

Joint Rate-Setting Process Under the Capitated Financial Alignment Initiative

This document describes a joint rate-setting process for Medicare-Medicaid Financial Alignment Initiative under a capitated financing model. Through these models, participating health plans would be responsible for delivering an integrated set of services for Medicare-Medicaid enrollees. This initiative will test whether aligning Medicare and Medicaid financing can foster more person-centered care models, achieve better outcomes, and lower costs through improvement.

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

Establishing baseline spending for the target population in the demonstration area.

Baseline spending is an estimate of what would have been spent in the payment year had the demonstration not existed. Baseline spending will be established prospectively on a year-by-year basis for each demonstration county. While the Medicaid methodology will vary State to State, the Medicare methodology will be consistent across all States participating in the initiative.

Medicaid:

- Responsible parties: The State and its actuaries will be responsible for providing historical spending and underlying data for Medicaid services to CMS's contracted actuaries. The contractors, with guidance and input from CMS, will validate the data and develop projected baseline costs in Medicaid (absent the demonstration).
- The historic spending will reflect costs for the services that will be included in capitation rates for the target population under the demonstration, and will incorporate data for the most recent years of prior experience available.
- The Medicaid baseline will take into account historic costs, and will include consideration of Medicaid managed care plan level payment (if the State currently serves Medicare-Medicaid enrollees through capitated managed care) as well as FFS costs.

Medicare:

- Responsible parties: CMS will calculate baseline spending (costs absent the demonstration).
- Given that the beneficiaries enrolled in demonstration plans will have come from both Medicare Advantage (MA) and FFS, demonstration baseline spending will be calculated based upon a weighted average of these populations' spending assumptions, proportional to the expected combination of enrolled dual eligible beneficiaries.
- CMS will develop an estimate of baseline costs for Medicare A and B services for each demonstration county.
 - For beneficiaries coming from Medicare FFS, the baseline costs will be calculated using the published Medicare standardized FFS county rates, which reflect historical costs of the Medicare FFS population. (Note: the standardized FFS county rates are calculated by CMS as part of the annual Medicare Advantage Rate Announcement and were released on April 2, 2012 for CY 2013.)
 - For beneficiaries coming from MA, the baseline will reflect the estimated amounts that would have been factored into payments made to MA plans in which the beneficiaries would have been enrolled in the absence of the demonstration, including Part C rebates. Rebates will be calculated based on the county benchmarks that incorporate quality bonuses.
 - Each county baseline will be a weighted average of these FFS and MA county costs based on the expected proportion of enrollment from FFS and MA.

- Amounts will be expressed as standardized rates (i.e. reflecting risk of an average 1.0 population).
- The Medicare Part D projected baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount for the payment year, which occurs in early August of each year. CMS will estimate an average monthly payment amount for the low-income cost sharing and Federal reinsurance subsidy amounts; these payments will be 100% cost reconciled after the payment year has ended.

Aggregate savings targets under the demonstration.

- CMS assumes that the demonstrations can achieve overall savings through improved care management and administrative efficiencies. Initial modeling suggests potential changes in utilization patterns and a range of potential savings in each State. This work, plus other input from States and others, will inform the selection of a savings target.
- Informed by the modeling, and with input from the State and others, CMS will establish a specific aggregate savings target for each year of the demonstration. The savings targets will be specified in each State's MOU.
- Savings targets may differ among States. For example, States with low historic Medicare spending, low utilization of institutional long-term care services, or a high penetration of Medicaid managed care may have lower savings potential than other States. However, we anticipate applying consistent savings targets across States with comparable ranges of feasible savings. For example, in some States, we expect the savings targets to be 1% in year 1, 3% in year 2, and 5% in year 3.

Applying aggregate savings target to components of the integrated rate.

- The aggregate savings target identified above would then be applied to the Medicare A/B and Medicaid components of the rate.
- By applying the savings target to the Medicare A/B and Medicaid components, both payers proportionally share in the contribution to the capitation rate and in the savings achieved through the demonstration regardless of underlying utilization patterns. That is, regardless of whether savings accrue from reducing hospitalizations (for which Medicare is primary) or reducing nursing facility placements (for which Medicaid is primary), both payers will benefit under the integrated approach.
- Savings targets will not be applied to the Part D component of the rate.

Applying risk adjustment methodology to each component of the integrated rate.

- The Medicare A/B and Part D Direct Subsidy components will be risk adjusted based on the risk profile of each enrolled beneficiary. The existing CMS-HCC and RxHCC risk adjustment models will be utilized for the demonstration for A/B and Part D, respectively.
- The Medicaid component will be risk adjusted or distributed into rating categories based on a methodology proposed by the State and agreed to by CMS. This may include the identification of various rate cells/cohorts of the population (e.g., by age or sex, nursing home level of care, care setting, etc.). We will allow these methodologies to vary from State to State, as they do among Medicaid managed care programs today, as long as the risk categories incent home and community based services over institutional placement and have clear operational rules and processes for assigning beneficiaries into a rate category that are compatible with an individual's risk level/profile.

Applying quality withhold policy to Medicaid and Medicare A/B components of the integrated rate.

- To incent quality improvement, CMS and the State will withhold a portion of the capitation payments that participating health plans can earn back if they meet certain quality thresholds.
- CMS expects the threshold measures to be a combination of certain core quality measures (consistent across all demonstrations under the Financial Alignment initiative), which will be a subset of a larger integrated quality reporting measurement set, and State-specified performance measures that are more specific to the target population of each demonstration. Each State will work with CMS as part of its MOU negotiation to develop the State-specific performance measures that will be used for the purposes of the quality withhold.
- In year 1, encounter reporting may be utilized as the basis for the 1% withhold, plus any additional CMS or State-proposed requirements. CMS expects that the quality withhold will be of increasing amounts (2% in year 2 and 3% in year 3) and will be based on performance in the core demonstration and State specified measures. (Note: Part D payments will not be subject to a quality withhold.)

Making payments to participating health plans for each component of the integrated rate.

- CMS will make separate payments to the participating health plans for the Medicare A/B and Part D components of the rate.
- The State will make a payment to the participating health plans for the Medicaid component of the rate.

Paying participating health plans relative to quality withhold requirements.

- CMS and the State will assess plan performance according to the specified quality withhold measures in each given year and calculate final payments to each plan.