NOTE TO: Medicare+Choice Organizations and Other Interested Parties

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2002 Medicare+Choice (M+C) Payment Rates

In accordance with Section 1853(b)(2) of the Social Security Act, we are required to notify you of any proposed changes in the M+C capitation rate methodology or risk adjustment methodology for CY 2002. Preliminary estimates of the various national per capita M+C growth percentages and the methodology changes for CY 2002 are attached.

Please note that this Notice does not include a description of all provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) that affect M+C payments. This Notice discusses those BIPA provisions affecting payments for 2002.

Comments or questions may be addressed to:

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Health Care Financing Administration
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C4-01-22
Baltimore, Maryland 21244

In order to receive consideration prior to the March 1, 2001 announcement of M+C capitation rates, comments must be received by January 31, 2001.

/ s /
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Attachments

Attachment 1

Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year (CY) 2002

The Balanced Budget Act of 1997 (BBA) changed the payment methodology for determining payments to Medicare+Choice (M+C) organizations. This payment methodology is based in part on increases in the national per capita M+C growth percentage as defined in Section 1853(c)(6) of the Social Security Act (the Act). In this notice, we provide preliminary estimates of (1) the national per capita M+C growth percentages in CY 2002, and (2) the increase in the floor payment rates in CY 2002. Each of these estimates reflects the components required by the BBA: an underlying trend change for CY 2002, a statutory adjustment of -0.3 percent (as required by section 1853(c)(6)(B) of the Act), and an adjustment for changes in the estimates of prior years' growth percentages.

The estimates shown in this attachment reflect the enactment of P.L. 106-554, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Two provisions of this law significantly impacted the Medicare + Choice ratebook for 2001. Section 601 of the BIPA establishes a new monthly minimum payment amount in 2001 for months after February. The new minimum payment is $525 for any payment area in a Metropolitan Statistical Area (MSA) within the 50 States and the District of Columbia with a population of more than 250,000; for any other area within the 50 States, it is $475. For any area outside of the 50 States and the District of Columbia, the minimum amounts cannot exceed 120 percent of the minimum amounts for such areas as determined for 2000. Section 602 establishes the minimum percentage increase in monthly payment rates to be 3 percent for 2001. This minimum percentage increase applies for all months in 2001 except January and February.

The current estimate of the change in the national per capita M+C growth percentage for aged enrollees in CY 2002 is 8.3 percent. This percentage applies to the area-specific rates implicit in the CY 2001 M+C rates announced on March 1, 2000. (If the national per capita M+C growth percentage for CY 2002 were determined based on the area-specific rates implicit in the revised CY 2001 rates announced on January 4, 2001, which reflect the impact of the BIPA provisions, the total change would be 4.9 percent). The 8.3 percent estimate reflects an underlying trend change for CY 2002 in per capita costs of 5.6 percent, an adjustment of -0.3 percent (as required by Section 1853(c)(6)(B) of the Act), and an adjustment for the fact that the current estimate of prior years' cumulative aged M+C growth percentages (for CYs 1998 through 2001) is 2.8 percent higher than the estimates actually used in calculating the CY 2001 capitation rate book that was published March 1, 2000 (as required by Section 1853(c)(6)(C) of the Act). The adjustment for prior years' estimates includes an increase of about 3.2 percent in CY 2001 for the impact of the enactment of P.L. 106-554.

The table below shows the increases in the national per capita growth percentages for the aged, disabled, ESRD, and the combined aged + disabled.

The preliminary estimate of the floor for aged beneficiaries in CY 2002 is $552.92 for any area in an MSA within the 50 States and the District of Columbia with a population of more than 250,000, and $500.26 for all other areas within the 50 States. In both cases this represents a 5.3 percent increase over the respective CY 2001 floors of $525 and $475. As with the estimate of the national per capita M+C growth percentage, this estimate reflects an underlying trend change for CY 2002 in per capita costs of 5.6 percent and an adjustment of -0.3 percent (as required by Section 1853(c)(6)(B) of the Act). This estimate of the rate of change for the floors does not include an adjustment for revised estimates of prior years' aged M+C growth percentages due to the provision in the BIPA mentioned above, which reestablishes the base floor amounts in 2001.

The following tables summarize the estimates for the change in national per capita M+C growth percentage and the floor increase:

National Per Capita Growth Percentage (for Blend)[1]

	Aged	Disabled	ESRD	Aged+Disabled
2002 Trend Change	5.6%	5.8%	2.0%	5.6%
BBA Adjustment	-0.3%	-0.3%	-0.3%	-0.3%
2002 Trend plus BBA Adjustment	5.3%	5.5%	1.7%	5.3%
Revision to CY 1998 Estimate	1.9%	2.6%	-2.1%	2.0%
Revision to CY 1999 Estimate	-0.9%	0.2%	-3.3%	-0.8%
Revision to CY 2000 Estimate	-2.1%	-2.5%	-3.3%	-2.2%
Revision to CY 2001 Estimate[2]	4.0%	5.1%	3.8%	4.2%
Total Change	8.3%	11.2%	-3.5%	8.6%

[1] Applies to the area-specific rates implicit in the M+C rates announced March 1, 2000.

[2] For aged beneficiaries, the revision for 2001 includes 3.2 percent for the impact of the enactment of P.L. 106-554 and 0.8 percent for other revisions.

NOTE: The BBA adjustment is additive. The remaining numbers are multiplicative. The numbers are also not exact, due to rounding.

National Per Capita Growth Percentage (for Floor)

	Aged	Disabled	ESRD	Aged+Disabled
2002 Trend Change	5.6%	5.8%	2.0%	5.6%
BBA Adjustment	-0.3%	-0.3%	-0.3%	-0.3%
Total Change[1]	5.3%	5.5%	1.7%	5.3%

[1] For CY 2002, there are no adjustments to prior years' estimates because Section 601 of the BIPA reestablishes the floors.

NOTE: The BBA adjustment is additive.

These estimates are preliminary and could change before the final rates are announced on March 1, 2001. Further details on the derivation of the national per capita M+C growth percentage will also be presented in the March 1 announcement.

Attachment 2

Changes in Methodology Since Calendar Year (CY) 2001 Rates

A. Risk Adjustment System

ICD-9 code modifications. There are no revisions to the Principal Inpatient-Diagnostic Cost Group (PIP-DCG) risk adjustment methodology for CY 2002. However, there are additions and modifications to the ICD-9 diagnosis codes upon which the PIP-DCG risk adjustment payment model will be based in CY 2002. A new look-up table reflecting the new 2001 ICD-9 diagnosis codes (which were effective October 1, 2000) can be found on the HCFA website at http://cms.hhs.gov/healthplans/rates/. The lookup tables will be posted on the HCFA website on or before January 15, 2001. Public use payment software for payment year 2002 will be available on the same website on or before March 1, 2001.

Encounter data submission deadlines. Inpatient encounters with discharge dates of July 1, 2000 through June 30, 2001 that are received at HCFA by September 30, 2001 will be incorporated into the risk factor that is used for making payments to M+C organizations (M+COs) during CY 2002. M+COs should submit these encounters no later than September 7, 2001 to ensure that there is sufficient time to complete the processing of these data.

If M+COs receive inpatient encounters after September 7, 2001, they may submit the late encounter data to HCFA, and the data will be processed under the reconciliation process set forth in Operational Policy Letter 2000.126. The deadline for submission of all late inpatient encounter data with discharge dates of July 1, 2000 through June 30, 2001 is September 30, 2002. No encounters from this period will be accepted by HCFA after September 30, 2002. (Note that the June 30 deadline for late submission of inpatient encounter data in Operational Policy Letter 2000.126 has been extended to September 30.)

After the payment year is completed, HCFA will recalculate risk factors for 2002 for individuals for whom late encounters have been submitted. Then we will determine any payment adjustments that are required. This reconciliation will be undertaken during 2003 and will be a one-time reconciliation for payment year 2002.

B. Risk adjustment transition

Section 603 of the BIPA amends Section 1853(a)(3)(C) of the Act (amended by Section 511 of the Balanced Budget Refinement Act (BBRA)) by specifying that for CY 2002 the risk adjustment method will be used to adjust 10 percent of the rate. (The BBRA provided that for 2002 the risk adjustment method would be used to adjust “not more than 20 percent” of the rate.) Under the BIPA, therefore, HCFA will continue to apply the transition percentages applied in CYs 2000 and 2001: 90 percent demographic method and 10 percent risk-adjustment method.

Payment amounts for each enrollee are separately determined using the demographic method and the PIP-DCG risk adjustment method. These separate payment amounts are then blended according to the percentages for the transition year, which under the BIPA are 90/10 for CYs 2001 through 2003.

C. Extra payment in recognition of the costs of successful outpatient congestive heart failure care

This section discusses the extra payment provisions announced in Operational Policy Letter 2000.129, which are effective January 1, 2002. This Notice does not address Section 607 of the BIPA on full implementation of risk adjustment for congestive heart failure (CHF), since this provision is effective only for CY 2001. Information on full implementation of risk adjustment for CHF in 2001 can be found on the HCFA website at http://www.cms.hhs.gov/healthplans/acr/cy2001.asp.

CHF extra payment initiative. The Health Care Financing Administration will make extra payments to Medicare+Choice organizations (M+COs) in recognition of the costs of successful outpatient congestive heart failure care. This extra payment will be made in CY 2002 to M+COs that qualify on the basis of attaining threshold levels on both of two quality indicators, described below. Consistent with the risk adjustment payment methodology, extra payment will only be made for those enrollees in an M+CO who are identified in HCFA’s records as having had the required principal inpatient discharge diagnosis of CHF and who are enrolled in the M+CO at the beginning of each payment month in 2002.

More detailed information on the CHF extra payment is contained in OPL 2000.129. Note that if an enrollee with a CHF hospitalization disenrolls from an M+CO that qualified for extra payment and then enrolls in an M+CO that does not qualify for extra payment, the new M+CO would not receive the extra payment for that enrollee.

Payment for Qualifying M+COs. HCFA takes two reporting years into account when assessing whether an M+CO qualifies for an extra payment in 2002: July 1, 1999 to June 30, 2000; and July 1, 2000 to June 30, 2001. M+COs are paid for a qualifying CHF diagnosis under several scenarios, listed below. Scenario (1) describes the "normal" payment HCFA makes under the PIP-DCG methodology for a principal inpatient diagnosis of CHF during the reporting year. Scenarios 2 and 3 describe special conditions under which M+COs may qualify for the CHF extra payment.

(1) In 2002, M+COs with enrollees hospitalized with a greater than one-day stay for a principal diagnosis of CHF between July 1, 2000 and June 30, 2001 will receive the regular PIP-DCG-16 amount, at the phased-in level of 10 percent under the risk adjustment payment methodology.

(2) Under the extra payment provision for 2002, qualifying M+COs with an enrollee hospitalized with a qualifying CHF diagnosis between July 1, 1999 and June 30, 2000 who did not have a hospital stay during the July 1, 2000 to June 30, 2001 period will receive an extra payment for the CHF hospitalization incurred during the first reporting year (July 1, 1999 to June 30, 2000), at the phased-in level of 10 percent under the risk adjustment payment methodology.

(3) Under the extra payment provision for 2002, qualifying M+COs with an enrollee hospitalized with a qualifying CHF diagnosis between July 1, 1999 and June 30, 2000 who also had a discharge for another diagnosis during the period July 1, 2000 to June 30, 2001 will receive the **greater of the two possible payments**. Two examples are provided below:

(a) If an enrollee had a qualifying discharge for CHF between July 1, 1999 and June 30, 2000 and also had a discharge during the period July 1, 2000 to June 30, 2001 that fell into PIP-DCG 8 or higher (which would also include a diagnosis of CHF), the M+CO will receive payment for the qualifying diagnosis incurred during the second reporting year (July 1, 2000 to June 30, 2001), because that payment would be greater than the payment for the CHF diagnosis that occurred during the July 1, 1999 and June 30, 2000 period.

(b) If an enrollee had a qualifying discharge for CHF between July 1, 1999 and June 30, 2000 and also had a discharge during the period July 1, 2000 to June 30, 2001 that fell into PIP-DCG 7 or below, the M+CO will receive payment for the CHF diagnosis incurred during the first reporting year (July 1, 1999 to June 30, 2000), because that payment would be greater than the payment for the diagnosis that occurred during the July 1, 2000 to June 30, 2001 period.

The extra payments made to qualifying M+COs for CHF discharges between July 1, 1999 and June 30, 2000 will be based on approximately one-third of the full PIP-DCG-16 amount, subject to the risk adjustment transition schedule. Given the payment blend of 90 percent demographic payment and 10 percent risk adjusted payment for 2002, the additional payments to qualifying M+COs would be based approximately on the following **formula**: 0.33 (representing one third of PIP-DCG 16 amount) X 2.438 (representing the PIP-DCG-16 risk factor) X 0.10 (representing the payment blend in 2002) of the risk adjusted county rate.

Section A of Attachment 2 (above) addresses the deadlines for receipt of inpatient encounter data between July 1, 2000 and June 30, 2001. Note that extra payments for CHF in 2002 are based on inpatient discharges from the prior year. Encounters for CHF discharges from July 1, 1999 to June 30, 2000 that are submitted after September 30, 2001 will be incorporated into a reconciliation conducted during 2003 for payments made to M+COs in 2002. See OPL 2000.126 for further information on reconciliation for risk adjustment.

Quality indicators for extra payment. HCFA indicated in Operational Policy Letter 2000.129 that we would publish the threshold levels for both quality indicators in this Notice. Therefore, the two quality indicators and thresholds follow. M+COs must meet or exceed the threshold level on both quality indicators to qualify for the extra payment.

Quality Indicator 1: Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have evaluation of left ventricular function as of October 1 of the reporting year.

Threshold for extra payment: 75%

Quality Indicator 2: Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have left ventricular systolic dysfunction (LVSD) and, as of October 1 of reporting year:

- Are prescribed angiotensin converting enzyme inhibitors (ACEI); or

- Have a documented reason for not being on ACEI.

Threshold for extra payment: 80%

Audits. As stated in Operational Policy Letter 2000.129, HCFA will select a sample of M+COs in 2002 for auditing of the submitted data. Consistent with procedures developed for the risk adjustment payment methodology, these audits will confirm that the principal inpatient discharge diagnosis reported by the M+CO is supported by the medical record. The audits will also verify that M+COs met the quality indicator thresholds. If the review of the medical record or other supporting documentation fails to confirm the principal inpatient discharge diagnosis of CHF or attainment of both quality indicators, then HCFA will recover all associated payments from the M+CO.

D. Expansion of the time frame for offering the New Entry bonus

Section 608 of the BIPA extends by one year the BBRA time period that delineates an "unserved" payment area. Under the BBRA, the first M+C organization that offers a plan in a previously unserved payment area during the period beginning January 1, 2000 and ending December 31, 2001 is eligible for bonus payments (as described in Operational Policy Letter 2000.117). The BBRA defines a previously unserved payment area as:

- A payment area in which an M+C plan has not been offered since 1997; or

- A payment area in which an M+C plan (or plans) had been offered since 1997, but in which every M+C organization offering an M+C plan in that payment area since then has notified HCFA (no later than October 13, 1999) that it would no longer offer M+C plans in that payment area as of January 1, 2000.

Under the BIPA, a payment area is considered as "previously unserved" if every M+C organization offering an M+C plan in that payment area since 1997 notified HCFA no later than October 3, 2000 that it will no longer offer M+C plans in that payment area as of January 1, 2001.

Under the BIPA provision, an M+C organization that enters a previously unserved payment area on, for example, March 1, 2001 will receive 5 percent bonus payments until February 2002 and 3 percent bonus payments until February 2003.

Finally, the BIPA amendment applies as if it were included in the enactment of the BBRA. See OPL 2000.117 for additional information on the New Entry Bonus.

E. Revision of payment rates for ESRD patients enrolled in M+C plans

Section 605 of the BIPA provides that by June 21, 2001 the Secretary will publish for public comment a description of the adjustments to be applied to CY 2002 payment rates for M+C enrollees determined to have end-stage renal disease (ESRD).

F. Treatment of Certain Demonstrations

There are currently several demonstration projects that involve the provision of care to special populations, such as the frail elderly. Such projects offer enhanced benefit packages and include other unique features designed to meet

the special needs of these populations. These projects are currently paid based on adjustments to M+C capitation rates that are specific to each demonstration model. They include Evercare, the Social Health Maintenance Organization (SHMO) demonstration, the Program of All-inclusive Care for the Elderly (PACE) demonstration, the Minnesota Senior Care project, and the Wisconsin Partnership demonstration.

We are continuing to analyze refinements to the risk adjustment methodology for these demonstration projects. To support these analyses, we have been collecting hospital inpatient encounter data and are beginning to collect physician and hospital outpatient encounter data from these projects. We have also been collecting functional status information via the Health Outcomes Survey. In addition, we are developing a special survey instrument to collect information that could be used in the development of a hybrid risk adjustment approach for frail populations. However, the ongoing analyses to support risk adjustment for these projects will not be completed in time to apply any refinements in CY 2002.

The Evercare demonstration is currently scheduled to end December 31, 2001. Pending a decision on the extension of waivers for the Evercare demonstration, we intend to maintain the current payment approach for Evercare.

The BIPA extended the SHMO demonstration until 30 months after the Secretary submits a report to Congress that includes a plan to transition SHMO as an option under Medicare+Choice. The report has not yet been submitted. We will maintain the current SHMO payment in 2002.

PACE demonstrations in 2002 will include the current non-profit organizations and new for-profit entities. The current PACE sites are scheduled to transition to program status by November 24, 2002. The present PACE payment approach will apply to both current and new PACE demonstration sites in 2002.

We will also maintain the present payment approaches for organizations participating in the Minnesota Senior Care and Wisconsin Partnership demonstrations in 2002.

Treatment of the PACE program. We are still investigating refinements to the risk adjustment approach that account for the frailty of the PACE population. Therefore, PACE providers will be exempt from M+C risk adjustment during 2002. The present PACE demonstration payment approach will be used for the PACE program.