendar year. In some states, CMS also adjusts the rates to account for the disproportionate share of bad debt attributable to dual eligible beneficiaries in Medicare FFS, compared to all Medicare FFS beneficiaries.
 - For beneficiaries previously enrolled in MA, CMS calculates baseline costs from the amounts that would have been paid to MA plans in which the beneficiaries would have been enrolled in the absence of the demonstration, including Part C rebates. Rebates are calculated based on the county benchmarks that incorporate quality bonuses.
 - Each county baseline is a weighted average of these FFS and MA county costs based on the expected or actual proportion of enrollment from FFS and MA.
 - For beneficiaries with end stage renal disease (ESRD) in the dialysis and transplant status phases, CMS estimates baseline costs using the state-level ESRD rates annually published with the standardized county rates. For enrollees in the functioning graft status phase, the Medicare A/B baseline is the Medicare Advantage 3.5% bonus county benchmark for the applicable county.
 - Amounts are expressed as standardized rates (i.e. reflecting risk of an average 1.0 population).

Medicare Part D:

- CMS sets the Medicare Part D baseline for the Part D direct subsidy at the Part D national average monthly bid amount for the payment year, which is released in early August of each year.
- CMS annually estimates average monthly payment amounts for the low-income cost sharing and federal reinsurance subsidy amounts; these payments vary by state and are 100% cost reconciled after the payment year has ended. This reconciliation typically occurs in November of the subsequent payment year.

Aggregate savings percentages under the demonstration

- CMS assumes that the demonstrations can achieve overall savings through improved care management, lowered utilization of high-cost services in institutional settings, and administrative efficiencies.

- For each demonstration, CMS and the participating state established a specific aggregate savings percentage for each year of the demonstration.
- Savings percentages differ among demonstrations. For example, states with low historic Medicare spending, low utilization of institutional long-term care services, or a high penetration of Medicaid managed care prior to the demonstration may have lower savings potential than other states.

Applying aggregate savings percentage to components of the integrated rate

- The aggregate savings percentages identified above are applied to the Medicare A/B and Medicaid components of the rate.
- By applying the same 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 benefit under the integrated approach.
- Savings percentages are not applied to the Part D component of the rate, nor to the Medicare A/B component for beneficiaries with ESRD.

Applying risk adjustment methodology to each component of the integrated rate

- CMS risk adjusts the Medicare A/B and Part D Direct Subsidy components of the rate based on the risk profile of each enrolled beneficiary in the demonstration by applying the prevailing CMS Hierarchical Condition Categories (CMS-HCC) (or CMS-HCC ESRD) and Prescription Drug Hierarchical Condition Categories (RxHCC) risk adjustment models for A/B and Part D, respectively.
- States adjust the Medicaid component through risk adjustment or by assigning enrollees to various rating categories. Approaches 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.). Methodologies vary from state to state, as they do among Medicaid managed care programs today, although in all cases CMS requires that 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 withhold a portion of the capitation payments that participating MMPs can earn back if they meet certain quality thresholds. The quality withhold applies to the Medicaid and Medicare A/B rate components.
- The quality withhold measures are a combination of certain core performance measures (consistent across all demonstrations under the capitated model), which are a subset of a larger quality reporting measurement set, and state-specified performance measures that are more specific to the target population of each demonstration. Each state worked with CMS to

develop the state-specific performance measures that are used for the purposes of the quality withhold.

- Quality withhold amounts generally increase over the first three years of each demonstration, typically from 1% of payment in year 1 to 3% in year 3 and beyond.³

Making payments to participating MMPs for each component of the integrated rate

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

Paying participating MMPs relative to quality withhold requirements

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

³ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf>

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidance042916.pdf>

Capitated Financial Alignment Model Financing and Payment FAQs

Payments to MMPs

How are rates under the demonstrations different than those currently paid under Medicare Advantage?

Unlike Medicare Advantage, MMPs do not submit bids. Instead, CMS and the state jointly develop capitation rates for Medicare A/B, Part D, and Medicaid services. CMS develops payment rates for Medicare A/B and Part D services using baseline estimates of what Medicare would have spent on behalf of the enrollees absent the demonstration.

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

When calculating demonstration rates, CMS incorporates the standardized county FFS rates that are calculated each year by the CMS Office of the Actuary. These standardized county FFS rates reflect projected FFS United States per capita costs (USPCC), adjusted to reflect the historical 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, Disproportionate Share Hospital (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 paid through Medicare FFS for all Medicare beneficiaries. CMS excludes direct Graduate Medical Education (GME) and the operating component of Indirect Medical Education (IME) payments in establishing standardized county FFS rates. CMS also calculates a separate statewide rate for beneficiaries with end stage renal disease (ESRD).

CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the demonstrations.

How is the Medicare Advantage component of the rate updated for CY 2017 rates?

The Medicare Advantage component of the 2017 rate was updated based on Medicare Advantage trends, using the 2016 Medicare Advantage portion of the rate and trending it forward based on bids among non-MMPs submitted for the 2017 contract year.

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.

How are rates being paid under the demonstrations for 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 is the ESRD state rate; for enrollees in the functioning graft status phase, the Medicare A/B baseline is the Medicare Advantage 3.5% bonus county benchmark for the applicable county.

Are MMP capitation rates plan-specific?

The base Medicare rates do not vary from plan to plan, but the Medicare rates are risk adjusted for each enrollee when the Medicare payment is calculated and, hence, actual payment may differ. States have discretion, subject to CMS approval, in 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.

Is payment tied to quality under the demonstrations?

To incent quality, CMS and the state withhold a portion of the capitation payments that MMPs can earn back if they meet certain quality thresholds. These threshold measures are 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?

MMPs do not submit bids for Part D. Instead, the Medicare Part D projected baseline for the Part D Direct Subsidy is set at the Part D national average monthly bid amount, which is derived each year from the competitive Part D bidding process. As reference, for contract year 2017, that amount is \$61.08. CMS estimates an average monthly payment amount for the low-income cost sharing and federal reinsurance subsidy amounts; these payments are 100% cost reconciled after the payment year has ended, as occurs with Part D plans today.

How are the interim Part D low-income cost sharing and reinsurance amounts calculated?

Generally, the interim Part D low-income cost sharing (LICS) and reinsurance payments are calculated based on the LICS and reinsurance amounts in MA-PD bids in the relevant demonstration state, weighted by actual MA-PD dual eligible enrollment. In certain instances, based on experience through the reconciliation process, CMS adjusts interim payments to minimize the risk of large reconciliation payments or recoupments.

What is the MMP Part D Administrative Cost Ratio?

The Part D Administrative Cost Ratio for MMPs is updated annually by CMS. The CY 2017 Part D Administrative Cost Ratio for MMPs is 20%. This percentage is used for the reconciliation of the CY 2017 Part D risk corridors applicable to MMPs for the direct subsidy portion of the Part D payment.

Does sequestration impact payment to MMPs?

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 model CMS reduces 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 Part D low-income cost sharing subsidy payments, Part D reinsurance payments, and Part D risk corridor reconciliation.)

Does the Health Insurance Providers Fee apply to MMPs?

Section 9010 of the Affordable Care Act (ACA) created a fee to each covered entity engaged in the business of providing health insurance. If a MMP 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 MMP 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.

The Consolidated Appropriations Act of 2016, Division Q, Title II, § 201, suspends collection of the Health Insurance Provider Fee (“Fee”) for the 2016 calendar year. Thus, health insurance issuers are not required to pay the Fee in 2017. This also applies to MMPs.

How do federal Medicare Advantage and Medicaid medical loss ratio (MLR) regulations apply for MMPs?

Currently, application of MLR rules depend on the terms of the specific demonstration. Generally, MMPs are required to either report a joint Medicaid-Medicare MLR or have a risk corridor or other risk mitigation arrangement.

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. For Medicaid rating periods that begin on or after July 1, 2017, based on the Medicaid and CHIP Managed Care Final Rule⁴, all MMPs will either need to calculate and report their MLR experience for Medicaid, or calculate and report an MLR covering both Medicare and Medicaid experience. CMS intends to provide additional guidance for the MLR requirement for MMPs.

Is Medicare bad debt built into the Medicare FFS portion of the capitated rate?

Provider payments associated with Medicare bad debt are included in the standardized FFS county rates and the Medicare Advantage capitation rates used to determine the Medicare baseline estimates for the demonstration capitation rates. The bad debt load is based on actual CMS payments to providers for allowable bad debt. The bad debt proportion of FFS expenditures varies by county and is approximately 0.8 percent nationwide. In addition, an explicit adjustment is made to the county-level FFS rates for some states to reflect the higher

⁴ Final Rule published May 6, 2016: <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>

incidence of Medicare bad debt among dual eligible beneficiaries versus the total Medicare population. The adjustment is based on actual bad debt reported by inpatient, outpatient, and SNF providers during an experience period and is trended to the contract year. The adjustment, which for 2017 ranges from 0.0 percent to approximately 1.7 percent, is based on state-specific Medicaid cost-sharing policies for the applicable services.

Risk Adjustment

How are the rates risk-adjusted?

The Medicare A/B and Part D direct subsidy components of the rate are risk-adjusted based on the risk profile of each enrollee in the demonstrations. The existing CMS-HCC (or CMS-HCC ESRD) and RxHCC risk adjustment models are utilized to calculate risk scores for paying MMPs for Parts A/B and D, respectively. The Medicaid component of the rate may be risk adjusted according to state-specific methodologies.

How is encounter data used in risk adjustment?

For the Medicare rate component, the use of encounter data in risk adjusting payment to MMPs follows the prevailing approach used in the Medicare Advantage program more broadly. Historically, CMS has used diagnoses submitted into CMS' Risk Adjustment Processing System (RAPS). In 2015, CMS began using diagnoses from encounter data to calculate risk scores. In 2016, CMS began blending encounter data-based risk scores with RAPS-based risk scores. In 2017 payment, CMS will continue using a blend, with a higher percentage of encounter data-based risk scores than in 2016. Specifically, CMS will calculate 2017 risk scores with a blend of 25% weighting of encounter data and FFS and a 75% weighting of RAPS and FFS.

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 FFS. The adjustment for 2017 is 5.66%. At the start of each demonstration and when there are significant new waves of passive enrollment, the majority of new enrollees may come from Medicare FFS, and risk scores for those individuals are based on FFS. Generally, at the start of each demonstration or when there are significant waves of passive enrollment, CMS applies an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience.

What elements are included in the updated version of the CMS-HCC risk adjustment model that went into effect as of January 2017?

The model encompasses the following updates, which were finalized in the CY 2017 Announcement of Medicare Advantage Capitation Rates⁵:

⁵<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>

- Updated data used to recalibrate the model;
- Revisions to the community model that replace the single community segment with six separate model segments (non-dual aged, non-dual disabled, full benefit dual aged, full benefit dual disabled, partial benefit dual aged, partial benefit dual disabled);
- Updates to disease interactions, including a new interaction term for individuals with co-occurring substance abuse disorder and certain psychiatric conditions; and
- Updates to the community and long term institutional (LTI) segments, such that the community risk score will depend on the dual status in the payment month and the LTI risk scores will include a Medicaid factor based on Medicaid status in the payment year.

Why did CMS revise the CMS-HCC model for CY 2017?

CMS' analysis indicated that the revised CMS-HCC model would improve predictive performance for full-benefit dual, partial-benefit dual, and non-dual beneficiaries in the community. The updated model results in more appropriate relative weights for the HCCs because the relative weights reflect the disease and expenditure patterns of each of the six community segments. The revised model will improve the overall accuracy of the risk-adjustment model for complex vulnerable populations, including full-benefit dual eligible beneficiaries.

Payments to Providers

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

Providers that contract with MMPs will establish payment parameters in those contracts. MMPs 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 MMP and the provider, and not prescribed by CMS, consistent with CMS policy for Medicare Advantage plan-provider contracts.

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

MMPs 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. CMS follows Medicare Advantage policy in regards to payment requirements for out-of-network providers, as described below.

For payment of emergent or urgent care services, providers are required to accept as payment in full by the MMP the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare or Medicaid FFS. However, the MMP is not required to pay a provider (other than a "provider of services" as defined in section 1861(u) of the Social Security Act⁶) more than the provider's charge for that service. Per Section 1861(u), providers of services may be paid an amount that is less than the amount they would receive if the beneficiary were

⁶ Section 1861(u) defines the term "provider of services" as "a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund."

enrolled in original Medicare if the provider expressly notifies the plan in writing that it is billing at lesser amount.

For other out-of-network services that are part of the traditional Medicare benefit package, MMPs are required to pay non-contracting providers the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare or Medicaid FFS (less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers of services), regardless of the setting and type of care for authorized out-of-network services. Payment rates must include capital IME and DSH as applicable.

What are the federal requirements for MMP payment to Federally Qualified Health Centers (FQHCs)?

MMP payments to FQHCs should be no less than the sum of the following:

- 1) The level and amount of payment that the MMP would make for such services if the services were furnished by an entity providing similar services that was not an FQHC; and
- 2) The difference between 80% of the Medicare FFS rate for that FQHC and the Medicaid PPS amount for that FQHC, where the Medicaid PPS amount exceeds 80% of the Medicare rate; or the applicable 20% copayment (depending on the state's Medicaid FQHC cost sharing payment policy).

Can FQHCs claim Medicare wraparound payments for services delivered to MMP enrollees?

Yes, FQHCs can claim Medicare wraparound payments from the appropriate Medicare Administrative Contractor in the same manner they would for individuals enrolled in Medicare Advantage.

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 further adjusts the Medicare baseline amounts to account for the disproportionate share of bad debt attributable to dual eligible beneficiaries in Medicare FFS, compared to all Medicare FFS beneficiaries. As a result, providers will not bill Medicare separately for bad debt under the demonstrations. This is consistent with current CMS policy under which Medicare does not pay 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.

Are Medicare graduate medical education (GME) payments impacted?

Nothing about the Medicare GME payments changes as a result of the capitated financial alignment model. Medicare provides direct graduate medical education (DGME) and indirect

medical education (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 continue to receive all GME payments (DGME and IME) payments in the same manner in which they received those payments prior to the demonstrations. Beneficiaries in the demonstrations 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 generally do not include amounts related to DGME or IME payments.

How do Medicare disproportionate share hospital (DSH) payments work under the demonstrations?

As with Medicare bad debt, 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 cannot separately claim DSH payments for beneficiaries in the demonstrations. Beneficiaries in the demonstrations count toward a hospital's qualification for DSH payments in the same way as other beneficiaries in Medicare managed care.