

Proposed Capitation Rate Question & Answer

Issued on: January 4, 2012

For Request for Proposals RFP-MQD-2011-003

QUEST Managed Care Plans to Cover Eligible Medicaid and Other Eligible Individuals who are not Aged, Blind, or Disabled

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
1	20.100		Issue Final Capitation Rates	<p>It is our understanding from the capitation rate orientation that the capitation rates issued on January 4, 2012 will not be the 'final capitation rates' but will be base capitation rates which will be adjusted after the DHS has determined the projected PPS eligible members and the project SMI eligible members for each contracted health plan.</p> <p>Additional capitation add-ons will be applied to the capitation rates issued on January 4, 2012. Is this correct?</p>	Yes. After the Initial Enrollment Period.
2	20.100	16		<p>With the issues that were raised in the capitation orientation meeting that were not considered in the rate development, and the State's request for additional data which should result in adjustments to the rates, we request that the adjusted rates be issued as <u>proposed</u> rates with one additional opportunity to ask clarifying questions prior</p>	No. The rates issued will be the final rates. Any adjustments to the rates presented at the orientation were made in response to the questions/comments that have been submitted. The potential bidders have had an opportunity to submit any and all questions they have.

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				to the release of the final rates.	
3	20.200	17	2	Our preliminary analysis indicates that these rates will result in significant financial losses. We respectfully request an opportunity to have a meeting between our plan and the State to discuss rates before they are finalized. The purpose of the meeting is to present proprietary information to the State that we believe the State should consider in making the final rate determination.	No. The State will not meet with applicants during the bidding process. However, the base rate will be the same for all health plans and the State will ensure that rates are actuarially sound. The health plans will have an opportunity to meet to discuss the final rates (see item #12).
4	30.520	75	2 nd paragraph	RFP section 30.520 page 75 states that “all members of a newly eligible household shall be auto-assigned to the same plan”. Can you explain how this will be administered? If a plan receives 4 members within a household, are they excluded from the next three rounds of auto assignments?	Newly eligible family members are auto-assigned by case number if choice does not occur. Members are only auto-assigned once. Members receive option of choice during Annual Plan Change thereafter.
5	30.900	98	2 nd full paragraph	Aid to disabled review committee (RFP section 30.900)-the RFP changes the timeline for member disenrollment from the plan from the first day of the second month following the date the ADRC packet is <u>submitted</u> , to the first day of the second month following the date the ADRC packet is <u>approved</u> . Disabled members will be on the plan longer and will result in increased cost to plans. Was this factored into the rates and if so, what was the pmpm impact of this	DHS does not anticipate a change in time for determination following complete submission. This change is in response to identified practices of submitted ADRC packets at the very end of a month. DHS will continue to determine as quickly as possible, and the timeframe stated is the upper limit.

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				change? If not, please explain the rational.	
6	50.500	257-262		Shouldn't there be cost considerations for the expectation that plans implement value-driven health care - aligning provider payment to quality and efficiency? Higher reimbursement to providers may have to be considered to achieve greater quality and efficiency that are not represented in base year data.	<p>The cost considerations are integrated into the contract design. Those plans that have higher quality and efficiency are more likely to realize a profit and to receive the financial incentives. In addition, higher quality health plans can receive a greater proportion of auto-assigned recipients.</p> <p>If higher quality and efficiency is expected to improve patient-oriented outcomes such as reduced ER visits and hospital admissions, then savings will be realized from the reduced utilization.</p>
7	60.310	374	3	Our understanding from the capitation rate orientation is that the completion factors used to develop the projected rates do not reflect the extension in the claims filing deadline to one year (RFP 60.310). We note that the State has requested additional data. It is our expectation that your analysis of the data will likely indicate the need to make adjustments in the rates, and it is our understanding that you intend to adjust the rates if so. Is this correct? If not, please explain the rational.	Correct.

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8	60.530	385	Footnote under table	Our understanding from the capitation rate orientation is that the projected rates do not reflect the change in the catastrophic care (State share) that is now limited to the Medicaid fee schedule amount not the health plan's reimbursement structure (RFP 60.530). We note that the State has requested additional data. It is our expectation that your analysis of the data will likely indicate the need to make adjustments in the rates, and it is our understanding that you intend to adjust the rates if so. Is this correct? If not, please explain the rational.	Correct.
9	90.300	465	-	<p>We request that the State provide a detailed Actuarial Rate Setting Methodology memo that details the RFP contract period rate setting and assumptions (including historical and prospective utilization and unit cost trends, data used, completion, managed care savings, other adjustments, etc.).</p> <p>Can the State provide the reimbursement basis upon which the State's actuaries base the capitation rate, e.g. will the capitation rates assume 110% of Medicaid FFS rate(s)? If not, please explain the rational.</p>	<p>This information has been provided in the proposed capitation rate letter. In addition, the proposed capitation rate letter will be updated to account for any changes in final rates.</p> <p>Rates have been calculated based on historical health plan reimbursement levels.</p>
10	Appendix B	24		Appendix B is labeled 'Statewide Base Rates', while the bottom section is labeled 'Base Monthly Claim Costs'. Do the PMPM	Rates in Appendix B do not include administration, P4P reduction, PPS FQHC add-on or the MRO add-on.

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				values in the bottom section include administrative load, or are they only the claims costs? Do they exclude or include the PPS add-on and MRO add-on?	
11	Appendix D			The title states, “includes \$2 P4P withhold”. Does this mean that the rates reported here have been reduced by the \$2?	Correct.
12	General			It is our understanding from the capitation rate orientation that a contract health plan will have the opportunity to discuss the final capitation rates and any capitation add-ons with the DHS and their actuary after the DHS has completed the initial open enrollment period. Is this correct?	Yes.
13	General			Were the rates adjusted for the PPACA requirement that PCPs be paid at 100% of the Medicare fee schedule starting January 1, 2013? If not, will that be a change to the rates mid-contract year?	Rates have not been adjusted for this change. We will make a mid-contract adjustment once more information is available from CMS.
14	General	n/a	n/a	Given the recent industry-wide medical cost depression, was any consideration made in the State’s trend analysis for a return to historical trend levels? Our own internal review of this indicates a correction of 0.5% - 1.5% through 2013.	We have no evidence that a correction is required.
15	General	n/a	n/a	In May 2011, the FDA approved two new drugs to treat certain adults with chronic Hepatitis C (Incivek and Victrelis). Both drugs are used in combination with	Pharmacy trends account for new drugs as well other factors that may lower drug costs.

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				<p>peginterferon alfa and ribavirin (Peg/Rib). The cost of therapy for the new drugs is significant.</p> <p>Based on our health plan's experience, the average costs per week (as a function of drug cost per week, based on experience, and the recommended treatment length) per drug are: Incevik \$4,200 - \$4,500, Victrelis \$1,000 - \$1,500, Peg/Rib: \$750 - \$1,000. Treatment costs vary by patient as patients require different lengths of treatment. At a high level, the recommended treatment regimen for Incevik is 12 weeks of Incevik paired with 24-48 weeks of Peg/Rib. For Victrelis, the recommended treatment is 24-44 weeks of Victrelis paired with 28-48 weeks of Peg/Rib.</p> <p>Using the average cost of therapy per week from our health plan's experience and average treatment durations, the average cost of therapy for these drugs including Peg/Rib is \$78,000 for Incevik and \$70,000 for Victrelis. Excluding the costs of Peg/Rib, the average costs of therapy is \$53,000 and \$41,000 for Incevik and Victrelis, respectively.</p> <p>Will this new course of treatment be covered</p>	

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				under managed care, and if so, how was this factored into the pharmacy rate development and prospective trends?	
16	General	n/a	n/a	What consideration did the state make for the recent changes made to pharmacy rebate levels due to ACA? Historical pharmacy rebates achieved by health plans will not be reflective of future rebate amounts.	We assumed no health plan rebates.
17	General	n/a	n/a	Recent health reform laws require that Medicaid reimburse primary care providers (PCP's) at Medicare rates beginning in 2013 and extending through 2014. Since the increase differential will be funded through the federal government, how will the State verify that increased rates are fully passed through to MCOs and ultimately to providers? What considerations did the State make to account for this in the rate setting?	See response to question #13.
18	General	n/a	n/a	During the Capitation Rate Orientation Meeting on December 4 th , the State's Actuaries indicated that they would consider the application of a risk adjustment methodology in the future. Will the State be willing to allow the health plans to participate in the establishment of the risk adjustment methodology and the validation?	Yes. After contract award.
19	General	n/a	n/a	Can the State clarify its methodology for adjusting base year data to reflect the impact of benefit day limits? At the capitation rate	We looked at claims that were less than 30 days to assess the cost of first 30 days verses days beyond 30

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				meeting, the State's actuaries indicated they identified stays that exceeded the benefit day limits and adjusted expense for those stays to average daily cost multiplied by the new benefit limits. Our concern is that if actual average daily cost was used, the claims expense included in the capitation build may be understated. We typically find that daily costs are highest at the start of a hospital stay, so average daily cost may not adequately cover the estimated expense.	days. We found that this methodology overstated the reduction. We therefore used an average per diem for the actual claims that were in excess of 30 days with the assumption that any additional early costs in a stay as long as 30+ days would be minimal. The same methodology was used to adjust the reinsurance reduction.
20	General	n/a	n/a	The member months provided in the Milliman rate documentation are between 2.2M and 2.3M, but 2010 QUEST membership previously provided by the State was more than 2.5M. Can the State provide information to accounts for the difference in membership?	Member months in each exhibit are consistent with the underlying claims. For many exhibits Kaiser data was not used and therefore those member months were not included.
21	General	n/a	n/a	During the capitation rate meeting, the State mentioned that the open enrollment period will be in March. Can the State confirm the expected to/from dates of the upcoming open enrollment for the July 1 st commencement of services?	The State said that March is being considered as the time frame for Initial Enrollment period at this time. However, no dates have officially been decided at this time.
22	Milliman Letter-12/6/2011		Appendix A	Our understanding from the capitation rate orientation is that the projected rates do not reflect the difference between the health plan's reimbursement structure and the Medicaid fee schedule in developing the	Correct.

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				retroactive member claims amounts in the cost models (cost model line RTQ). We note that the State has requested additional data. It is our expectation that your analysis of the data will likely indicate the need to make adjustments in the rates, and it is our understanding that you intend to adjust the rates if so. Is this correct? If not, please explain the rationale.	
23	Milliman Letter- 12/6/2011		Appendix A	<p>Please provide details of what is included in the additional costs line in the cost models? If not, please explain the rationale.</p> <p>Is this intended to cover costs such as provider risk pool payments & quality payments? If provider risk pool payments & quality payments are not covered in this line, where are they in the cost models?</p>	Health plans were asked to provide health plan specific costs that were not part of the member level claim data. These costs were included in this line.
24	Milliman Letter- 12/6/2011	2	7 th bullet, 4 th paragraph	It is our understanding that the State adjusted the claim encounter experience to remove inpatient days beyond the new 30 day threshold. How were SNF days treated in the analysis? Specifically, if a patient exhausts the 30 day inpatient benefit and is later downgraded to an SNF level of care and is waiting to transfer from an acute facility to a SNF facility (and is on a waiting list to transfer), is the member still eligible for the 60 long term days? If so, how was	We excluded SNF and waitlist days from the reduction.

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				this reflected in the adjustment? If not, please explain the rational.	
25	Milliman Letter-12/6/2011	2	Base Year Data	Were there any data gaps or data issues with the base year data provided by the current QUEST health plans that could have an impact on Appendix A cost models?	Data included in Appendix A reconciled very well with information provided by health plans. We do not believe there are any gaps in the data.
26	Milliman Letter-12/6/2011	2	Base Year Data Section	Did the State evaluate the health status or PMPM cost of individuals above 133% FPL? If not, please explain the rational. If so, what difference did that indicate, and did the State reflect that difference in the proposed rates? If not, would the State consider making such an adjustment?	We did not evaluate the health status of these individuals. We simply removed the members and their costs.
27	Milliman Letter-12/6/2011	4	-	Please provide the pmpm impact of the adjustments made for each of the following: a. Claims filing deadline extension to one year (RFP section 60.310) b. Additional benefits for QUEST NET/ACE/BHH to a full drug benefit (Milliman Ltr 12/6/2011 pg 4) c. Reduced vision services for adults (Milliman Ltr 12/6/2011 pg 2)	This information is included in the final rate documentation letter.
28	Milliman Letter-12/6/2011	4	Age Gender Rates Section	It is our understanding that the QUEST NET/ACE/BHH populations will now be eligible for the adult benefit package. Was an adjustment made to the rates to account for the increased inpatient, outpatient and	We reviewed risk factors and PMPM costs by service type for these populations compared to other QUEST populations with full benefits. We also reviewed data for

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				<p>professional benefits that these populations will be receiving under the new adult benefit package (refer to Amendment #5, item 6 which modified the adult benefits coverage limits which allow more services than the current QUEST Net, ACE and BHH benefit packages)?</p> <p>In the letter from Milliman to DHS dated December 6, 2011, (page 4) under the Age Gender Rates section it refers to an adjustment for the enhanced drug benefit, however there is no mention of an adjustment for the other enhanced benefits for these populations. If not, please explain the rational.</p>	<p>these members to assess the number that meet or are near benefit limits. We found that for similar risk levels the reduced benefit populations had higher PMPMs. We therefore have adjusted for pharmacy but not for the other benefit changes.</p>
29	Milliman Letter-12/6/2011	4	Reinsurance Section	<p>It is our understanding that the State adjusted the claim encounter experience to remove claims that would be subject to the revised reinsurance program. In doing so, did the State revise the encounters to reflect the State fee schedule, rather than the reimbursement agreement between the payer and the provider? What was the impact of the reinsurance adjustment? If not, please explain the rational.</p>	<p>Initial rates were not repriced at FFS levels. Final rates will be adjusted for this change.</p>
30	Milliman Letter-12/6/2011	4	Trend	<p>Can you provide justification for the cost trend assumptions of 2.5%?</p>	<p>Trend rates were based on Medicaid FFS changes, historical trends and trends observed by</p>

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					bidding plans for similar programs in recent procurement work.
31	Milliman Letter-12/6/2011	4	Trend Section	We noticed the ER utilization trend used in the rate development is 0%. Our plan is actively managing ER visits and has experienced a utilization trend greater than 0%. Will the state consider reevaluating the encounter data to see if a utilization trend over 0% is reflected in the data? If not, please explain the rational.	Our intent was to emphasize the State's expectation to further manage this service.
32	Milliman Letter-12/6/2011	6	FQHC	How will the FQHC PPS enhancement be allocated to each health plan – based on what criteria?	Our intent is to allocate additional FQHC funds based on the member where available and by historical plan FQHC use rates for new members.
33	Milliman Letter-12/6/2011	6	SMI Supplement	How will the SMI supplement be added to the rates of each health plan - based on what criteria?	The supplement will be added based on enrollment of SMI members.
34	Milliman Letter-12/6/2011	6	SMI Supplement Section	On the SMI supplement, could you please provide a breakdown of the major service categories that comprise the \$371.58 Medicaid Rehabilitation Option (MRO) cost. If not, please explain the rational.	All services included in this supplement are from the same major service category – MRO services. We cannot provide additional details and keep plan data confidential.
35	Milliman Letter-12/6/2011	9	Appendix A	Based on our understanding of the cost models, the adjustment for the retroactive member claims is substantial. Because of the potential impact this change has, we request that you provide cost model detail regarding	This information will be provided by major service type in final rate documents.

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				this adjustment. If not, please explain the rational.	
36	Milliman Letter-12/6/2011	9	Appendix A	On the retroactive member claims adjustment in the cost models, did you adjust the fee for service data to account for the difference between the higher plan reimbursement to providers compared to the Medicaid fee for service reimbursement to providers? If not, please explain the rational.	We did not include this in the initial rates. However, we will make an adjustment in the final rates.
37	QUEST Data Book			Were the retroactive member months pro-rated in the rate development given that the members will be added to the health plans roll mid-month?	Yes.
38	QUEST Data Book	2	2	When calculating the adjustment to the rate for members who gain eligibility retroactively, what fee schedule was used? Since plans may contract above the state fee schedule, the cost of these claims may exceed what was paid in the fee-for-service data	Rates will be adjusted for fee level differences.
39	QUEST Data Book	4	1	Since the data used to build the rates is from January 1, 2010 through December 31, 2010, and the rates are effective from July 1, 2012 through December 31, 2013, there are 2.75 years between the middle of the base data to the middle of the rate effective period. Should 2.75 years of trend be applied to the rates instead of 2.5 years?	Yes, we have corrected this in the final capitation rates.

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40	QUEST Data Book	Appendix A	n/a	During the capitation rate meeting, the State's actuaries mentioned they could share more detailed worksheets that support Appendix A. We would like to request a copy of such supporting data/worksheets.	We intend to provide additional details on retro claims. The level of detail beyond Appendix A is the member level claims which we do not intend to provide.
41	QUEST Data Book	Page 2	n/a	The State's actuaries indicated that they priced the encounters for the members who gain retro eligibility at the State FFS level. Given that existing plans paying at higher than FFS levels, would state re-visit that assumption to include a reimbursement level higher than the State FFS?	Rates will be adjusted for fee level differences.
42	QUEST Data Book	Page 2	n/a	The State's actuaries indicated that they relied primarily upon data provided by existing QUEST health plans. Was there any adjustment made for the completeness of this reported data (not an IBNR adjustment). Typically we find that reported encounters are roughly 97% - 98% complete and see an additional 2-3% encounter data completeness adjustment. Did the State factor this in to the base data?	We used health plan financials as well as additional information from health plans to assess completeness of data.
43	QUEST Data Book	Page 4	n/a	Can the state provide details behind the flat utilization trend assumptions for Inpatient and Emergency Room? Did the state factor additional utilization savings into this assumption? Based on a review of historical data from the QUEST incumbents, as well as our own internal trend forecast model, we	Trend rates were based on Medicaid FFS changes, historical trends and trends observed by bidding plans for similar programs in recent procurement work. The flat ER trend was to emphasize

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				project utilization trends of 1% – 1.5% for these services.	the State’s expectation to further manage this service.
44	QUEST Data Book	Page 4	n/a	Why was the base period data trended to January 1, 2013 instead of to April 1, 2013, the midpoint of the initial contract term? An additional 3 months of trend applied to the given base data at the trends indicated in the rating documentation provided by Milliman would result in approximately a 1% medical cost increase.	The final capitation rates correct for this oversight.
45	QUEST Data Book	Page 6	n/a	Can the state describe how it will distribute the FQHC enhanced payment? Our recommendation is that this enhanced payment would follow the member by means of the creation of an FQHC rate cell.	Our intent is to allocate additional FQHC funds based on the member where available and by historical health plan FQHC use rates for new members.
46	QUEST Data Book	Page 6	n/a	As the SMI population does not have distinct rate cells, how will rates be adjusted on a go-forward basis if there are significant changes from one QUEST plan to another in share of the SMI population?	The supplement will be added based on enrollment of SMI members.
47	QUEST Data Book			Were all three of the current QUEST health plans’ data included in the rate analysis?	Data was used from all three current QUEST health plans. Final claims costs in Appendix A did not include data from Kaiser.
48	QUEST Data Book			Health Plans are expected to incentivize practices that meet the criteria to be a medical home. Has this added expense been factored into the rates?	Our expectation is that these practices will be cost beneficial.

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49	QUEST Data Book	3	Pharmacy	In calculating the capitation, will plan-specific adjustments be made based on current generic prescription utilization rates? If a plan has already achieved the targeted benchmark, they will not incur the expected cost savings compared to plans whose current generic prescription utilization is not as favorable.	Since rates are based on a blend of health plan claim experience, a health plan that is already doing better than other plans will benefit from rates set with data of lesser performing plans.
50	QUEST Data Book	4	Trend	Is the cost trend an annual rate or based on 2.5 years?	Annual rates.
51	QUEST Data Book	4-5	Reinsurance	In calculating the reinsurance amount, were the claim amounts adjusted to reflected the Medicaid fee schedule (and not contracted rates)?	Rates will be adjusted for fee level differences.
52	QUEST Data Book	4	Age Gender Rates	This section addresses the additional drug benefit for QUEST-Net/ACE/BHH populations. Has the increase in outpatient visits for QUEST-Net/ACE/BHH also been factored into the rates? If so, what is the pmpm increase? Also, the drug benefit equivalent is said to be similar to TANF for like age/gender bands. If so, why do the rates appear lower, in general, than the current QUEST-Net/ACE/BHH rates?	We reviewed risk factors and PMPM costs by service type for these populations compared to other QUEST populations with full benefits. We also reviewed data for these members to assess the number that meet or are near benefit limits. We found that for similar risk levels the reduced benefit populations had higher PMPMs. We therefore have adjusted for pharmacy but not for the other benefit changes.

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					QUEST-Net/ACE/BHH Adult rates are higher than AFDC/TANF rates for similar age/gender bands.
53	RFP-MQD-2011-003, Amendment #5	2-3	Items #6 and #7	Amendment #5 items #6 & #7 state that the benefit limits are subject to change. Is the State committed to an increase to plan reimbursement if the benefit change results in higher costs to plans? If not, please explain the rational.	Yes.