

Proposed Capitation Rate Question & Answer

Issued on: December 6, 2013

For Request for Proposals RFP-MQD-2014-005

QUEST Integration (QI) Managed Care to Cover Eligible Medicaid and Other Eligible Individuals

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
1	30.510	71	2	Eligibility: The eligibility rules have changed allowing members to retroactively enroll up to 10 days prior to the application as compared with the previous 5 days requirement contained in the prior RFP. Can you please provide the amount of the adjustment that was included in the rates to account for the change in retroactive enrollment? If no adjustment was made, can you share the analysis that was performed demonstrating that no adjustment to the rates was necessary?	This policy has been in place for over a year. Milliman has not noticed a need for change in rates due to this change in policy. However, we will monitor the effect of this policy change to see if any adjustment is necessary.
2	40.740.1	169	3	What is the rate adjustment for Cognitive Rehabilitation Services?	There is no adjustment at this time. This is not a new service.
3	60.200	415	2	Please clarify why rates are actuarially sound with or without the refund of the \$2.00 PMPM P4P withhold.	The rates are calculated to be actuarially sound, and this assessment includes the assumption that a health plan does not earn any of the financial incentives. In addition, a review of best practice managed Medicaid plans shows that there

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					are opportunities to manage down costs in excess of \$2.00 PMPM.
4	90.200	505	1	Please provide a breakdown of the current enrollment based on the six aid categories (Medicaid expansion, ABD-Medicare eligible, ABD-Medicaid only, CHIP, Foster Care, and Adults & Children).	The final report includes a summary of age/gender and island enrollment by rating cell.
5	90.300	506	3	This section states that DHS will provide final capitation rates as part of the contracted award. How may these rates differ from capitation rates distributed and discussed in December (i.e., health-plan specific adjustments, rating updates based on recent health plan data submissions)? If there are material changes between the December 6 rates and final rates, will the plans have an opportunity to review after the Contract Award Date?	Plan specific adjustments include: ABD blended rate, risk adjustment, FQHC adjustment, admin adjustment if not on all islands, and tax adjustment. In addition if there are issues that require an adjustment to the rates given the long period before implementation we will make the appropriate adjustment. Plans would have an opportunity to review any such changes similar to past rate setting.
6	90.300	507	1	How much of the administrative expenses will be discounted for plans that serve only Oahu and another island?	The expected administrative expense discount is 0.5% for all rates except for aged, blind and disabled (ABD) and a discount of 0.25% for the ABD. The administrative expenses would be 9% for all rates except for ABD and 6.25% for the ABD.

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7	90.300	507	1	Will the State request updated health plan medical expense data in order to calculate the risk adjustments that will be made to rates after the initial enrollment period? We believe that rating of Medicaid Expansion members in particular would benefit from using actual CY13 claims experience.	Given the age of the data by the time of implementation we expect to use a more recent data set to develop risk scores that will be effective 1/1/2015. Risk adjustment is intended to be budget neutral so a more current risk adjustment will likely not address expansion concerns. We do however intend to monitor that population and if necessary rebase those rates before 2015.
8	90.300	508	1	When the risk adjustment process is refreshed in subsequent years, if completion of the risk adjustment is delayed beyond the start of a fiscal year, will the factors be applied retroactively to the start of that year? If not, will the previous year's risk adjustment continue until the new factors are implemented?	If risk adjustment is delayed, once calculated the risk adjustment will be applied retroactively or prospectively but adjusted to account for the delay.
9	90.300	508	1	Can Milliman provide actual average risk scores for the QUEST Integrated populations? If not yet calculated, can Milliman provide average risk score estimates based on similar populations?	Risk scores will be available for the QUEST program shortly. We have not computed current risk scores for the ABD program. Each program's risk scores are applied to a different base and have different condition coefficients, but on average for similar programs each generally composite to 1.000.
10	90.300	508	1	How does Milliman intend to handle durational influences that are likely to impact diagnostic comparison between	We require more than 6 months of exposure in order for a member to be scored. In addition, outside of the ABD

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				plans with continuing mature enrollment and plans with a disproportionate share of newly eligible members?	population which is very stable, all health plans have been providing services to these members for over a year and should have a base continuing enrollment to be scored.
11	Appendix E	E-1	Risk Share Program	With regard to an asymmetrical risk corridor, capitation rates provided to plans are subject to fluctuation due to general uncertainty even under ideal pricing circumstances. The proposed corridor may not allow plans to accrue enough risk based capital in favorable years under the capped gain scenario to offset years of poorer experience under the more open-ended loss scenario. Would the state be open to the idea of a symmetrical risk sharing agreement between itself and the plans?	No.
12	Appendix E	E-1	Risk Share Program	To the extent that plans have different underlying risk composition, not all plans may be able to achieve the same target loss ratio. Risk adjustment could be a mitigating factor for this. However, we believe that this is another reason to consider using a symmetric risk sharing (at least initially) since initial rate methodology may not initially capture the full effect of the differences in plan risk. The current risk corridor design	A symmetric corridor does not add protection for the plans, unless the percentages of the corridor are changed or the losses are determined based on the plan specific results.

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				could hurt plans simply based on having a higher population morbidity. Could a symmetric risk corridor be reconsidered to mitigate this possibility?	
13	Appendix E	E-1	Risk Share Program	Justin Birrell of Milliman stated in the capitation rate meeting for QUEST Integration on 11/15/2013 that the State fully intends to retroactively adjust rates that are deemed to be insufficient. If the State is planning to implement the current proposed risk share program, sufficient rates would be crucial to the viability of participating plans. Can the final contract include written language that recognizes the inclusion of a process to discuss rate concerns that supports Mr. Birrell's intention for potential retroactive rate adjustments?	Mr. Birrell's statement was that when there has been an unforeseen issue that would make the previously developed rates insufficient in aggregate for a population, the state has been willing to address that issue. As an example, he mentioned the issues with the current QUEST-ACE population. In that case CMS has allowed a retroactive repayment of those rates. This adjustment of previously developed rates is contingent upon CMS approval and therefore could not be included in contractual language. The state will make such decisions on a case by case basis at their sole discretion.
14	Appendix E	E-1	Risk Share Program	In the event that retroactive adjustments to rates become necessary, the applicable capitation used in the risk sharing calculation should be refined to adjust for the impact of retroactivity. For example, if capitation payments are retroactively paid for coverage months in a previous risk sharing measurement period, then those payments should be allocated back	The Risk Share Program is calculated on an incurred basis therefore any retroactive changes would be applied to the period they were incurred.

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				to the appropriate coverage month in the previous measurement period as opposed to having them count as higher paid revenue in the current measurement period. Can the language in the Risk Share Program be amended to reflect this distinction?	
15	Appendix E	E-1	Risk Share Program	The risk share agreement caps the State's loss sharing at \$5,000,000. Does this apply to the ABD and "All other populations" separately, allowing for \$5,000,000 in loss sharing for each program, or is the \$5,000,000 cap to be split between the two programs?	Yes. The \$5 million is loss sharing applied separately for each of three populations: new adult group, ABD, and other (non-ABD non-newly eligible).
16	Appendix E	E-1	Risk Share Program	What percentage of premium is the loss cap when divided by total program-wide premium subject to the loss cap? For example, if there is a maximum \$5,000,000 loss cap in place, and the projected premiums for programs subject to the cap are \$150,000,000, then the maximum cap is 3.33% of projected premium. Understanding this amount is helpful for plans to better understand the maximum level of program-wide protection afforded by the cap.	The absolute loss amount is not based upon a pre-determined percentage.
17	Appendix E	E-1	Risk Share Program	The current risk share program design only reimburses plans that experienced a loss. However, actual loss	While this may be possible, given the relatively low total compensation for programmatic losses, the state prefers the

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				reimbursements are based on member months. This seems to reward plans with higher revenue while not necessarily considering the potential for risk variation between plans. Would the State be willing to consider adjusting the allocation of loss sharing based on that company's losses?	simplicity of the proposed method. Med-QUEST would consider a more complicated model if the reimbursement level was adjusted at some point.
18	Appendix E	E-1	Risk Share Program	The State mentions that no plan shall receive remit above its losses in the event of a loss share among plans. If one plan hits this limit and there are still dollars to be split out for the loss share (since it is \$PMPM * Member Months), do these remaining dollars get redistributed among other plans, and If so, what is the methodology to do this?	Additional funds shall be distributed as additional PMPM x remaining member months.
19	Appendix E			We recognize and support the need for specific population ratings and different administrative cost levels. We also recognize the reality of differing member mixes across health plans and the need to calculate and report gain/loss results by population cohort. However, we are concerned that imposing the gain share model by population cohort, rather than in aggregate for each health plan, may result in situations where a health plan is returning funds to the State for one	See #1 of Amendment #6.

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				cohort and at the same time incurring losses for another cohort. This could result in health plan losses and ultimately jeopardize the stability and success of the QUEST Integration program. Would the State consider changing its risk share methodology so that, while calculated and reported by cohort, the amount due to/from each health plan is based on the plan's aggregate results in QUEST Integration?	
20	Appendix E - Risk Share Program	n/a		Risk Share: States that employ risk share programs typically make them symmetrical; can the state please discuss why the arrangement being proposed is not symmetrical?	More and more states are using non-symmetrical models. Note that this is a full risk capitation program but with provisions that address two specific and different issues. The gain-share is to limit profits by health plan in a publicly funded program. The risk share on the loss side is to address that due to unforeseen events the rates were mispriced.
21	Appendix E - Risk Share Program	n/a		Risk Share: Risk share health plan profits are assessed at the plan level whereas risk share losses are assessed at the program (all health plan) level, can you please discuss why a similar methodology is not imposed for profits and losses?	See response to question #20.

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22	Appendix E - Risk Share Program	n/a		Risk Share: The current arrangement states that losses in excess of 5% will trigger payments by the state to health plans which will be based on eligible months; can you please discuss why eligible months are being used rather than say the proportion of losses plans incur?	See response to question #17. In addition, a mispriced cell would affect all health plans equally based on members in that cell. Basing on total losses confounds mispricing with other factors such as poor plan performance.
23	Appendix E - Risk Share Program	n/a		Risk Share: The current arrangement states that the state will not pay out in excess of \$5 million in the event the total program experiences losses greater than 5%. If program losses were to exceed that threshold it could imply that the developed rates were not actuarially sound, can the state and Milliman address why losses would be capped and if such losses were incurred how the rates would be certified as actuarially sound?	Actuarial soundness implies that the rates were computed prospectively based on sound actuarial principles. It does not mean that it is impossible for health plans to lose money. Health plans losing money is not always correlated with those rates being developed on unsound principles. Expected events may occur that causes health plans to lose money.
24	Appendix E - Risk Share Program	n/a		Risk Share: A \$5 million stop loss on an estimated \$1.5 billion annual program seems inappropriate given that a 1% loss equals \$15 million. Can the State please consider a higher stop loss amount?	No. The State had previously removed all stop-loss components of the risk corridor; however, MQD has added a stop loss ratio for QUEST Integration. DHS does not expect losses to occur in all populations and will allow application of profits from one category to losses in another as described in amended Appendix E.

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25	Milliman Letter – 11/12/13	Pages 1 and 3	Page 1 – Table I-1; Page 3 – Table I-7	Currently, QExA is the "ABD" population with movement of members from QUEST to QExA based on disability determination through the ADRC process or evidence of SSI determination. Since the ADRC process will be limited to only determination for SHOTT or NFLOC, this will likely lead to an increase in disabled members in the non-ABD categories. Has Milliman adjusted for this?	We believe that there may be a limited number of members who are slower to move than previously. Milliman is currently acquiring the data to make such an adjustment.
26	Milliman Letter – 11/12/13	1		The report states "Following additional information from bidders and Med-QUEST, we expect that adjustments will be made before rates are final", what specifically has been requested from the health plans?	In past procurements, issues have evolved in the Q&A or proposed capitation rate meeting (held November 15, 2013). After a review of both the Q&A and proposed capitation rate meeting, Milliman is making adjustments to rates. There has been no specific request from a health plan to change the rates.
27	Milliman Letter – 11/12/13	1		The report states "Following additional information from bidders and Med-QUEST, we expect that adjustments will be made before rates are final", what is the time frame in which you expect to evaluate and potentially adjust the rates?	See response to question #26. In addition, MQD is releasing a modified data book and revised rates on 12/6/13.
28	Milliman Letter – 11/12/13	1		The report states "Following additional information from bidders and Med-QUEST, we expect that adjustments will	See response to question #26. In addition, MQD is releasing a modified data book and revised rates on 12/6/13.

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				be made before rates are final", is there an expectation for the type and level of adjustment that is being anticipated?	
29	Milliman Letter – 11/12/13	3	Table I-6	The current Medicaid Expansion program contains rate cells for members under age 19 and for members 65 and over. Separate age gender factors for these populations have not been provided for QUEST Integration. Assuming these age cohorts remain eligible under QUEST Integration, what age gender factors does the State intend to use for these cohorts?	If there are eligible months for members under age 19 they will be paid at the 19-20 year rates. Similarly if there are eligible months for members over 64 years old they will be paid at the 40-64 year old rates.
30	Milliman Letter – 11/12/13	6	Methodology and Assumptions – Medicaid Expansion - Paragraph 4	Since the base data to support the Medicaid Expansion rates was based on "immature" data from the current plans for Net/ACE, are there plans to gather more data from the plans before the January 1, 2015 rates are finalized?	The expansion population is partially "immature." There are three subpopulations in this group: legacy QUEST-ACE members, QUEST members shifted to QUEST-ACE and new QUEST-ACE members. The experience for the first two of these populations is mature. Information reported including both detailed claims and summary level information from plans indicated that this third population has the same characteristics as the QUEST shifted members when adjusted for pregnancy. Although we feel we have a good base for this rate, we will monitor emerging experience for this population

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					and adjust if necessary.
31	Milliman Letter – 11/12/13	6	Methodology and Assumptions - Aged, Blind and Disabled (ABD) - Paragraph 1	Are you able to provide further clarification on the timing and frequency of the membership basis with regard to the following extract from page six of the Actuary letter, “Once membership is assigned to plans each plan will have initial blended rates calculated, resulting in a unique set of age/gender and geographic factors.”	In the second half of 2014, MQD will have an initial enrollment period and from that enrollment we will determine the member mix for blending. This will then be shared with health plans. In the past we have rebased capitation rates on an annual basis.
32	Milliman Letter – 11/12/13	Pages 6 and 8	Page 6 – Para 2 and 5; Page 8 – Para 6	What is the actual basis for the Expansion rates? The rate letter indicates in the first listed section that Expansion base data is primarily based on QUEST-Net and QUEST-Ace experience during the previous fiscal year (CY2012), but in the second listed section it states that CY2010 data and completion factors were used.	Ultimately we used both CY 2010 and CY 2012 data. We reviewed the detailed claim experience for CY 2012 but given that for half the year we only had legacy QUEST-ACE members and the other half of the year was this period of transition this data was not sufficient. We asked for and received from most plans additional higher level information on this population through the end of FY13 and used that to calibrate the prior rates (based on CY 2010) to an appropriate level.
33	Milliman Letter – 11/12/13	6		Medicaid expansion: Will there be a rate adjustment process for health plans that experience unexpected increases in medical costs due to the expansion of coverage to previously uninsured individuals?	We have not assumed an additional increase for this purpose. The expansion rates are significantly higher than prior QUEST-ACE rates and we do not expect significant enrollment increases due to expansion.

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34	Milliman Letter – 11/12/13	7		Identification of Rate Populations: Has there been any assessment of further carving out higher cost populations that could disadvantage plans that enroll a disproportionate share, such as individuals that are developmentally disabled, those that are ventilator dependent, etc?	Given that membership will now be allocated between up to five plans, we intend to apply risk adjustment to the medical portion of Medicaid-Only populations. In addition to the plan specific blend by populations listed in the Milliman letter the state does not intend further stratifications.
35	Milliman Letter – 11/12/13	7	Identificati on of Rate Populations - Paragraph 1	For Nursing Home Residents, if the payment to plans for these types of members is based on actual claims data, what is the reconciliation process to ensure plans are appropriately paid?	Payment is based on an actual blend of members at the beginning of the rate period. Plans are at risk of adverse experience from that base. There is no reconciliation process.
36	Milliman Letter – 11/12/13	7	Identificati on of Rate Populations - Paragraph 2	For HCBS Recipients, if the payment to plans for these types of members is based on actual claims data, what is the reconciliation process to ensure plans are appropriately paid?	Payment is based on an actual blend of members at the beginning of the rate period. Plans are at risk of adverse experience from that base. There is no reconciliation process.
37	Milliman Letter – 11/12/13	7	Identificati on of Rate Populations - Paragraphs 3 and 4	For Medically Frail Children, Breast and Cervical Cancer Women and "At Risk" Members, will the payment to plans for these types of members be based on actual claims data? And if so, what is the reconciliation process to ensure plans are appropriately paid?	Payment is based on an actual blend of members at the beginning of the rate period. Plans are at risk of adverse experience from that base. There is no reconciliation process.
38	Milliman Letter – 11/12/13	8	Collect Experience Data - Paragraph	Were there any specific data gaps or data issues with the experience data provided by the current QUEST plans that could have an impact on Attachment A or B	We did not find data gaps. We did find a few deficiencies and resolved those with health plans.

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			2	cost models?	
39	Milliman Letter – 11/12/13	8	Collect Experience Data - Paragraph 3	Were there any data elements provided by plans (not encounter data) that were excluded from the experience data used to compute the cost models, such as provider risk pool, incentive or quality/value-based payments or plan population or disease management programs?	No.
40	Milliman Letter – 11/12/13	9-10		Completion Factors: Why is the data still being limited when run-out is available through CY 2013?	The data was not limited; it was based on what was provided.
41	Milliman Letter – 11/12/13	9-10		Completion Factors: Can you please provide the analysis performed for "FFS Retro Claims", as we would anticipate that the level of adjustment would be more comparable to inpatient.	The "FFS Retro Claims" data had significantly more run-out than the other data used for this base.
42	Milliman Letter – 11/12/13	10	Milliman 11/12/13 Draft Capitation Rate Report	On page 10 of the Milliman draft rate report, the base data time period does not seem to be included for the ABD completion factors. Can this timeframe be shared by Milliman?	The ABD analysis was based on CY 2012 data, the same as the Adult and Children base data and completion factors. The expansion base was based on the older data but has been calibrated to the information provided by plans current through fiscal year 2013.
43	Milliman Letter – 11/12/13	10	Milliman 11/12/13 Draft Capitation Rate	On page 10 of the Milliman draft rate report, the base data time period does not seem to be included for the ABD completion factors. Is it possible to get a short description of how Tables 11-1, 11-	See response to question #42.

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			Report	2, and 11-3 were developed?	
44	Milliman Letter – 11/12/13	11	Trend - Paragraph 1	Do the trends consider any 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.	If higher reimbursement is required for better quality and efficiency we would assume that that added efficiency would be cost beneficial.
45	Milliman Letter – 11/12/13	11	Trend - Paragraph 1	Can the trends be segregated into cost and utilization percentages instead of a combined percentage?	Trends are segregated in the final report.
46	Milliman Letter – 11/12/13	11	Trend - Paragraph 1	Given the likelihood of material difference in utilization patterns by population, are you able to share the trends segregated by major population type (e.g. ABD, Medicaid Expansion, and Other Adults and Children)?	We have assumed consistent trends by service line. Differences by population are assumed to be related to the distribution and volume of services by service line.
47	Milliman Letter – 11/12/13	11	Trend - Paragraph 1	Please explain the presented decrease in administrative load to 9.5% with respect to the 10% communicated in the published Request for Proposal (RFP).	The RFP includes a maximum administration load. At this time the state has set the load to 9.5%
48	Milliman Letter – 11/12/13	11	3	What is the State's intended Health Insurer Assessment Fee treatment? Please confirm whether capitation rates for each health plan will be adjusted to reflect the full fiscal impact incurred by the plan, including any income tax liability due as a result of the	The state intends to fund plans appropriately for their costs for the Insurer Assessment Fee including any tax liability expenses.

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				assessment's excise tax classification.	
49	Milliman Letter – 11/12/13	11		Trend Rates: Please provide the component trends for utilization and cost per unit of service for each eligibility classification?	This information is included in the databook that is released on December 6, 2013.
50	Milliman Letter – 11/12/13	11		Trend Rates: It was stated during the rate meeting that the trend rates being used in the rate development were "aggressive." We understand that when trend rates are developed there is an inherent range around a point estimate with the high end being conservative and the low end being aggressive. Can you discuss why the low end assumptions are being used especially in light that the data used in the CY14 and CY15 rates is consistent yet the assumed trends have been reduced?	A review of additional information including trends from other states subsequent to the CY 2014 rate development resulted in the current trend rates. We have observed lower trends in other states when accounting for additional medical management and more aggressive contracting requirements.
51	Milliman Letter – 11/12/13	11		Trend Rates: It was stated during the rate meeting that no trend adjustment has been made to account for the utilization changes of PCP services due to increased payment rates. We have noted in a number of states that the industry on average is expecting a 5% increase in PCP services with no corresponding offset to other services, such as emergency room utilization. Can you please provide the reason why no	No adjustment is included as we have assumed that if there are additional PCP visits that the additional visits should result in a better PCP relationship reducing emergency department and inpatient visits.

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				adjustment is being included?	
52	Milliman Letter – 11/12/13	12	Table II-6	The Behavioral Health Pharmacy Classes listed in Table II-6 as covered by CCS contain more drug classes than were removed in the May 2013 QExA Rx rate adjustment (although the original list of QExA removed drugs is similar to the QI list). Please confirm that this more-inclusive list of drugs should be covered by CCS and that the QI databook capitation build is based on this more-inclusive list.	Table II-6 has been updated to include the correct drug exclusions. The data book has been built based on the shorter list found in the current report.
53	Milliman Letter – 11/12/13	13	2	This indicates that no cost/utilization adjustment is being made for the addition of habilitative services. While PT/OT/ST is currently being provided to QExA and QUEST members, the scope of such services is clearly expanded, in particular for the adult population (EPSDT has fairly broad requirements already). Habilitative Services were indicated by MQD as one of the "Notable Changes" for QI, referencing 40.700 of the QI RFP "Adding New Services" during the QI RFP Orientation meeting 8/12/13. In addition, the Draft Capitation Rates do not appear to address the added service "Cognitive Rehabilitation" which is a much broader scope that previously	At this point we have not included additional funding for these changes. We have reviewed the claims data for these services separately for adults and children. We found that these services are currently provided to both adults and children. We will continue to monitor this benefit to see if there is more change than expected, but at this time we believe that these services are covered although formally there is a policy change.

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				defined (in QUEST and QExA) rehabilitation services.	
54	Milliman Letter – 11/12/13	13	7	How was the hourly rate of \$41.57 for service coordinator costs determined? This seems low given prevailing market rates and benefit load.	This is based on data provided by health plans for assumed hourly rates for service coordinator from CY 2010. This amount \$39.16, was then trended to CY 2015 at an annual rate of 1.2% per year.
55	Milliman Letter – 11/12/13	13		Habilitative Services: Can you provide clarification for the level of costs that have been included in the rate development?	See response to question #53.
56	Milliman Letter – 11/12/13	13		Habilitative Services: If this was previously not a covered benefit, why is the claims level included in the data deemed sufficient?	See response to question #53.
57	Milliman Letter – 11/12/13	13		Service Coordinator: Can you describe the methodology and data sources that were used to determine that 5% of children and adults have special health care needs?	That was based on a state assumption. The final assumption will be based on data analysis closer to implementation.
58	Milliman Letter – 11/12/13	13		During the Capitation Orientation meeting, Justin Birrell indicated that Milliman would use claims data to determine the QI program SHCN percentage based on the criteria in Sections 40.910.1 and 40.910.2. Please present Milliman’s findings.	The findings will be presented based on data analysis closer to implementation.

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59	Milliman Letter – 11/12/13	13		Service Coordinator: Is the \$41.57 salary assumption only or does it include a benefit component? If a benefit component is included, can you please provide the breakdown.	See response to question #54.
60	Milliman Letter – 11/12/13	13		Service Coordinator: Please describe the salary surveys or comps that have been done to substantiate the \$41.57 salary?	See response to question #54.
61	Milliman Letter – 11/12/13	13		Service Coordinator: Were there any assumptions regarding percentage of social workers vs. nurses?	See response to question #54.
62	Milliman Letter – 11/12/13	14	7	There is a reference to adjusting for FQHC PPS 2015 rates. Will a similar review and adjustment be done for CAH and Nursing Facility rates for 2015?	Yes.
63	Milliman Letter – 11/12/13	14	7	In the past, certain fee schedules provided by the State were different for QUEST and QExA. For example, CAH acute and LTC rates published for QUEST were different than those for QExA. Under QI, will the State continue to publish such fee schedules separately, or will the State provide blended-rate fee schedules? If blended, what blending methodology will the State use?	MQD will blend the rates into one rate not making a distinction between FFS and QExA in the future under QI.
64	Milliman Letter – 11/12/13	15	MCO Contracting Levels - Paragraph	Is the State expecting the plans to pay their contracting providers using the Medicaid FFS rates for the ABD population considering this was the	The state does not intend to dictate contracting, but rather be clear that current rates are near Medicaid FFS levels.

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			1	experience basis in the cost model for the rates?	
65	Milliman Letter – 11/12/13	15	MCO Contracting Levels - Paragraph 1	For the non-ABD population, since the cost model was priced "at levels consistent with those currently experienced by servicing MCOs" do the annual trend factors on page 11 consider more current provider rates of the plans (2013 vs. 2012)?	The period of our baseline data was CY 2012 for the adults and children and ABD populations and the expansion has been calibrated based on data current through FY 2013. Trends are expected to cover unit cost and utilization increases from that point in time. No additional or more current contracting information was made available at the time of rate setting.
66	Milliman Letter – 11/12/13	15	Additional Notifications - Paragraphs 1 and 1	There was no mention of catastrophic reinsurance, was additional funding considered in the cost models?	Given that the state catastrophic reinsurance program has been terminated we no longer reduce the capitation rates by the value of this benefit. However, we did not add additional capitation to pay for reinsurance. Health pPlans can make their own decision about securing reinsurance.
67	Milliman Letter – 11/12/13	15	MCO Contracting Levels - Paragraph 1	With respect to stated contractual differences between the ABD populations and the former QUEST program, are you able to provide quantifiable detail with regard to the unit cost considerations?	We are not able to provide more specific details than that ABD populations are historically paid at approximately Medicaid FFS levels. In addition, as described in Section 60.310, for the dual eligible members (approximately 65% of ABD population) Medicare co-payments are up to 100% of Medicare rate for outpatient services. This rate structure is included in the capitation rates.

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68	Milliman Letter – 11/12/13	15	2	Did Milliman base the spenddown deduction on 100% collection of the spenddown amounts by the MCOs?	Although spenddown is required, that the MCOs be the ones to collect the spenddown is not required. Milliman does not compute the deduction. Milliman did add into the rates 100% of the deduction.
69	Milliman Letter – 11/12/13	15	3	Preliminary ABD rates are not adjusted by \$2.00 PMPM to fund the health plan performance incentives detailed in RFP Section 60.200. Does the State intend to offer performance incentives for ABD membership? If so, how will the incentives be funded?	Not at this time.
70	Milliman Letter – 11/12/13 Rate Tables	All Rate Tables		Can Milliman confirm the administrative percentages used in the preliminary databook revenue build? Also, on what basis are administrative rates calculated (i.e., what items are included in the denominator)?	Additional detail has been added to the databook released on December 6, 2013.
71	Milliman Letter – 11/12/13 Rate Tables	All Rate Tables		Can Milliman provide the full revenue calculation, including administrative and premium tax loads, confirming how these loads are applied to pass through and withhold amounts (e.g., share of cost)?	Additional detail has been added to the databook released on December 6, 2013.
72	Milliman Letter – 11/12/13 Rate Tables	All Rate Tables		Can Milliman provide the coding logic/mapping that was used to segregate the data into the category of service descriptions provided in the databook?	Milliman can respond to where specific services are mapped to, but will not provide the coding logic for all service lines as this is a proprietary tool.

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73	Milliman Letter – 11/12/13 Rate Tables	All Rate Tables		Is Milliman able to share each population’s member detail by island and rate/gender cohort?	This information is included in the databook released on December 6, 2013..
74	Milliman Letter – 11/12/13	Attachment A and C		How are non-emergent transportation expenses accounted for in Attachments A and C?	Included in the non-standard benefits or in the additional cost (no member level detail) lines of the cost model.
75	Milliman Letter – 11/12/13 Rate Tables	Rate Tables B1-B21		There is a \$2.9M discrepancy between the aggregate ABD “Other” subtotal and the sum of the individual “Other components” in the databook (rows 76-86). What is the reason for the discrepancy?	This issue has been fixed in the databook released on December 6, 2013.
76	Milliman Letter – 11/12/13 Rate Tables	Rate Tables B1-B21		There is a \$20.9M discrepancy between aggregate ABD total medical costs and total medical costs calculated using the subtotal rows of the databook. This discrepancy exactly matches the CHORE/CDPA line (Row 88). What is the reason that the CHORE/CDPA costs are left out of the revenue build?	This issue has been fixed in the databook released on December 6, 2013.
77	Milliman Letter – 11/12/13 Rate Tables	Rate Table B-3		Service Coordinator cost of \$156.71 pmpm appears too low for the medically fragile children, in particular for those also who are DD/ID. In our experience, we believe the service coordinator ratio should be closer to that for members choosing self-direction (1:30). Please	We have reviewed this calculation and found an issue with the applied service coordinator ratio for nursing home members. The \$156.71 assumes a 1:30 ratio for nursing home members; the RFP indicates a ratio for this population of 1:120. This correction results in a PMPM

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				confirm how this amount was determined.	of \$107.08. Note that the prior databook the self-direction members previously assumed a 1:120 ratio and have now been adjusted to the correct 1:30 ratio. These ratios and categories were determined by Med-QUEST. This population is distributed 70% HCBS and 30% Nursing Facility resulting in the \$107.08. The HCBS portion has a ratio 1:50 and Nursing Home ratio is 1:120..
78	Milliman Letter – 11/12/13	Attachment B-6		Attachment B-6 has HCBS costs for individuals identified as non-LTSS. Is it DHS’ intention that a non-LTSS individual would receive HCBS services?	Yes. This is the “at risk” population that is described in Section 40.920.2. In addition, the non-LTSS designation is per Milliman for rate setting purposes, not necessarily the same as the state designation.
79	Milliman Letter – 11/12/13		Milliman 11/12/13 Draft Capitation Rate Report	The ABD population will be paid based on a blended rate. Is the blending process consistent with how this population has been rated in the past?	Yes.
80	Milliman Letter – 11/12/13		Milliman 11/12/13 Draft Capitation Rate Report	Does Milliman expect to review member mix annually, or is the frequency of member mix review still under discussion?	It is expected to be done annually unless a significant member shift between plans or a material amount of new enrollment necessitates rebasing the mix.

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81	Milliman Letter – 11/12/13		Milliman 11/12/13 Draft Capitation Rate Report	Would more frequent member mix updates and/or risk adjustment updates be considered in cases where populations are more dynamic? (i.e., such as the effect of the new Ace/Net members seen in the QUEST program during 2013	Yes.
82	Milliman Letter – 11/12/13		Milliman 11/12/13 Draft Capitation Rate Report	Will the recent supplemental data supplied to the State for the QUEST program as part of the Risk Adjustment data request be utilized in determining QUEST Integration rates?	No.
83	Milliman Letter – 11/12/13		Milliman 11/12/13 Draft Capitation Rate Report	Critical Access Hospital rates have typically differed between the QUEST and QExA plans. Will there be a blended rate under the QUEST Integration program? Will the blend be plan-specific?	MQD will blend the rates into one rate not making a distinction between FFS and QExA in the future under QI.
84	Milliman Letter – 11/12/13		Milliman 11/12/13 Draft Capitation Rate Report	During the 11/15/2013, we recall discussion around ‘managed care savings factors’ that were applied to base data to adjust for managed care implementation. Given that the programs are relatively mature under managed care already, it seems that applying additional managed care savings assumptions may overstate the possible savings under a well-managed care delivery system. Can	No additional managed care savings factors were applied, although it would be inappropriate to assume that while this is a mature program that all programs are managed to optimal levels.

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				Milliman provide an overview of any managed care factors used in the rate development and how they were applied in relation to the data sources?	
85	General	n/a		Base Data: Historically non-credible data for select health plans was not included in the rate development - was a similar adjustment made this year? Under either event, please provide the rationale that was used when making the determination.	Yes. Kaiser data was excluded from the rate development.
86	General	n/a		Capitation Rates: It was stated during the rate meeting that if rates were not correct / adequate that they would be adjusted, similar to what has been done in the past. Can you describe the process and the timing of evaluating the adequacy of the rates; for example is it plan specific and/or based on MLR thresholds, etc?	The only scheduled rate review is the annual update. Should unique circumstances emerge, the State will make a determination as to whether a rate review will be performed. Such a review is not necessarily MLR driven. Also, CMS would need to approve any rate adjustment.
87	General	n/a		Risk Adjustment Data: Although Milliman has requested additional data, it was stated that the data to be used for risk adjustment may still be incomplete and/or inaccurate. Using flawed data could materially impact each of the participating HMOs, we request the methodology that Milliman is using to determine whether the data is credible and consistent across the plans.	The process is not a simple formula. Once the results are computed the documentation will be as transparent as possible.

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88	General	n/a		Risk Adjustment Data: How will infants be treated in the risk adjustment process, and more generally what age is being used to develop a score?	There is an age component in the risk adjustment methodology. If an infant has sufficient exposure the infant is scored. Each person is scored based on the age of the member at the time of the membership snapshot.
89	General	n/a		Risk Adjustment Data: Can the state please provide the CDPS risk adjustment indicator files and risk scores for the data that is provided by the participating health plans?	No.
90	General	n/a		Mock Risk Adjustment Scores: Milliman has been running simulations on what the scores would be by plan. To assist in determining the impact to the budget, can you please provide normalized scores to the plans based on these preliminary simulations?	Yes, once that analysis is complete.
91	General	n/a		Risk Adjustment Implementation: It was noted that the state anticipates applying prospective payment; given risk adjustment is being newly implemented, that there are still data concerns, and there are several new plans that have entered the program why isn't retrospective payment being employed?	We continue to work to ensure appropriate encounter data is used for the risk adjustment process.
92	General	n/a		Risk Adjustment Implementation: Regarding prospective or retroactive payments, can the state provide a	We expect that rates will be risk adjusted effective 1/1/2015 relative to the QI program.

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				<p>timeline in which payments are anticipated to be adjusted to account for the risk scores?</p>	
93	General	n/a		<p>Please list the type of adjustments (FQHC, LTSS setting, etc) that will be made after the initial enrollment period to calculate a health plan's final capitation rates.</p>	<p>See response to question #5.</p>
94	General	n/a		<p>Based on our preliminary analysis of the data provided, it appears that our plan will incur financial losses. Given that we were only provided the data book and not the actual rates, we respectfully request another meeting individually with each plan after the rates are provided to the plans on December 6th and prior to the December 11th conference call. The purpose of the meeting is for plans to discuss any questions/concerns before the rates are finalized.</p>	<p>Preliminary rates were included in the data book. In addition, revised rates are released on December 6, 2013 as part of the revised databook.</p>