Medicare-Medicaid Alignment Initiative
CY 2016 Final Rate Report
November 1, 2016

The Illinois Department of Healthcare and Family Services (HFS), in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing the updated Medicare component of the CY 2016 rates for the Medicare-Medicaid Alignment Initiative (MMAI).

The general principles of the rate development process for the Demonstration have been outlined in the three-way contract between CMS, the State of Illinois, and the Demonstration 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 final CY 2016 Medicaid component of the rates is also illustrated.

I. Components of the Capitation Rate

CMS and the State of Illinois will each contribute to the global capitation payment. CMS and the State of Illinois will each make monthly payments to Demonstration Plans for their components of the capitated rate. Demonstration 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 HFS 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. To adjust the Medicaid component, the State assigns each enrollee to a rating category (RC) according to the individual enrollee's setting of care, age and geographic service area for the purposes of risk adjusting the Medicaid payment.

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

II. Medicaid Component of the Rate – CY 2016

This section provides an overview of the capitation rate development for the Medicaid component of the Medicare-Medicaid Alignment Initiative for CY 2016 and has been developed to address the requirements outlined under 42 CFR 438.6(c) related to actuarial soundness of the capitation rates.

The basis for the Medicaid rates began with costs developed prior to the application of the Medicare and Medicaid composite savings percentages established by the state and CMS, informed by estimates from CMS and its contractors. The final Medicaid capitation rates were set consistent with 42 CFR 438.6(c) in combination with a qualification that the Medicare capitation rates were established by CMS and the Medicare and Medicaid composite savings percentages were established by the state and CMS.

The following table illustrates the proposed monthly capitation rates for each rate cell for MMAI Medicaid benefits. MMAI beneficiaries are defined as a community resident to the extent the individual does not meet the HFS nursing home level of care criteria and does not reside in a nursing facility or qualify for a Home and Community-Based Services (HCBS) waiver. The blended long-term services and supports (LTSS) capitation rates were developed based on the estimated regional membership distribution between the Nursing Home and Other Waiver rate cells. MCO-specific rates paid will reflect each MCO's individual membership distribution between the Nursing Home and Other Waiver rate cells as of January 2016. The rate cell structure was developed based upon level of care and age (over/under age 65), with separate rates developed for the Greater Chicago and Central Illinois regions based on historical experience. The 3% shared savings percentage for Demonstration Year 2 of the program, as outlined in the Three-Way Contract, has been applied to these rates. The 2% quality withhold for the Demonstration Year 2 of the program has not been applied to the rates below.

MMAI Medicaid Component Demonstration Capitation Rates Effective Calendar Year 2016		
Rate Cell	**Greater Chicago**	**Central Illinois**
Age 21-64		
Community	$ 136.98	$ 100.97
Blended LTSS	$ 2,638.49	$ 2,157.39
Age 65+		
Community	$ 46.75	$ 65.87
Blended LTSS	$ 2,093.26	$ 1,860.32

The data serving as the base experience in the capitation rate development process was incurred during state fiscal year 2015 (July 1, 2014 to June 30, 2015). The fee-for-service data used in the rate development process reflects adjudicated data through September 2015. For the purposes of trend development and analyzing historical experience, fee-for-service data and enrollment experience from state fiscal years 2013 and 2014 were also reviewed. Additionally, completion factor adjustments were developed using internal regression time-series models to estimate future paid amounts (incurred but not reported) based on historical incurred to paid lag patterns.

Adjustments were developed by rate cell (Community, Nursing Facility, Other Waiver) and major category of service.

DATA RELIANCE

The following experience served as the primary data sources for the CY 2016 MMAI capitation rate development:

- Fee-for-services data for the MMAI eligible population for July 1, 2012 through June 30, 2015 and paid through September 2015;
- Detailed fee-for-service and MMAI managed care enrollment data for July 1, 2012 through June 30, 2015;
- Summary of policy and program changes through state fiscal year 2015 (including changes to fee schedules and other payment rates).
    - A 2.55% unit cost program adjustment was applied to historical experience in the Waiver – Nursing Services category. This reflects the hourly rate increase provided to the personal attendant workers on December 1, 2014 that was assumed to be reflected in only seven months of the base data.
    - An adjustment was applied to reflect the reversal of the 12.6% rate cut effective in May and June 2015 for nursing homes.

Prospective risk selection factors were applied to the base data in order to reflect the voluntary and opt-out nature of MMAI. Separate selection factors were developed for non-LTSS and LTSS. Selection factors reflect the termination of Health Alliance and the majority of its members from the MMAI program effective January 1, 2016. The table below summarizes the selection factor adjustments applied by rate cell for the Greater Chicago and Central Illinois regions.

MMAI Summary of Selection Factor Adjustments				
	Greater Chicago		Central Illinois	
Rate Cell	Non-LTSS	LTSS	Non-LTSS	LTSS
Community 21-64	0.8560	1.0000	0.9350	1.0000
Community 65+	0.7340	1.0000	0.9170	1.0000
Nursing Facility 21-64	0.9230	1.0000	0.9230	1.0000
Nursing Facility 65+	0.8790	1.0000	0.8790	1.0000
Other Waiver 21-64	0.8890	0.9450	0.8890	0.9450
Other Waiver 65+	0.7360	0.9240	0.7360	0.9240

TREND ADJUSTMENTS

Trend rate assumptions were developed for the populations and services covered under the MMAI program based on claims experience data from July 1, 2012 through June 30, 2015. Utilization, cost per unit, and PMPM costs were summarized for the experience period by incurred month, rate cell, and medical service category. Trend rate assumptions were developed based on a review of regression modeling results, Medicare market based forecasts, and actuarial judgment.

Separate trend rates were developed by demonstration tier and medical services category and separate trend adjustments were developed for utilization and cost per service. Cost per unit trend rates reflect both changes in the unit cost of a given medical service and changes in the mix or intensity of services over time within a given medical services category. The tables below document utilization and cost per service trend assumptions.

MMAI Summary of Utilization Trend Assumptions			
	Utilization		
Rate Cell	**Community**	**Nursing Facility**	**Other Waiver**
Inpatient	(0.5%)	(0.5%)	(0.5%)
Outpatient	(0.0%)	(0.0%)	(0.0%)
Ancillary	1.0%	1.0%	1.0%
Physician	2.0%	1.5%	1.0%
DMHDD	1.0%	1.0%	1.0%
Long-Term Care	2.0%	1.0%	2.0%
Waiver	1.0%	1.0%	2.0%
Pharmacy	1.0%	1.0%	1.0%

MMAI Summary of Unit Cost Trend Assumptions			
	Utilization		
Rate Cell	**Community**	**Nursing Facility**	**Other Waiver**
Inpatient	2.5%	2.5%	2.5%
Outpatient	2.0%	2.0%	2.0%
Ancillary	1.0%	1.0%	1.0%
Physician	1.0%	1.0%	1.0%
DMHDD	1.0%	1.0%	1.0%
Long-Term Care	1.5%	1.5%	1.5%
Waiver	1.0%	1.0%	1.0%
Pharmacy	4.0%	4.0%	4.0%

Further documentation of the development of the Medicaid component of the MMAI rates is contained in the May 12, 2016 report published by Milliman, Inc. entitled *Medicare-Medicaid Alignment Initiative Rates – Calendar Year 2016 Medicaid Capitation Rate Development*. This report should be referenced for additional details and limitations regarding the rate development process for the Medicaid rate component of the CY 2016 MMAI program.

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 MMAI enrollees would be enrolled absent the MMAI.

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 adjustments 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 as used to set 2014-2015 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 MMAI 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 6.83% 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 CY 2016, based on the enrollment process for the demonstration, CMS established the FFS component of the Medicare A/B baseline in a manner that did not lead to lower amounts due to this coding intensity adjustment.

In 2016, CMS will apply a coding intensity adjustment 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 as of September 30, 2015. CMS' calculations take into account planned passive enrollment and rates of opt-out in the passive enrollment process. For Illinois, the applicable 2016 coding intensity adjustment is 4.44%.

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 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 CY 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment for all enrollees.

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 MMAI 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 Demonstration Plan and is calculated using an enrollment-weighted average of the rates for each county in which the Demonstration Plan participates.

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2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]							
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 CY 2016 bad debt adjustment)	**2016 Final Medicare A/B FFS Baseline** (increased to offset application of coding intensity adjustment factor in 2016)[2]	**2016 Final Medicare A/B Baseline** (incorporating final Medicare A/B FFS baseline and Medicare Advantage component)	**2016 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 3% savings percentage)	**2016 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Champaign	$685.73	$732.56	$746.03	$753.34	$754.14	$731.52	$716.89
Christian	763.88	816.04	831.06	839.20	838.83	813.67	797.40
Cook	887.14	947.72	965.16	974.61	969.09	940.02	921.22
DeWitt	736.64	786.94	801.42	809.27	807.62	783.39	767.72
DuPage	807.27	862.40	878.26	886.87	884.38	857.85	840.69
Ford	837.00	894.16	910.61	919.53	916.44	888.94	871.16
Kane	829.11	885.73	902.02	910.86	906.26	879.07	861.49
Kankakee	814.89	870.54	886.55	895.24	894.91	868.06	850.70
Knox	767.85	820.28	835.38	843.56	840.14	814.94	798.64
Lake	824.08	880.35	896.55	905.33	904.57	877.43	859.88
Logan	742.85	793.58	808.18	816.09	815.32	790.86	775.04
McLean	686.64	733.53	747.02	754.34	754.86	732.21	717.57
Macon	712.53	761.19	775.19	782.78	782.76	759.28	744.09
Menard	683.42	730.09	743.52	750.80	750.91	728.39	713.82
Peoria	703.64	751.69	765.52	773.02	774.24	751.01	735.99
Piatt	785.06	838.67	854.10	862.47	862.47	836.60	819.87
Sangamon	689.39	736.47	750.02	757.36	757.45	734.73	720.04
Stark	695.72	743.23	756.90	764.32	764.32	741.39	726.56
Tazewell	733.34	783.42	797.83	805.65	806.00	781.82	766.18
Vermillion	723.81	773.24	787.46	795.18	794.26	770.43	755.02
Will	874.85	934.59	951.79	961.11	956.71	928.00	909.44

[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.

[2] For CY 2016 CMS calculated and applied a 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 Illinois-specific modified CY 2016 coding intensity adjustment factor of4.44%)] to determine the CY 2016 Final Medicare FFS A/B Baseline.

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 Illinois ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2016 ESRD dialysis state rate for Illinois is $7,172.97 PMPM; the updated CY 2016 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $7,029.51 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 Illinois ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2016 ESRD dialysis state rate for Illinois is $7,172.97 PMPM; the updated CY 2016 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $7,029.51 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 is not 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			
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)
Champaign	$775.66	$783.26	$767.59
Christian	765.76	773.26	757.79
Cook	873.83	882.39	864.74
DeWitt	781.26	788.91	773.13
DuPage	815.34	823.32	806.85
Ford	824.44	832.51	815.86
Kane	816.67	824.67	808.18
Kankakee	802.67	810.53	794.32
Knox	781.02	788.67	772.90
Lake	811.72	819.67	803.28
Logan	771.63	779.19	763.61
McLean	781.33	788.98	773.20
Macon	782.58	790.25	774.45
Menard	762.45	769.91	754.51
Peoria	833.81	841.98	825.14
Piatt	785.06	792.75	776.90
Sangamon	764.53	772.02	756.58
Stark	808.34	816.26	799.93
Tazewell	821.07	829.11	812.53
Vermillion	780.09	787.73	771.98
Will	861.73	870.17	852.77

*For CY 2016 CMS has calculated and applied a 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 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 2016 Updated Medicare A/B Baseline is divided by [(1-standard the CY 2016 coding intensity adjustment factor of 5.41% minus the Illinois-specific modified CY 2016 coding intensity adjustment factor of 4.44%)] to determine the CY 2016 Final Medicare A/B Baseline. For beneficiaries with an ESRD status of functioning graft, 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 Demonstration 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. Demonstration 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 Demonstration Plans. Demonstration 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 2016 is $64.66 and the CY 2016 Low-Income Premium Subsidy Amount for Illinois is $29.60. Thus, the updated Illinois Part D monthly per member per month payment for a beneficiary with a 1.0 RxHCC risk score applicable for CY 2016 is $63.96. 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.

- Illinois low income cost-sharing: $122.08 PMPM
- Illinois reinsurance: $84.27 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

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 Illinois established composite 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	Savings percentage
Demonstration Year 1	January 1 through December 31, 2015	1%
Demonstration Year 2	January 1 through December 31, 2016	3%
Demonstration Year 3	January 1 through December 31, 2017	5%

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: http://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.