

Cal MediConnect CY 2014 Final Joint Medicare-Medicaid Rate Report October 2017

The State of California (California), in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing final calendar year (CY) 2014 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, California, and the Prime Contractor Plans.

Included in this report are final Medicare county base rates and information supporting the estimation of risk adjusted Medicare components of the rate. Also included is the CMS-approved Medicaid component of the rate, subject to a series of amendments highlighted in Section II and identified in Attachment A. This report containing the final rates supersedes all previous reports released for CY 2014.

I. Components of the Capitation Rate

CMS and California will each contribute to the global capitation payment. CMS and 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 California reflecting coverage of Medicaid services.

The Medicare Parts A/B rate component will be risk adjusted using the 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.

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II. California Medicaid Component of the Rate

Base Rate Development

California has developed actuarially sound capitation rate ranges for full-benefit dual-eligible beneficiaries age 21 or older in Cal MediConnect for the rating period of April 1, 2014 through December 31, 2014 (CP 2014). The base data utilized was primarily historical Fee-for-Service (FFS) claims data and managed care encounter data for state fiscal year 2009-10 (SFY 2009-10) and SFY 2010-11, and plan-reported cost and utilization data for CY 2011. The base data was identified and/or adjusted to reflect covered services for beneficiaries eligible for Cal MediConnect. Therefore, some populations, such as the developmentally disabled and members enrolled in Medicare managed care products, were excluded from the rate development process for this rating period.

The base data used to develop the CP 2014 capitation rate ranges was divided into population groupings representing differing levels of risk. These four populations are defined as follows:

- *Institutional*: Members with a long-term care (LTC) aid code, or residing in an LTC facility for 90 days or more.
- *HCBS High*: Members who receive Community-Based Adult Services (CBAS), or are clients of Multipurpose Senior Services Program sites, or receive In-Home Supportive Services (IHSS) and are classified as “Severely Impaired” (receiving at least 20 hours of personal care services per week).
- *HCBS Low*: Members who receive IHSS and are classified as “Not Severely Impaired” (receiving less than 20 hours of personal care services per week).
- *Community Well/Healthy*: All members not classified in other categories.

Adjustments were made to the selected base data to match the covered population risk and the State Plan-approved benefit package for CP 2014. The adjustments appropriately reflect the differing effective dates for Cal MediConnect and enrollment phase-in patterns for some counties and populations.¹ Additional adjustments were then applied to the base data to incorporate:

- Trend factors to forecast the expenditures and utilization to the contract period.
- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- Managed care adjustments.
- Administration and underwriting profit/risk/contingency loading.

Trend information and data were gathered from multiple sources, including plan-reported data, financial statements, FFS experience, historical California Medical Assistance Commission adjustments, Consumer Price Index, National Health Expenditures updates, and multiple industry reports. The weighted category of service (COS) per-member-per-month (PMPM) trends vary from a high of 6.3% for Emergency Room to a low of 0.5% for LTC.

¹ Cal MediConnect commenced on April 1, 2014 in San Mateo County; on May 1, 2014 in Riverside, San Bernardino, and San Diego counties; and on July 1, 2014 in Los Angeles County.

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The major program changes that were viewed to have a material impact on the capitation rates include:

- LTC facility rate adjustments – multiple dates.
- Hospice rate increases – multiple dates.
- IHSS county wage adjustments – multiple dates.
- Reinstatement of optometry services – July 2010.
- Elimination of inpatient provider payment reduction – April 2011.
- CBAS member transition from FFS – October 2012.
- Medicare Improvements for Patients and Providers Act – January 2013.
- IHSS settlement/utilization adjustment – July 2013.
- Affordable Care Act Section 1202 primary care fee increase – January 2013.

Because the underlying base data in most counties was primarily FFS, managed care adjustments were applied (with the exception of County Organized Health Systems counties). First, the application of trend and program changes to the base FFS data produced FFS-equivalent utilization per thousand, unit cost, and PMPM amounts for each COS. These individual components were then reviewed and adjusted to reflect managed care impacts that would be expected within the Cal MediConnect program. Overall, the impact of these managed care adjustments varied by county and ranged between 0.7% and 3.1% at the midpoint.

The second component of the managed care adjustments was the assumption of a member shift. This shift was assumed in two directions. First, it was assumed that there would be a small shift away from Institutional; that is, members who leave an institution would not be immediately replaced at the same rate as in the past, instead these members would remain in HCBS High. Secondly, it was assumed that there is some current unmet need in the Community Well population, and that a small number of these members would be determined to be in need of HCBS services and would transition to HCBS Low.

Utilization changes associated with the shift in the distribution of members were factored in as well. It was assumed that as members stay in HCBS High longer, the LTC and HCBS costs for these members would be higher than they would have been under the old distribution. Similarly, the members who make up the Institutional population would generate higher LTC and HCBS costs than the old Institutional population. The opposite was assumed for the Community Well and HCBS Low transition. The members with unmet needs in Community Well who transition to HCBS Low would have been higher-than-average Community Well members, but would be lower-than-average HCBS Low members, so LTC and HCBS costs for these two population groups were both assumed to be lower after the shift in membership relative to historical figures.

The administration loading for the Prime Contractor Plans participating in Cal MediConnect was developed by population group, and reviewed in aggregate. The administration load factor is expressed as a percentage of the capitation rate. This mid-point percentage was developed from a review of historically reported administrative expenses. The administrative costs were reviewed to ensure that they are appropriate for the approved State Plan services and Medicaid eligible members. The rates assume an aggregate administration load of 3.2% at the midpoint across all

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counties. The underwriting profit/risk/contingency load assumes approximately 1.5% at the lower bound, 2.3% at the midpoint, and 3.1% at the upper bound across all counties.

CY 2014 County-Specific Base Rates (without SB78 Tax)

County	Category of Aid	Lower Bound	Midpoint	Upper Bound
Los Angeles	Institutional	\$ 5,000.47	\$ 5,045.41	\$ 5,091.21
Los Angeles	HCBS High	\$ 1,713.81	\$ 1,765.35	\$ 1,818.93
Los Angeles	HCBS Low	\$ 801.09	\$ 826.02	\$ 851.98
Los Angeles	Healthy	\$ 80.50	\$ 84.85	\$ 89.44

County	Category of Aid	Lower Bound	Midpoint	Upper Bound
Riverside	Institutional	\$ 4,866.71	\$ 4,911.57	\$ 4,957.29
Riverside	HCBS High	\$ 1,932.20	\$ 1,989.84	\$ 2,049.74
Riverside	HCBS Low	\$ 875.61	\$ 902.18	\$ 929.80
Riverside	Healthy	\$ 75.69	\$ 79.67	\$ 83.86

County	Category of Aid	Lower Bound	Midpoint	Upper Bound
San Bernardino	Institutional	\$ 5,253.25	\$ 5,301.40	\$ 5,350.47
San Bernardino	HCBS High	\$ 1,536.30	\$ 1,582.98	\$ 1,631.52
San Bernardino	HCBS Low	\$ 720.91	\$ 743.44	\$ 766.87
San Bernardino	Healthy	\$ 71.85	\$ 75.72	\$ 79.80

County	Category of Aid	Lower Bound	Midpoint	Upper Bound
San Diego	Institutional	\$ 5,456.19	\$ 5,504.84	\$ 5,554.40
San Diego	HCBS High	\$ 1,642.94	\$ 1,692.89	\$ 1,744.82
San Diego	HCBS Low	\$ 694.86	\$ 717.06	\$ 740.18
San Diego	Healthy	\$ 85.06	\$ 89.55	\$ 94.28

County	Category of Aid	Lower Bound	Midpoint	Upper Bound
San Mateo	Institutional	\$ 7,978.35	\$ 8,047.22	\$ 8,117.28
San Mateo	HCBS High	\$ 2,061.61	\$ 2,117.61	\$ 2,175.64
San Mateo	HCBS Low	\$ 1,027.50	\$ 1,057.04	\$ 1,087.70
San Mateo	Healthy	\$ 152.06	\$ 157.00	\$ 162.14

Rates Blending and Recasting

The Medi-Cal rate will be paid as a single, blended rate that accounts for the relative risk of the population actually enrolled in each Prime Contractor Plan and weights the rate accordingly. Final rates will be calculated by applying the appropriate savings percentages described in Section IV.

California used a projected acuity mix across the four populations to determine the initial, blended rate. In response to the uncertainty related to the early stages of the enrollment of this population due to the unknown Cal MediConnect opt-out rate, the impact of the monthly phase-in of all populations, and how enrollees would be distributed among Prime Contractor Plans, California has recast the rates using actual enrollment data. The final, blended capitation rates will reflect each Prime Contractor Plan's actual enrollment as opposed to the initial estimates.

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CY 2014 Monthly Recast Rates by County and Prime Contractor Plan

County	HCP	04/2014	05/2014	06/2014	07/2014	08/2014	09/2014	10/2014	11/2014	12/2014
Los Angeles	LA Care Health Plan				\$ 430.32	\$ 378.71	\$ 353.30	\$ 339.63	\$ 340.28	\$ 347.22
Los Angeles	Health Net				\$ 532.54	\$ 544.92	\$ 535.35	\$ 609.29	\$ 610.85	\$ 630.65
Los Angeles	Molina Dual Options				\$ 763.78	\$ 747.66	\$ 745.87	\$ 749.48	\$ 733.94	\$ 731.59
Los Angeles	Care First Health Plan				\$ 608.95	\$ 656.53	\$ 655.57	\$ 644.31	\$ 606.28	\$ 636.16
Los Angeles	CareMore				\$ 570.85	\$ 658.04	\$ 649.51	\$ 661.29	\$ 700.92	\$ 690.42
Orange	Cal Optima	<i>Cal MediConnect will commence in Orange County in August 2015.</i>								
Riverside	IEHP Dual Choice		\$ 489.52	\$ 484.22	\$ 519.66	\$ 530.02	\$ 524.42	\$ 523.65	\$ 539.79	\$ 530.50
Riverside	Molina Dual Options		\$ 303.59	\$ 274.51	\$ 437.36	\$ 437.00	\$ 456.82	\$ 483.59	\$ 479.05	\$ 489.91
San Bernardino	IEHP Dual Choice		\$ 344.51	\$ 358.64	\$ 463.08	\$ 484.28	\$ 499.44	\$ 516.77	\$ 532.23	\$ 497.45
San Bernardino	Molina Dual Options		\$ 382.61	\$ 368.11	\$ 494.70	\$ 469.32	\$ 477.59	\$ 496.96	\$ 477.49	\$ 486.45
San Diego	Care First Health Plan		\$ 391.13	\$ 449.73	\$ 659.93	\$ 715.02	\$ 743.91	\$ 807.77	\$ 799.41	\$ 750.61
San Diego	CommuniCare Advantage		\$ 257.97	\$ 258.40	\$ 285.24	\$ 282.17	\$ 299.42	\$ 318.47	\$ 354.12	\$ 356.52
San Diego	Health Net		\$ 387.90	\$ 356.69	\$ 490.51	\$ 509.78	\$ 557.04	\$ 565.54	\$ 619.08	\$ 605.42
San Diego	Molina Dual Options		\$ 343.75	\$ 328.48	\$ 550.18	\$ 550.73	\$ 524.34	\$ 555.06	\$ 566.71	\$ 571.21
San Mateo	Care Advantage CMC	\$ 974.69	\$ 974.69	\$ 974.69	\$ 974.69	\$ 974.69	\$ 974.69	\$ 930.20	\$ 930.20	\$ 930.20
Santa Clara	Anthem Blue Cross	<i>Cal MediConnect will commence in Santa Clara County in January 2015.</i>								
Santa Clara	Santa Clara Family Health Plan	<i>Cal MediConnect will commence in Santa Clara County in January 2015.</i>								

* Rates are after application of savings percentages (see Section IV).

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III. Medicare Components of the Rate – CY 2014

Medicare A/B Services

CMS has developed baseline spending 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 CY 2014 Medicare baseline for A/B services is the Medicare Fee-for-Service (FFS) Standardized County Rates.

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 will be updated annually consistent with the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage and Part D rate announcement.

Medicare A/B Component Payments: CY 2014 Medicare A/B Baseline County rates are provided below. The rates for CY 2014 are the CY 2014 FFS Standardized County Rates, updated to incorporate the adjustments noted below. The CY 2014 Medicare A/B rate component payments do not include projected costs associated with Medicare Advantage, as enrollment of beneficiaries into the Demonstration from Medicare Advantage plans is expected to be negligible during CY 2014. During CY 2014, Demonstration enrollment will be primarily from beneficiaries in Medicare FFS.

The Medicare A/B component of the rate includes the following adjustments:

- The CY 2014 Medicare A/B baseline rates have been updated to fully incorporate the most current hospital wage index and physician geographic practice cost index. The rate update factor for this change varies by county (see following tables for additional information).
- In addition, the CY 2014 Medicare A/B baseline rate has also been updated to reflect a 1.89% 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 1.89% adjustment applies for CY 2014 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 2014 is 4.91%. The majority of new Cal MediConnect enrollees will come from Medicare FFS, and CY 2014 Prime Contractor Plan risk scores for those individuals will be based solely on prior FFS claims. Therefore, for CY 2014 CMS will establish the Medicare A/B baseline in a manner that does not lead to lower amounts due to this coding intensity adjustment. Operationally, due to systems limitations, CMS will still apply the coding intensity adjustment factor to the risk scores but will increase 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.

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In CY 2015, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Cal MediConnect enrollment phase-in as of September 30, 2014. Additional information will be included in the CY 2015 Rate Report.

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 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.

CY 2014 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County*					
County	CY 2014 Medicare A/B Baseline PMPM (after application repricing**, bad debt and coding intensity adjustments)	CY 2014 Medicare A/B Baseline, Savings Percentage Applied (after application of 1% minimum savings percentage)	2014 County-Specific Interim Savings Percentages	2013 Final Medicare A/B PMPM Baseline, Interim Savings Percentage Applied (after application of county-specific interim savings percentage)	CY 2014 Medicare A/B PMPM Payment (after application of 2% sequestration reduction and prior to quality withhold)
Los Angeles	981.02	971.21	+0.00%	971.21	951.78
Orange	928.61	919.32	+0.42%	915.42	897.11
Riverside	877.16	868.39	+0.22%	866.46	849.13
San Bernardino	886.96	878.09	+0.44%	874.19	856.70
San Diego	856.63	848.05	+0.23%	846.09	829.17
San Mateo	862.41	853.80	+0.47%	849.74	832.74
Santa Clara	871.09	862.38	+0.23%	860.37	843.17

Note: See subsequent table for additional detail.

*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.

**Repricing to reflect most recent current hospital wage index and physician geographic practice cost index.

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2014 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County (Additional Detail)*									
County	CY 2014 Published FFS Standardized County Rate	CY 2014 Percentage Update for Re-pricing (county- specific)	CY 2014 Medicare A/B FFS Re- Priced Baseline (updated to incorporate repricing)	CY 2014 Medicare FFS A/B Baseline (updated by 1.89 bad debt adjustment)	CY 2014 Medicare A/B Baseline (increased to offset application of coding intensity adjustment factor in CY 2014)**	CY 2014 Medicare A/B Baseline, Savings Percentage Applied (after application of 1% minimum savings percentage)	2013 County- Specific Interim Savings Percentages	2013 Medicare A/B Baseline PMPM, Interim Savings Percentage Applied (after application of county- specific interim savings percentage) ***	CY 2014 Medicare A/B PMPM Payment (2% sequestratio n reduction applied and prior to quality withhold)
Los Angeles	911.73	0.42%	915.54	932.85	981.02	971.21	+0.00%	971.21	951.78
Orange	863.00	0.42%	866.63	883.01	928.61	919.32	+0.42%	915.42	897.11
Riverside	811.47	0.88%	818.62	834.09	877.16	868.39	+0.22%	866.46	849.13
San Bernardino	821.53	0.76%	827.77	843.41	886.96	878.09	+0.44%	874.19	856.70
San Diego	791.72	0.98%	799.46	814.57	856.63	848.05	+0.23%	846.09	829.17
San Mateo	795.90	1.13%	804.86	820.07	862.41	853.80	+0.47%	849.74	832.74
Santa Clara	800.49	1.56%	812.95	828.32	871.09	862.38	+0.23%	860.37	843.17

*Rates do not apply to beneficiaries with ESRD or those electing the Medicare hospice benefit. See Section IV for information on savings percentages.

**For CY 2014 CMS will establish rates in a manner that does not lead to lower amounts for this coding intensity adjustment. Operationally, due to systems limitations, CMS will still apply the coding intensity adjustment factor to the risk scores but has increased 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; (as above, the CY 2014 Medicare FFS A/B Baseline is divided by (1-the CY 2014 coding intensity adjustment factor of 4.91%) to determine the CY 2014 Final Medicare FFS A/B Baseline.

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

Beneficiaries with End-Stage Renal Disease (ESRD): Separate Medicare A/B baselines and risk adjustment will apply to enrollees with ESRD. The Medicare A/B baselines for beneficiaries with ESRD will 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 will be the CY 2014 California ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2014 ESRD dialysis state rate for California is \$7,481.92 PMPM; the updated CY 2014 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,332.28 PMPM. This will apply to applicable enrollees in all counties and will be risk adjusted using the existing HCC-ESRD risk adjustment model.
- **Transplant:** For enrollees in the transplant status phase (inclusive of the 3-months post-transplant), the Medicare A/B baseline will be the CY 2014 California ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2014 ESRD dialysis state rate for California is \$7,481.92 PMPM; the updated CY 2014 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,332.28 PMPM. This will apply to applicable enrollees in all counties and will be risk adjusted using the existing 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 will be the Medicare Advantage 3-star county rate/benchmark (see table below). The Medicare A/B component will be risk adjusted using the existing HCC-ESRD 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).

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CY 2014 Medicare A/B Baseline PMPM, ESRD Beneficiaries in Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County			
County	CY 2014 3-Star County Rate (Benchmark)	CY 2014 Final Medicare A/B PMPM Baseline (increased to offset application of coding intensity adjustment factor in CY 2014)*	CY 2014 Sequestration Adjusted Rate (after application of 2% sequestration reduction and prior to quality withhold)
Los Angeles	932.52	980.68	961.07
Orange	878.09	923.43	904.96
Riverside	894.20	940.38	921.57
San Bernardino	878.70	924.08	905.60
San Diego	840.02	883.40	865.73
San Mateo	832.53	875.52	858.01
Santa Clara	871.60	916.60	898.27

*For CY 2014 CMS will establish rates in a manner that does not lead to lower amounts for this coding intensity adjustment. Operationally, due to systems limitations, CMS will still apply the coding intensity adjustment factor to the risk scores but has increased the Medicare A/B baseline for beneficiaries with an ESRD status of functioning graft to offset this. Specifically, CMS has increased the Medicare A/B baseline by a corresponding percentage; as above, the CY 2014 Updated Medicare A/B Baseline is divided by (1-the CY 2014 coding intensity adjustment factor of 4.91%) to determine the CY 2014 Final Medicare A/B Baseline. For beneficiaries with an ESRD status of functioning graft status, the prospective payment will not include the adjustment to offset the application of coding intensity adjustment factor; this payment adjustment will be made on a retrospective basis.

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. 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. Prime Contractor Plans will continue to receive the Medicare Part D and Medicaid payments, for which no changes would occur.

Medicare Part D Services

The Part D plan payment will be 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 2014 is \$75.88 and the CY 2014 Low-Income Premium Subsidy Amount for California is \$28.10. 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 2014 is \$74.92. This amount incorporates a 2% sequestration reduction to the non-premium portion of the NAMBA.

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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: \$120.44 PMPM
- California reinsurance: \$70.70 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%

*See additional detail below

Limited Risk Corridors

Limited risk corridors will be established for Demonstration Years 1-3. The Demonstration will utilize a limited downside 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.

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	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.

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- 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 1, a 1% quality withhold will be applied to the Medicaid and Medicare A/B components of the rate. The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3.