

Cal MediConnect CY 2018 Final Medicare Rate Report September 15, 2017

The Centers for Medicare & Medicaid Services (CMS), in conjunction with the State of California, is releasing the final Medicare component of the CY 2018 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 2018 Medicare county base rates. The California Medicaid component of the rate will be released at a later date. An updated report will be provided when the 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, with an outlier adjustment for beneficiaries in Los Angeles and Orange Counties as noted in Section III. 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 2018

Pending

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III. Medicare Components of the Rate – CY 2018

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 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 2018 Medicare A/B Baseline County rates are provided below.

The rates represent the weighted average of the CY 2018 FFS Standardized County Rates, updated to incorporate the adjustment noted below, and the Medicare Advantage projected payment rates for CY 2018 based on the expected enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to the demonstration at the county level.

Bad Debt Adjustment: The FFS component of the CY 2018 Medicare A/B baseline rate has been updated to reflect a 1.77% 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).

Outlier Adjustment: Beginning January 1, 2017, CMS will also make an outlier adjustment for Medicare A/B payments for non-ESRD beneficiaries served by the contractor in Los Angeles and Orange Counties. This adjustment is limited to those Cal MediConnect members who newly enroll in the Cal MediConnect demonstration as of January 1, 2017, or later; were in Medicare long-term institutional (LTI) status at the time of their Cal MediConnect enrollment; and were in Medicare FFS at the time of their Cal MediConnect enrollment. This adjustment will reflect the historical ratio of actual Medicare A/B FFS costs for the LTI population in these counties to the predicted costs for this population, based on the standardized FFS county rates and the HCC risk adjustment model. This payment adjustment will be made retroactively after the end of each demonstration year, beginning in CY 2017 and going forward. The outlier adjustment is a multiplicative factor equal to 95% of 1 (one) subtracted from the ratio of actual costs to predicted costs for people in the “LTI” category for

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a baseline period. Specifically, the adjustment will equal: (the outlier adjustment percentage of 95%) times (the underprediction figure) times (the standardized FFS county rate for the CY 2018 for the applicable county) times (the average final HCC risk score for the CY 2018 for the population meeting the required criteria) times (the number of member months for CY 2018 associated with this population).

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 2018 in Medicare Advantage is 5.91%. For 2018, CMS will apply the full prevailing Medicare Advantage coding intensity adjustment.

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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2018 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County¹							
County	2018 Published FFS Standardized County Rate	2018 Medicare A/B FFS Baseline (updated by 2018 bad debt adjustment)	2018 Medicare A/B Baseline (incorporating Medicare A/B FFS baseline and Medicare Advantage component)	2018 Medicare A/B Baseline PMPM, Minimum Savings Percentage Applied (after application of minimum savings percentage)	2018 County-Specific Savings Percentages	2018 Medicare A/B Baseline PMPM, Savings Percentage Applied (after application of county-specific savings percentages)	2018 Medicare A/B PMPM Payment (2% sequestration reduction applied and prior to quality withhold)
Los Angeles	\$944.68	\$961.40	\$950.80	\$912.78	-1.50%	\$898.51	\$880.54
Orange	890.45	906.21	883.78	848.43	-1.50%	835.17	818.47
Riverside	866.56	881.90	864.67	830.09	-1.14%	820.23	803.83
San Bernardino	828.56	843.23	835.46	802.04	-1.50%	789.51	773.72
San Diego	850.05	865.10	856.33	822.09	-1.10%	812.66	796.41
San Mateo	853.96	869.08	846.15	812.30	0.00%	812.30	796.06
Santa Clara	864.28	879.58	878.75	843.60	-0.95%	835.25	818.55

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. Rates do not reflect the retroactive outlier adjustment for LTI enrollees noted above.

Note: For CY 2018 CMS will apply the full prevailing Medicare Advantage coding intensity adjustment of 5.91%.

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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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 2018 California ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2018 ESRD dialysis state rate for California is \$7,753.97 PMPM; the updated CY 2018 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,598.89 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 2018 California ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2018 ESRD dialysis state rate for California is \$7,753.97 PMPM; the updated CY 2018 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,598.89 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).

2018 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	2018 3.5% bonus County Rate (Benchmark)	2018 Sequestration-Adjusted Medicare A/B Baseline (after application of 2% Sequestration reduction)
Los Angeles	\$930.51	\$911.90
Orange	877.09	859.55
Riverside	875.23	857.73
San Bernardino	886.56	868.83
San Diego	879.80	862.20
San Mateo	883.85	866.17
Santa Clara	872.92	855.46

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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.

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 2018 is \$57.93 and the CY 2018 Low-Income Premium Subsidy Amount for California is \$35.51. Thus, the updated California Part D monthly per member per month payment for a beneficiary with a 1.0 RxHCC risk score applicable for CY 2018 is \$57.48. 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: \$107.52 PMPM
- California reinsurance: \$84.55 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: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf>

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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%
Demonstration Year 4	January 1 through December 31, 2018	4%
Demonstration Year 5	January 1 through December 31, 2019	4%

* We anticipate effectuating a demonstration extension to extend the demo through December 31, 2019 with the Demonstration Year 3 savings percentage continued for Demonstration Years 4 and 5. County-specific savings percentages for Demonstration Years 4-5 are provided below.

County-specific Savings Percentages

County	Demonstration Years 4-5
Los Angeles	+ 1.50%
Orange	+ 1.50%
Riverside	+ 1.14%
San Bernardino	+ 1.50%
San Diego	+ 1.10%
San Mateo	+ 0.00%
Santa Clara	+ 0.95%

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Quality Withhold

In Demonstration Year 1, a 1% quality withhold will be applied to the Medicaid and Medicare A/B components of the rate. 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 Years 3-5. CMS strongly encourages Prime Contractor Plans to review the DY 4 methodology and plan ahead to maximize the chances of fully recouping the withheld amounts.

More information about the DY 2 and 3 quality withhold methodology (which will also apply for DY 4 and 5) is available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidance042916.pdf>.