NOTE TO: Medicare+Choice Organizations and Other Interested Parties

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2003 Medicare+Choice (M+C) Payment Rates

In accordance with Section 1853(b)(2) of the Social Security Act, we are notifying you of proposed changes in the M+C capitation rate methodology and risk adjustment methodology for CY 2003. Preliminary estimates of the various national per capita M+C growth percentages and the methodology changes for CY 2003 are also attached.

Based on these estimates, we project that the CY 2003 M+C payment rates for all counties will reflect the minimum 2 percent update. There are no changes in payment methodology for CY 2003, and we will continue paying M+C organizations on a fee-for-service basis for covered clinical trial items and services provided to their members. There are also no revisions to the risk adjustment methodology.

Comments or questions may be addressed to:
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In order to receive consideration prior to the March 1, 2002 announcement of M+C capitation rates, comments must be received by January 31, 2002.

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/ s /

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Attachments

Attachment 1

Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year (CY) 2003

Payments to Medicare+Choice (M+C) organizations are based on the highest of three amounts specified in statute for each payment area (generally a county): (1) a "blended rate" based on both national and local data; (2) a "floor" amount specified in statute; and (3) an amount representing 102 percent of the prior year's rate. Both the blended rate and the floor amount are annually adjusted based on the national per capita M+C growth percentage defined in Section 1853(c)(6) of the Social Security Act (the Act). In this notice, we provide preliminary estimates of the national per capita M+C growth percentages in CY 2003, and the increase in the floor payment rates in CY 2003. Each of these estimates reflects the components required by the BBA: an underlying trend change for CY 2003; and an adjustment for changes in the estimates of prior years' growth percentages. Note that CY 2003 is the first year for which the adjustment to the national M+C growth percentage specified in section 1853(c)(6)(B) of the Act will not be made.

The current estimate of the change in the national per capita M+C growth percentage for aged enrollees in CY 2003 is -2.9 percent. This estimate reflects an underlying trend change for CY 2003 in per capita costs of 0.9 percent and an adjustment for the fact that the current estimate of prior years' cumulative aged M+C growth percentages (for CYs 1998 through 2002) is 3.8 percent lower than the estimates actually used in calculating the CY 2002 capitation rate book that was published March 1, 2001 (as required by Section 1853(c)(6)(C) of the Act).

The table below shows the increases in the national per capita growth percentages for the aged, disabled, ESRD, and the combined aged + disabled.

The preliminary estimate of the floor for aged beneficiaries in CY 2003 is $547.54 for any area in an MSA within the 50 States and the District of Columbia with a population of more than 250,000, and $495.39 for all other areas within the 50 States. In both cases this represents a 1.0 percent decrease over the respective CY 2002 floors of $553.04 and $500.37. As with the estimate of the national per capita M+C growth percentage, this estimate reflects an underlying trend change for CY 2003 in per capita costs of 0.9 percent. The total change for the floors includes an adjustment of -1.9 percent for revised estimates of prior years' aged M+C growth percentages only for 2002, since legislation reestablished the base floor amounts in 2001. Since the floor amounts are estimated to drop for CY 2003, counties that were paid based on the floor amount in CY 2002 will receive a 2 percent increase over that amount for CY 2003.

The following tables summarize the estimates for the change in the national per capita M+C growth percentage and the floor increase.

National Per Capita Growth Percentage (for Blend)

	Aged	Disabled	ESRD	Aged+Disabled
2003 Trend Change	0.9%	0.9%	2.1%	0.9%
Revision to CY 1998 Estimate	0.0%	3.1%	-8.2%	0.3%
Revision to CY 1999 Estimate	0.7%	0.1%	1.2%	0.7%
Revision to CY 2000 Estimate	-1.1%	-1.9%	-2.8%	-1.2%
Revision to CY 2001 Estimate	-1.6%	-1.9%	14.2%	-1.7%
Revision to CY 2002 Estimate	-1.9%	-1.9%	-5.2%	-1.9%
Total Change	-2.9%	-1.8%	-0.1%	-2.8%

National Per Capita Growth Percentage (for Floor)

	Aged	Disabled	ESRD	Aged+Disabled
2003 Trend Change	0.9%	0.9%	2.1%	0.9%
Revision to CY 2002 Estimate	-1.9%	-1.9%	-5.2%	-1.9%
Total Change	-1.0%	-1.0%	-3.2%	-1.0%

Note: The above percentages are multiplicative not additive.

These estimates are preliminary and could change before the final rates are announced on March 1, 2002. Further details on the derivation of the national per capita M+C growth percentage will also be presented in the March 1 announcement.

Attachment 2

Changes in Methodology Since Calendar Year (CY) 2002 Rates

A. Risk adjustment system

ICD-9 code modifications. There are no revisions to the Principal Inpatient-Diagnostic Cost Group (PIP-DCG) risk adjustment methodology for CY 2003. However, there are additions and modifications to the ICD-9 diagnosis codes upon which the PIP-DCG risk adjustment payment model will be based in CY 2003. A new look-up table reflecting the new 2002 ICD-9 diagnosis codes (which were effective October 1, 2001) can be found on the CMS website at http://cms.hhs.gov/healthplans/rates/. The lookup tables will be posted on the CMS website on or before January 15, 2002. Public use payment software for calendar year 2003 will be available on the same website on or before March 1, 2002.

Encounter data submission deadlines. Inpatient encounters with discharge dates of July 1, 2001 through June 30, 2002 that are received at CMS by September 27, 2002 will be incorporated into the risk factor that is used for making payments to M+C organizations during CY 2003. M+C organizations should submit these encounters no later than September 6, 2002 to ensure that there is sufficient time to complete the processing of these data.

If M+C organizations receive inpatient encounters after September 6, 2002, they may submit the late encounter data to CMS, and the data will be processed under the reconciliation process set forth in Operational Policy Letter 2000.126 or Chapter 7 (Section 210) of the Medicare Managed Care Manual found at http://www.cms.hhs.gov/manuals/116%5Fmmc/mc86c07.asp#Sect210. The deadline for submission of all late inpatient encounter data with discharge dates of July 1, 2001 through June 30, 2002 is September 30, 2003. No encounters from this period will be accepted by CMS after September 30, 2003.

After the payment year is completed, CMS will recalculate risk factors for 2003 for individuals for whom late encounters have been submitted. Then we will determine any payment adjustments that are required. This reconciliation will be undertaken during 2004 and will be a one-time reconciliation for payment year 2003.

B. Risk adjustment transition

Section 603 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amends Section 1853(a)(3)(C) of the Act (amended by Section 511 of the Balanced Budget Refinement Act (BBRA)) by specifying that for CY 2003 the risk adjustment method will be used to adjust 10 percent of the rate. Under BIPA, therefore, CMS will continue to apply the transition percentages applied in CYs 2000, 2001 and 2002: 90 percent demographic method and 10 percent risk-adjustment method.

Payment amounts for each enrollee are separately determined using the demographic method and the PIP-DCG risk adjustment method. These separate payment amounts are then blended according to the percentages for the transition year, which under BIPA are 90/10 for CYs 2000 through 2003.

C. Extra payment in recognition of the costs of successful outpatient congestive heart failure care

CHF extra payment initiative. CMS will make extra payments to M+C organizations in recognition of the costs of successful outpatient congestive heart failure care. This extra payment will be made in CY 2003 to M+C organizations that qualify on the basis of attaining threshold levels on both of two quality indicators, referenced at the end of section C. Consistent with the risk adjustment payment methodology, extra payment will only be made for those enrollees in an M+C organization who are identified in CMS's records as having had the required principal inpatient discharge diagnosis of CHF and who are enrolled in the M+C organization at the beginning of each payment month in 2003.

More detailed information on the CHF extra payment is contained in OPL 2000.129 and Chapter 7 of the Medicare Managed Care Manual found at http://www.cms.hhs.gov/manuals/116%5Fmmc/mc86c07.asp. Note that if an enrollee with a CHF hospitalization disenrolls from an M+C organization that qualified for extra payment and then enrolls in an M+C organization that does not qualify for extra payment, the new M+C organization would not receive the extra payment for that enrollee.

Payment for Qualifying M+C organizations. CMS takes three reporting years into account when assessing whether an M+C organization qualifies for an extra payment for CHF enrollees in 2003: July 1, 1999 to June 30, 2000; July 1, 2000 to June 30, 2001; and July 1, 2001 to June 30, 2002. M+C organizations are paid for a qualifying CHF diagnosis under several scenarios, listed below. Scenario (1) describes the "normal" payment CMS makes under the PIP-DCG methodology for a principal inpatient diagnosis of CHF during the reporting year. Scenarios 2 and 3 describe special conditions under which M+C organizations may qualify for the CHF extra payment.

(1) In 2003, M+C organizations with enrollees hospitalized with a greater than one-day stay for a principal diagnosis of CHF between July 1, 2001 and June 30, 2002 will receive the regular PIP-DCG-16 amount, at the phased-in level of 10 percent under the risk adjustment payment methodology.

(2) Under the extra payment provision for 2003, qualifying M+C organizations with an enrollee hospitalized with a qualifying CHF diagnosis between July 1, 1999 and June 30, 2000 or July 1, 2000 and June 30, 2001 who did not have a hospital stay during the July 1, 2001 to June 30, 2002 period will receive an extra payment for the CHF hospitalization incurred during either July 1, 1999 to June 30, 2000, or July 1, 2000 to June 30, 2001, based on the CHF extra payment formula described below after (3), at the phased-in level of 10 percent under the risk adjustment payment methodology.

(3) Under the extra payment provision for 2003, qualifying M+C organizations with an enrollee hospitalized with a qualifying CHF diagnosis between July 1, 1999 and June 30, 2000 or July 1, 2000 to June 30, 2001 who also had a discharge for another diagnosis during the period July 1, 2001 to June 30, 2002 will receive the **greater of the two possible payments**. Two examples are provided below:

(a) If an enrollee had a qualifying discharge for CHF between July 1, 1999 and June 30, 2000 or between July 1, 2000 and June 30, 2001 and also had a discharge during the period July 1, 2001 to June 30, 2002 that fell into PIP-DCG 8 or higher (which would also include a diagnosis of CHF), the M+C organization will receive payment for the qualifying diagnosis incurred during July 1, 2001 to June 30, 2002, because that payment would be greater than the payment for the CHF diagnosis that occurred during the July 1, 1999 and June 30, 2000 or July 1, 2000 to June 30, 2001 period.

(b) If an enrollee had a qualifying discharge for CHF between July 1, 1999 and June 30, 2000 or between July 1, 2000 and June 30, 2001, and also had a discharge during the period July 1, 2001 to June 30, 2002 that fell into PIP-DCG 7 or below, the M+C organization will receive payment for the CHF diagnosis incurred during either July 1, 1999 to June 30, 2000 or July 1, 2000 to June 30, 2001, because that payment would be greater than the payment for the diagnosis that occurred during the July 1, 2001 to June 30, 2002 period.

The extra payments made to qualifying M+C organizations for CHF discharges between July 1, 1999 and June 30, 2000 or between July 1, 2000 and June 30, 2001 will be based minimally on approximately one-third of the full PIP-DCG-16 amount, subject to the 10 percent risk adjustment transition schedule. Given the payment blend of 90 percent demographic payment and 10 percent risk-adjusted payment for 2003, the additional payments to qualifying M+C organizations would be based approximately on the following formula: 0.33 (representing one-third of PIP-DCG 16 amount) X 2.438 (representing the PIP-DCG-16 risk factor) X 0.10 (representing the payment blend in 2003 of the risk adjusted county rate). (In addition to this PIP-DCG risk factor calculation for extra payment, the enrollee's risk score also would include the appropriate base factor and, if relevant, Medicaid and previously disabled factors.)

Section A of Attachment 2 (above) addresses the deadlines for receipt of inpatient encounter data between July 1, 2001 and June 30, 2002. Encounters for CHF discharges from July 1, 2001 to June 30, 2002 that are submitted after September 30, 2002 will be incorporated into a reconciliation conducted during 2004 for payments made to M+C organizations in 2003. For further information on reconciliation for risk adjustment, see OPL 2000.126 or Chapter 7 (Section 210) of the Medicare Managed Care Manual found at http://www.cms.hhs.gov/manuals/116%5Fmmc/mc86c07.asp#Sect210.

Quality indicators for extra payment. The two quality indicators and thresholds are the same as for extra payment in 2002 and may be found in Exhibit 6 of Chapter 7 in the Medicare Managed Care Manual, found at

http://www.cms.hhs.gov/manuals/116%5Fmmc/mc86c07exhibit6.asp. As in 2002, M+C organizations must meet or exceed the threshold level on both quality indicators to qualify for the extra payment.

D. Treatment of Certain Demonstrations

There are currently several demonstration projects that involve the provision of care to special populations, such as the frail elderly. Such projects offer enhanced benefit packages and include other unique features designed to meet the special needs of these populations. These projects are currently paid based on adjustments to M+C capitation rates that are specific to each demonstration model. They include Evercare, the Social Health Maintenance Organization (SHMO) demonstration, the Program of All-inclusive Care for the Elderly (PACE) demonstration, the Minnesota Senior Health Options and Minnesota Disability Health Options projects, and the Wisconsin Provider Partnership demonstration.

We are continuing to analyze refinements to the risk adjustment methodology for these demonstration projects. To support these analyses, we continue to collect hospital inpatient encounters and will collect ambulatory data from these projects consistent with the collection of these data for the Medicare+Choice program. For some demonstration sites that serve special populations we have also been collecting functional status information via the Health Outcomes Survey. For others, we are developing a special survey instrument to collect information that could inform a risk adjustment approach for frail populations. However, the ongoing analyses to support risk adjustment for these projects will not be completed in time to apply any refinements in CY 2003.

The Evercare demonstration is currently scheduled to end December 31, 2002. Pending a decision on an extension of the waivers, we intend to maintain the current payment approach for Evercare.

BIPA extended the SHMO demonstration until 30 months after the Secretary submitted a report to Congress that included a plan to transition the SHMO demonstration into an option under the Medicare+Choice program. The report to Congress was submitted on February 1, 2001. Therefore, the current SHMO payment methodology will be continued in 2003.

PACE demonstrations in 2003 will include the current non-profit organizations and new for-profit entities. Some of the current PACE demonstrations have transitioned to program status, and the remainder are scheduled to transition by November 24, 2003. The present PACE payment approach will apply to both current and new PACE demonstration sites in 2003.

We will also maintain the present payment approaches for organizations participating in the Minnesota Senior Health Options and Minnesota Disability Health Options projects and the Wisconsin Partnership demonstrations in 2003.

E. Treatment of the PACE program:

We are still investigating refinements to the risk adjustment approach that account for the frailty of the PACE population. Therefore, payments to PACE providers will continue to be adjusted under the existing PACE payment adjustment methodology.