# Cal MediConnect
# CY 2016 Final Medicare Rate Report
# January 27, 2016

The State of California, in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing the updated Medicare component of the CY 2016 rates for the California Demonstration to Integrate Care for Dual Eligible Beneficiaries, also known as Cal MediConnect.

The general principles of the rate development process for the Demonstration have been outlined in the three-way contract between CMS, the State of California, and the Prime Contractor Plans.

Included in this report are the final CY 2016 Medicare county base rates, updated to reflect an upward adjustment to better align payments with Medicare fee-for-service costs for full benefit dual eligible beneficiaries. The CY 2016 Medicaid component of the rates remains under development. An updated report will be provided when the Medicaid rates are finalized.

## I. Components of the Capitation Rate

CMS and the State of California will each contribute to the global capitation payment. CMS and the State of California will each make monthly payments to Prime Contractor Plans for their components of the capitated rate. Prime Contractor Plans will receive three monthly payments for each enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services, one amount from CMS reflecting coverage of Medicare Part D services, and a third amount from the State of California reflecting coverage of Medicaid services.

The Medicare Parts A/B rate component will be risk adjusted using the prevailing Medicare Advantage CMS-HCC and CMS HCC-ESRD models. The Medicare Part D payment will be risk adjusted using the Part D RxHCC model. California uses a single, blended payment rate that weights the relative risk of the population enrolled in each Prime Contractor Plan for the purpose of risk adjusting the Medicaid payment.

Section II of this report provides information on the Medicaid component of the capitation rate. Section III includes the Medicare Parts A/B and Medicare Part D components of the rate. Section IV includes information on the savings percentages and quality withholds.

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## II. Medicaid Component of the Rate – CY 2016

Pending

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## III. Medicare Components of the Rate – CY 2016

### Medicare A/B Services

CMS has developed baseline spending (costs absent the Demonstration) for Medicare A and B services using estimates of what Medicare would have spent on behalf of the enrollees absent the Demonstration. With the exception of specific subsets of enrollees as noted below, the Medicare baseline for A/B services is a blend of the Medicare Fee-for-Service (FFS) Standardized County Rates, as adjusted below, and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population that would otherwise be enrolled in each program in the absence of the Demonstration. The Medicare Advantage baseline spending includes costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

Both baseline spending and payment rates under the Demonstration for Medicare A/B services are calculated as PMPM standardized amounts for each Demonstration county. Except as otherwise noted, the Medicare A/B portion of the baseline is updated annually based on the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage and Part D rate announcement, and Medicare Advantage bids (for the applicable year or for prior years trended forward to the applicable year) for products in which potential Demonstration enrollees would be enrolled absent the Demonstration.

Medicare A/B Component Payments: CY 2016 Medicare A/B Baseline County rates are provided below.

The rates represent the weighted average of the CY 2016 FFS Standardized County Rates, updated to incorporate the adjustment noted below, and the Medicare Advantage projected payment rates for CY 2016 based on the expected enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to the demonstration start at the county level. The rates weight the FFS and Medicare Advantage components at the same weighting used to set the 2015 rates. The Medicare Advantage component of the 2015 rate has been updated for CY 2016 based on Medicare Advantage trends.

The FFS component of the CY 2016 Medicare A/B baseline rate has been updated to better align Cal MediConnect Plan payments with Medicare fee-for-service costs, by offsetting underprediction in the CMS-HCC risk adjustment model for full benefit dual eligible beneficiaries. This 9.16% upward adjustment applies to the Medicare A/B FFS rate component for CY 2016 only.

The FFS component of the CY 2016 Medicare A/B baseline rate has been updated to reflect a 1.84% upward adjustment to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS (in the absence of the Demonstration). This 1.84% adjustment applies for CY 2016 and will be updated for subsequent years of the Demonstration.

Coding Intensity Adjustment: CMS annually applies a coding intensity factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for CY 2016 in Medicare Advantage is 5.41%. For 2016, CMS will apply the full prevailing Medicare Advantage coding intensity adjustment to the rates for Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. There will be no upward adjustment to the Medicare A/B baseline rates to offset this reduction in the risk scores for these six counties.

In CY 2016 CMS will apply a coding intensity adjustment to the Medicare A/B FFS rates for Orange County based on the anticipated proportion of Demonstration enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in in Orange County as of September 30, 2015. CMS' calculations for Orange County take into account planned passive enrollment and rates of opt-out and engagement in the passive enrollment process. For Orange County, the applicable 2016 coding intensity adjustment is 0.14%.

For the Orange County rates, operationally, due to systems limitations, CMS will still apply the full coding intensity adjustment factor to the risk scores but has increased the FFS component of the Medicare A/B baseline for non-ESRD beneficiaries and the Medicare A/B baseline for beneficiaries with an ESRD status of functioning graft to offset this (by increasing these amounts by a corresponding percentage). The coding intensity factor will not be applied to risk scores for enrollees with an ESRD status of dialysis or transplant during the Demonstration, consistent with Medicare Advantage policy.

After 2016, CMS plans to apply the full prevailing Medicare Advantage coding intensity adjustment for Orange County.

Impact of Sequestration: 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 the Medicare components of the integrated rate. Therefore, under Cal MediConnect CMS will reduce non-exempt portions of the Medicare components of the integrated rate by 2%, as noted in the sections below.

Default Rate: The default rate will be paid when a beneficiary's address on record is outside of the service area. The default rate is specific to each Prime Contractor Plan and is calculated using an enrollment-weighted average of the rates for each county in which the Prime Contractor Plan participates.

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| **2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1] (Los Angeles, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara Counties)** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **County** | **2016 Published FFS Standardized County Rate** | **2016 Initial Medicare A/B FFS Baseline** (increased to reflect CY 2016 risk adjustment model update) | **2016 Final Medicare A/B FFS Baseline** (updated by 2016 bad debt adjustment) | **2016 Final Medicare A/B Baseline** (incorporating Final Medicare A/B FFS baseline and Medicare Advantage component) | **2016 Medicare A/B Baseline PMPM, Minimum Savings Percentage Applied** (after application of 2% minimum savings percentage) | **2016 County-Specific Interim Savings Percentages** | **2016 Medicare A/B Baseline PMPM, Interim Savings Percentage Applied** (after application of county-specific interim savings percentages) | **2016 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold) |
| Los Angeles | $924.80 | $1,009.49 | $1,028.06 | $1,006.67 | $986.54 | -1.50% | $971.43 | $952.01 |
| Riverside | 830.72 | 906.79 | 923.48 | 890.97 | 873.15 | -1.50% | 859.79 | 842.59 |
| San Bernardino | 817.15 | 891.98 | 908.39 | 874.13 | 856.65 | -1.50% | 843.53 | 826.66 |
| San Diego | 812.65 | 887.07 | 903.39 | 877.99 | 860.43 | -1.50% | 847.26 | 830.31 |
| San Mateo | 810.89 | 885.15 | 901.44 | 833.61 | 816.94 | -0.33% | 814.19 | 797.91 |
| Santa Clara | 820.39 | 895.52 | 912.00 | 910.73 | 892.52 | -1.45% | 879.31 | 861.73 |

[1] Rates do not apply to beneficiaries with End-Stage Renal Disease (ESRD) or those electing the Medicare hospice benefit. See Section IV for information on savings percentages.

Note: For CY 2016 CMS will apply the full prevailing Medicare Advantage coding intensity adjustment of 5.41% for Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties.

The Medicare A/B PMPMs above will be risk adjusted at the beneficiary level using the prevailing CMS-HCC risk adjustment model.

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| **2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[2] (Orange County)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **County** | **2016 Published FFS Standardized County Rate** | **2016 Initial Medicare A/B FFS Baseline** (increased to reflect CY 2016 risk adjustment model update) | **2016 Updated Medicare A/B FFS Baseline** (updated by 2016 bad debt adjustment) | **2016 Final Medicare A/B FFS Baseline** (increased to offset application of coding intensity adjustment factor in 2016[3]) | **2016 Final Medicare A/B Baseline** (incorporating Final Medicare A/B FFS baseline and Medicare Advantage component) | **2016 Medicare A/B Baseline PMPM, Minimum Savings Percentage Applied** (after application of 2% minimum savings percentage) | **2016 County-Specific Interim Savings Percentages** | **2016 Medicare A/B Baseline PMPM, Interim Savings Percentage Applied** (after application of county-specific interim savings percentages) | **2016 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold) |
| Orange | $868.70 | $948.25 | $965.70 | $1019.42 | $968.97 | $949.59 | -1.50% | $935.06 | $916.36 |

[2] Rates do not apply to beneficiaries with End-Stage Renal Disease (ESRD) or those electing the Medicare hospice benefit. See Section IV for information on savings percentages.

[3] Note: For Orange County, for CY 2016 CMS has calculated and applied a county-specific coding intensity adjustment (the modified CY 2016 coding intensity adjustment factor) proportional to the anticipated proportion of Demonstration Enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2015. Operationally, due to systems limitations, CMS will still apply the coding intensity adjustment factor to the risk scores but has increased the FFS component of the Medicare A/B baseline for non-ESRD beneficiaries to offset this. Specifically, CMS has increased the Medicare A/B baseline by a corresponding percentage; the CY 2016 Medicare FFS A/B Baseline is divided by [(1-the standard CY 2016 coding intensity adjustment factor of 5.41% minus the county-specific modified CY 2016 coding intensity adjustment factor of 0.14%] to determine the CY 2016 Final Medicare FFS A/B Baseline for the Orange County.

The Medicare A/B PMPMs above will be risk adjusted at the beneficiary level using the prevailing CMS-HCC risk adjustment model.

Beneficiaries with End-Stage Renal Disease (ESRD): Separate Medicare A/B baselines and risk adjustment models apply to enrollees with ESRD. The Medicare A/B baselines for beneficiaries with ESRD vary by the enrollee's ESRD status: dialysis, transplant, and functioning graft, as follows:

- **Dialysis**: For enrollees in the dialysis status phase, the Medicare A/B baseline is the CY 2016 California ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2016 ESRD dialysis state rate for California is $7,677.02 PMPM; the updated CY 2016 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $7,523.48 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.
- **Transplant**: For enrollees in the transplant status phase (inclusive of the 3-months starting with the transplant), the Medicare A/B baseline is the CY 2016 California ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2016 ESRD dialysis state rate for California is $7,677.02 PMPM; the updated CY 2016 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $7,523.48 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.
- **Functioning Graft:** For enrollees in the functioning graft status phase (beginning at 4 months post-transplant) the Medicare A/B baseline is the Medicare Advantage 3.5% bonus county rate/benchmark (see table below). This Medicare A/B component will be risk adjusted using the prevailing HCC-ESRD functioning graft risk adjustment model.

A savings percentage will not be applied to the Medicare A/B baseline for enrollees with ESRD (inclusive of those enrollees in the dialysis, transplant and functioning graft status phases).

| **2016 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County (Los Angeles, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara Counties)** | | |
|---|---|---|
| **County** | **2016 3.5% Bonus County Rate (Benchmark)** | **2016 Sequestration-Adjusted Medicare A/B Baseline**<br><br>(after application of 2% Sequestration reduction) |
| Los Angeles | $910.93 | $892.71 |
| Riverside | 838.69 | 821.92 |
| San Bernardino | 823.01 | 806.55 |
| San Diego | 841.09 | 824.27 |
| San Mateo | 839.27 | 822.48 |
| Santa Clara | 858.02 | 840.86 |

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| **2016 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County (Orange County)** | | | |
|---|---|---|---|
| **County** | **2016 3.5% Bonus County Rate (Benchmark)** | **2016 Final Medicare A/B PMPM Baseline** (increased to offset application of coding intensity adjustment factor in 2016)* | **2016 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction) |
| Orange | $855.67 | $903.27 | $885.20 |

* Note: For Orange County, for CY 2016 CMS has calculated and applied a county-specific coding intensity adjustment (the modified CY 2016 coding intensity adjustment factor) proportional to the anticipated proportion of Demonstration Enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2015. Operationally, due to systems limitations, CMS will still apply the coding intensity adjustment factor to the risk scores but has increased the FFS component of the Medicare A/B baseline for non-ESRD beneficiaries to offset this. Specifically, CMS has increased the Medicare A/B baseline by a corresponding percentage; the CY 2016 Medicare FFS A/B Baseline is divided by [(1- the standard CY 2016 coding intensity adjustment factor of 5.41% minus the county-specific modified CY 2016 coding intensity adjustment factor of 0.14%.)] to determine the CY 2016 Final Medicare FFS A/B Baseline for the Orange County.

Beneficiaries Electing the Medicare Hospice Benefit: If an enrollee elects to receive the Medicare hospice benefit, the enrollee will remain in the Demonstration but will obtain the hospice services through the Medicare FFS benefit. The Prime Contractor Plans will no longer receive the Medicare A/B payment for that enrollee. Medicare hospice services and all other Original Medicare services will be paid under Medicare FFS. The Prime Contractor Plans and providers of hospice services will be required to coordinate these services with the rest of the enrollee's care, including with Medicaid and Part D benefits and any additional benefits offered by the Prime Contractor Plans. The Prime Contractor Plans will continue to receive the Medicare Part D and Medicaid payments, for which no changes will occur.

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**Medicare Part D Services**

The Part D plan payment is the risk adjusted Part D national average monthly bid amount (NAMBA) for the payment year, adjusted for payment reductions resulting from sequestration applied to the non- premium portion of the NAMBA. The non-premium portion is determined by subtracting the applicable regional Low-Income Premium Subsidy Amount from the risk adjusted NAMBA. To illustrate, the NAMBA for CY 2016 is $64.66 and the CY 2016 Low-Income Premium Subsidy Amount for California is $31.05. Thus, the updated California Part D monthly per member per month payment for a beneficiary with a RxHCC risk score applicable for CY 2016 is $63.99. This amount incorporates a 2% sequestration reduction to the non-premium portion of the NAMBA.

CMS will pay an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be 100% cost reconciled after the payment year has ended. These prospective payments will be the same for all counties, and are shown below.

- California low income cost-sharing: $103.31 PMPM
- California reinsurance: $77.09 PMPM

The low-income cost sharing and reinsurance subsidy amounts are exempt from mandatory payment reductions under sequestration.

A savings percentage will not be applied to the Part D component of the rate. Part D payments will not be subject to a quality withhold.

**Additional Information*:*** More information on the Medicare components of the rate under the Demonstration may be found online at: Joint Rate-Setting Process for the Capitated Financial Alignment Model (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf)

## IV. Savings Percentages and Quality Withholds

### Savings Percentages

One of the components of the capitated financial alignment model is the application of aggregate savings percentages to reflect savings achievable through the coordination of services across Medicare and Medicaid. This is reflected in the rates through the application of aggregate savings percentages to both the Medicaid and Medicare A/B components of the rates.

CMS and California established composite minimum savings percentages for each year of the Demonstration, as shown in the table below. The savings percentage will be applied to the Medicaid and Medicare A/B components of the rates, uniformly to all population groups, unless otherwise noted in this report. The savings percentage will not be applied to the Part D component of the joint rate.

| Year | Calendar dates | Minimum savings percentage* |
|---|---|---|
| Demonstration Year 1 | April 1, 2014 through December 31, 2015 | 1% |
| Demonstration Year 2 | January 1 through December 31, 2016 | 2% |
| Demonstration Year 3 | January 1 through December 31, 2017 | 4% |

*See additional detail below

### Limited Risk Corridors

Limited risk corridors will be established for all Demonstration Years. The Demonstration will utilize a limited down-side risk corridor and a limited up-side risk corridor to include all Medicare Parts A and B and Medicaid eligible costs. The corridors will be applied on a Prime contract specific basis and will be reconciled after application of any risk adjustment methodologies and any other adjustments. Risk corridors will be reconciled as if the Prime Contractor Plan had received the full quality withhold payment. The three-way contract includes further details on how risk corridors are operationalized.

- Limited down-side risk corridor:
  - To reflect the underlying characteristics of the eligible population and differences between counties, initial payments will be made on a county specific basis and reconciled based on plan costs within the limits specified below.
  - The application of county-specific interim savings percentages in the table below establishes the initial capitation rates for purposes of this risk corridor calculation.

| | Demonstration Year 1 | Demonstration Year 2 | Demonstration Year 3 |
|---|---|---|---|
| **Minimum Savings Percentages** | **1.00%** | **2.00%** | **4.00%** |
| **County Specific Interim Savings Percentages: the sum of the minimum savings percentages and the county-specific addition** | | | |
| **Los Angeles** | + 0.00% | + 1.50% | + 1.50% |
| **Orange** | + 0.42% | + 1.50% | + 1.50% |
| **Riverside** | + 0.22% | + 1.50% | + 1.14% |
| **San Bernardino** | + 0.44% | + 1.50% | + 1.50% |
| **San Diego** | + 0.23% | + 1.50% | + 1.10% |
| **San Mateo** | + 0.47% | + 0.33% | + 0.00% |
| **Santa Clara** | + 0.23% | + 1.45% | + 0.95% |

  - If the Prime Contractor Plan costs exceed the initial capitation rates, excluding both Part D payments and costs, Medicare and Medicaid will reimburse the Prime Contractor Plan 67% of the costs above the initial capitation rates, provided that total federal/State payments to the Prime Contract Plan (including initial capitation payment amounts and risk corridor payment amounts) cannot exceed the total capitation amounts that would have been paid by the federal government/State with the minimum savings percentages in applied to the rates.
  - The Medicare and Medicaid contributions to the reconciled capitated payments will be in proportion to their contribution to the initial capitated rates, not including Part D. Therefore, payment will come in two separate transactions.

- Limited up-side risk corridor:
  - If the Prime Contractor Plan costs, excluding both Part D payments and costs, are lower than the initial capitation rates, this risk corridor will be triggered
  - The risk corridor will contain three bands. The percentages specified below are expressed as a percentage of the combined baseline amount for Medicaid and Medicare Part A and B.
  - The first band will be equal to the difference between the minimum savings percentage and the county specific savings percentage identified in Figure 6-5. In this band, Prime Contractor Plans will retain 100% of the excess. If a plan is in a county where the interim savings percentage is equal to the minimum savings percentage for that Demonstration year, the first band will be the difference between the minimum savings percentage and the following maximum savings percentages: 1.5% in Demonstration Year 1, 3.5% in Demonstration Year 2, and 5.5% in Demonstration Year 3.
  - The second band is the same size as the first band. It starts from the upper limit

of the first band and is the equivalent amount of percentage points. In this band, Medicare and Medicaid would share in 50 percent of plan savings and the Prime Contractor Plan would share in the excess 50 percent.

- The final band will be all amounts above the upper limit of the second band. In this band, the Prime Contractor Plan will retain 100% of the excess.

- Medicare and Medicaid recoupments in the risk corridor will be in proportion to their contribution to the initial capitated rates, not including Part D, and therefore will require separate recoupment processes.

**Quality Withhold**

In Demonstration Year 2, a 2% quality withhold will be applied to the Medicaid and Medicare A/B components of the rate. The quality withhold will increase to 3% in Demonstration Year 3. More information about the quality withhold methodology for Demonstration Year 1 is available at: Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes (DY 1) (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf). Updates to reflect any changes for Demonstration Year 2 are forthcoming.