

Amendment #4
Issued on: November 12, 2013

For Request for Proposals RFP-MQD-2014-005
QUEST Integration (QI) Managed Care to Cover Eligible Medicaid and Other Eligible Individuals

#	RFP Section #	RFP Language	Amendment
1	Section 90 Capitation Rate Structure		Insert document as Section 90.
2	Appendix E Risk Share Program		Insert document as Appendix E.

SECTION 90 RATE STRUCTURE

90.100 Introduction

This section describes the rate structure and the guidelines for future rate setting.

90.200 Overview of the Rate Structure

For any member of a given QUEST Integration contracted health plan, the DHS shall pay a capitation rate which varies by aid category, island and age/gender band. Aid categories include the following:

1. Medicaid Expansion;
2. Aged/Blind/Disabled (ABD):
 - ABD – Medicare Eligible, and
 - ABD – Medicaid Only;
3. Other Populations:
 - CHIP,
 - Foster Care, and
 - Adults and Children.

The capitation rates shall assume an administrative load of no more than 10% for all rates except for aged, blind and disabled, and an administrative load of no more than 7% for aged, blind and disabled, both inclusive of administrative expenses and risk margin expenses but excluding general excise and insurance premium tax, if applicable.

90.300 Rate Development

The DHS shall provide all applicants with proposed capitation rates with supporting documentation by the date identified in Section 20.100. The DHS shall conduct an orientation of proposed capitation rates as described in Sections 20.100 and 20.200. During this orientation, DHS shall describe the process used to generate the proposed capitation rates and receive input from the applicants regarding the proposed capitation rates. In addition, DHS shall receive written questions and comments from the applicants regarding the proposed capitation rates by the date identified in Section 20.100.

DHS shall have a second meeting with applicants on the date specified in Section 20.100 via meeting in person, via teleconference, or by another method deemed appropriate by DHS after reviewing written questions and comments to discuss the final capitation rates and changes resulting from applicant comments, if any.

The DHS shall provide final actuarially sound capitation rates to all selected applicants as part of the contracted award on the date specified in Section 20.100. All selected applicants shall receive the same base capitation rates as described in Section 90.200. Due to the lag in rate development and application of rates, further adjustments may be required before implementation. If this is the case DHS will provide documentation of the rate change similar to that provided during a rate renewal. The allowed administrative expenditures shall be

increased to an amount as described in Section 90.200 for those that serve Statewide. Allowed administrative expenses shall be discounted for plans that serve only Oahu and one other island

The capitation rates shall have three components of risk adjustment to the base rates. Each of these adjustments shall be made after the initial enrollment period as described in Section 30.540.1.

The first part of the enhanced payment is based on FQHC and RHC use rates for enrolled members. The enhancement is intended to provide for the additional cost for services at these facilities due to the requirement that they be reimbursed at the PPS rate. Rates for health plans shall be increased to cover this additional cost based on historical use rates at these facilities for members enrolled in each plan. This enhancement shall vary by health plan, aid category, island and age/gender cohort.

The second adjustment will account for the distribution and acuity of the membership with long-term services and supports (LTSS) within the rate cells below.

Aged/Blind/Disabled (ABD)

- ABD – Medicare Eligible; and
- ABD – Medicaid Only.

We anticipate that this will involve stratifying members into those residing in a nursing facility, those meeting institutional level of care (LOC) and receiving home and community services,

those at risk of deteriorating to LOC and receiving home and community based services, and those without LTSS needs. We will further evaluate the risk within these populations.

In addition, in order to account for risk selection between health plans, DHS may perform a diagnosis and/or pharmacy based, or other risk adjustment. This adjustment shall be performed in a budget neutral manner for each applicable rate category. That is, the result of the application of risk factors for each rate category shall be expected to shift revenue between the health plans, with no impact on aggregate state funding. Risk adjustment factors shall be applied as early as possible at program startup, with the expectation of being no later than the second month of enrollment. If the risk adjustment is delayed beyond the initial month of enrollment, no retroactive adjustments shall be made. Each year, the risk adjustment process shall be refreshed with the target implementation for the next CY.

90.400 Future Rate Setting

Subject to limitations imposed by CMS, legislative direction or other outside influence for which the DHS shall comply, it is the intent of the DHS to publish revised rates each CY throughout the term of the contract. The DHS specifically does not commit to any particular methodology or formula, or to any particular benchmark or objective, for rate revisions.

APPENDIX E RISK SHARE PROGRAM

Objective of the Program: The State acknowledges that due to circumstances beyond the control of the health plans and the State, the established capitation rates may not be appropriate for the services to be provided. Even with utilization data and experience serving enrollees, it is difficult for the plans and the State to accurately predict the actual performance or utilization of services by the enrolled population. It is possible that more recipients will utilize more services than estimated. Conversely, it is also possible that more recipients will utilize substantially less services than estimated.

To address the unknown risk to the health plans and the State, the DHS will implement a risk share program. The risk share program will be applied when there is an overall impact on the program such that there is a significant differential between the Total Revenue (as defined below) received by the plans for health care, and the aggregate health care expenses of the plans. It is not intended to protect any one health plan from poor performance due to ineffective management of utilization, shock claims, or the inability to negotiate effective and economical contracts.

The State will perform risk share calculations separately for three population groups served under this Contact. They are as follows:

- 1) Medicaid Expansion
- 2) Aged, Blind, and Disabled (ABD)
- 3) All other populations

This will require health plans to track these three populations separately in their financials. Due to differences in Federal funding it is necessary that the Medicaid Expansion population be accounted for separately. The other two populations are accounted for separately due to differences in assumed administrative loads in the rates for those programs.

Throughout this document when the risk share calculation is referred to, it should be assumed that it will be done separately for each of these three populations.

The risk share program included in this document does not treat profits and losses the same. The risk share related to losses is activated by losses in excess of 5% for the population across all health plans; it cannot be activated by losses from a single plan. References to the risk sharing for losses in this document refer to the aggregation of all plans and reimbursements if any are distributed based on membership, not plan specific losses.

Gain sharing is calculated on a health plan specific basis. Health plans have a profit limit of 3% that the health plan can retain.

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Definitions:

Total Revenue is the sum of all Pre-Tax Capitation Rates, net of any HHSC supplemental payments, paid to each health plan during the calendar year.

Health care services portion of the Total Revenue is equal to Total Revenue, net of any HHSC supplemental payments and net of an assumed administrative load. $[(\text{Revenue} - \text{HHSC supplemental payments}) \times (1 - \text{administrative load})]$ Actual administrative expenses will not be included in the computation since the intent of the program is to adjust for unknown risk associated with providing the health services to the enrolled population. Note that service coordination costs are reported as healthcare services and not as administrative costs for this computation.

Assumed administrative load is as follows:

- | | |
|------------------------------------|-----|
| 1) Medicaid Expansion | 10% |
| 2) Aged, Blind, and Disabled (ABD) | 7% |
| 3) All other populations | 10% |

Note that health plans who do not participate on all islands will have a lower administrative load. The health plan specific administrative assumption will be used for that calculation.

Net Health Care Expenses will be based on the actual service expenses less any reimbursements from third party reimbursements and less supplemental payments. The expenses will be taken from the financial reports provided by the health plans for the calendar year. DHS recognizes that the financial reports are due within 45 days from the end of the reporting period and that some data may not be available at the time the reports are submitted. Therefore, prior to compiling the profit/loss statement for the risk share program, the health plans will be requested to update their report for the year for any adjustments through June 30. That updated report will be due to the DHS by July 15.

Health Plan Gain/Loss will be calculated for each population using the following formula*:

Health care services portion of Total Revenue

Less: Net health care expenses (based on the actual incurred expenses for health care)

Equals: Net profit/loss (for the health care services provided by population)

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The net profit/loss divided by the Total Revenue will provide a percentage of the profit/loss which will be compared to the risk corridor established by the DHS.

Program Gain/Loss will be calculated for each population using the following formula*:

Σ Health care services portion of Total Revenue

Less: Σ Net health care expenses (based on the actual incurred expenses for health care)

Equals: Net profit/loss (for the health care services provided by population)

The net profit/loss divided by the Total Revenue will provide a percentage of the profit/loss which will be compared to the risk corridor established by the DHS.

Conceptual Framework: Under the risk share program, the DHS will share in a significant difference between the Total Revenue and the Net Health Care Expenses experienced by the health plans. Six (6) months following the end of the calendar year, using the financial reports provided by the participating health plans, a simple profit and loss statement will be developed for the health services portion for each of the three populations.

For each of the three populations, following the computation of the profit and loss statement (aggregate for the loss calculation and plan specific for the gain share calculation), a net loss or gain percentage will be computed based upon the Total Revenue paid to the health plans for health care provided to the population.

Loss Sharing

For the loss sharing calculation, the net loss or gain percentage will be computed in aggregate for all health plans combined. If the loss percentage is within a 5% risk corridor, there will be no loss sharing between the DHS and the health plans and the health plans will absorb all of the loss for that population. If the aggregate loss is outside of this risk corridor, the DHS will share equally in the loss for that population exceeding the risk corridor up to the risk share limit of \$5,000,000 for the ABD population and for the all other populations; there is no limit for the expansion population.

If there is to be loss sharing, each health plan would be compensated individually based on the number of eligible months. Using an example of a net loss of 7% for the ABD population, with the risk corridor at 5%, the 2% difference would be shared equally between the DHS and the health plans up to \$5,000,000. Since the DHS and the health

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plans share equally in the loss, the amount to be remitted back to the health plans is 1% of the Total Revenue paid to the health plans for health care. The individual amounts to be remitted to the health plans or to the State will be distributed based on eligible months. Only health plans experiencing an actual loss will be permitted to benefit from the risk share program, and no health plan shall receive an amount remitted back in excess of its losses.

Gain Sharing

For the loss gain calculation, the net loss or gain percentage will be computed for each health plan separately. If there is health plan specific gain exceeding 2%, the DHS will share equally in the gain between 2% and 4%. The DHS will recover all gains exceeding 4%.

Similarly, at the individual health plan level, if there is a net gain of 6%, there will be profit sharing for the 4% difference beyond the 2% corridor. The first 2% difference will be shared equally between the DHS and the health plan. The second 2% will be returned to the State. Only health plans experiencing an actual gain above the 2% corridor will be required to reimburse the State.

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Examples: The following examples illustrate how the Risk Share Program would be applied in aggregate and individually to the health plans. The example is based on an ABD population.

Example 1: Aggregate Program Calculation for Loss

Plan	Recipient Months	Total Revenue	Health Care Services Portion of Total Revenue		Medical Expenses	Net Loss	Loss Percentage
			%	\$			
A	205,200	102,600,000	93%	95,418,000	106,618,842	-11,200,842	-11.74%
B	<u>154,800</u>	<u>77,400,000</u>	93%	<u>71,982,000</u>	<u>79,122,150</u>	<u>-7,140,150</u>	<u>-9.92%</u>
	360,000	180,000,000		167,400,000	185,740,992	-18,340,992	-10.96%

Total Revenue Paid to the Plans for Health Care	167,400,000
Total Expenses Related to Health Care	<u>185,740,992</u>
Net Loss	18,340,992
Loss Percentage for the Program	10.96%
Risk corridor is 5%	<u>-5.00%</u>
% of loss to be shared equally between plans and DHS	5.96%
% to be returned to plans (50/50 share)	2.98%

Since in aggregate, the program experienced a loss greater than the 5% corridor, the risk share program will be implemented.

Example 2 Distribution to the Plans

The health plans and DHS share equally in the loss over 5% (i.e., in this example 5.96%). The total amount to be returned to the health plans is calculated based on 2.98% of the health care services portion of the Total Revenue received by the plan experiencing a loss (2.98% x \$167,400,000 = \$4,988,520). A per capita amount to be returned can be calculated using the total amount to be returned divided by the total number of recipient months served by the plans experiencing a loss (which could be a single plan). In this example, the per capita amount would be \$13.857 per recipient month (\$4,988,520 / 360,000). As long as the \$5,000,000 limit was not reached, the calculation would be computed as follows: Each health plan with a loss will receive \$13.857 per recipient month. Plan A would receive \$2,843,456 (205,200 x 13.857); and

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Plan B would receive \$2,145,063 (154,800 x 13.857). A health plan would not receive any payment from the Risk Share Program if it did not actually experience a loss.

If the limit of \$5,000,000 had been exceeded, each health plan with a loss will receive a pro rata share of the \$5,000,000 based on the health plan's recipient months. Plan A would receive \$2.85 million (57% x \$5,000,000); and Plan B would receive \$2.15 million (43% x \$5,000,000).

Example 2: Plan Calculation of Gain

If there is a net gain, the net gain percentage will be computed and collected from each health plan exceeding the 3% allowable gain. The example below is also based on an ABD population.

Plan	Recipient Months	Total Revenue	Health Care Services Portion of Total Revenue		Medical Expenses	Net Profit	Gain Percentage
			%	\$			
A	360,000	180,000,000	93%	167,400,000	158,546,999	8,853,001	5.29%

Total Revenue to the Plan for Health Care	167,400,000
Total Expenses Related to Health Care	<u>158,546,999</u>
Net Gain	8,853,001

Gain Percentage for the Program 5.29%

Risk corridor is 2% 2.00%

Since the population experienced a gain greater than the 2% corridor, the risk share program will be implemented.

Example 4: Plan Specific Calculations

The health plans and DHS share equally in the gain between 2% and 4% and any gain at or over 4% is returned to the State. If a health plan has a gain over 4%, the maximum amount that the health plan will be allowed to retain will be 3%. The gain allocation would be applied only to health plans which experienced a gain over 2%. In this example, Plan A had a gain of 5.29% and would return half of the gain in excess of 2% less than 4%, or 1.0% ($[4.00 - 2.00] / 2$) and all of the gain in excess of 4%, or 1.29%. Plan A would retain \$5,022,000 and would return \$3,831,001 to DHS.