Appendix L

RISK SHARE AND SETTLEMENT CORRIDORS

Objective of the Program

Med-QUEST acknowledges that due to circumstances beyond the control of the MCOs and Med-QUEST, 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 MCOs and Med-QUEST 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, or that unit costs may exceed estimates. Conversely, it is also possible that more recipients will utilize substantially fewer services than estimated, or that unit costs are lower.

To address the unknown risk to the MCOs and Med-QUEST, a risk share program was implemented. All of the settlements are MCO-specific (with the exception of the high risk newborn pool) and a MCO's settlement does not depend on the results of the program in aggregate.

We have included an excel workbook called "Appendix 10 – Risk Share and Settlement Corridors - Template" for each of these settlements. The templates are populated with an example to help illustrate the calculation of the settlements.

Note that service coordination costs are reported as healthcare services and not as administrative costs for this computation.

1. Retroactive Settlement Corridor

Background

Some Medicaid and CHIP members are retroactively enrolled with a MCO. During this retroactive enrollment period, a member may accrue claims prior to a MCO being aware of the member enrolling with the MCO. The MCO is financially responsible for these costs, but has no way to manage the member and their care during the retroactive enrollment period. To mitigate the MCO's risk during the retroactive period, Med-QUEST introduced a retroactive settlement corridor in CY 2015.

Methodology Summary

The corridor only applies to the portion of the enrollment deemed to be retroactive as identified by contract type Q, and the associated claims with that period. Claims are considered to be incurred during the retroactive period based on the same criteria for assigning financial responsibility related to transition of care as detailed in memorandum number FFS M14-16 QI-1432 dated December 31, 2014 from the Med-QUEST Division. This risk corridor is not applicable to the ABD population.

Revenue includes the full amount of withhold regardless of how much was earned back. Premium tax is not included. No supplemental payments are included in the capitation rate as of CY 2023. The health care services portion of the capitation revenues is consistent with the aggregate gain share calculation.

Expenses include incurred claims for medical and pharmacy (including high cost drugs) as well as other benefit costs including sub-capitation and care coordination/case management. More detail on the medical costs included can be found in the appendices. Expenses are net of pharmacy rebates and recoveries. Expenses determined not to be retroactive are not included.

Consistent with prior years, gain/loss is calculated separately for each MCO and population excluding ABD. If an MCO's calculated net gain/loss exceeds 2.5% of revenue for health care expenses, Med-QUEST will share equally in the gain/loss between 0% and 2.5%; Med-QUEST will recover/reimburse all gains/losses exceeding 2.5%. The premium tax assumed for rate development will be applied to positive or negative settlements.

Detailed Items needed from the MCOs

MCOs will provide a populated retroactive settlement form and detailed retroactive claims.

Detailed Mechanics

- Retroactive periods are identified by the contract type Q. During the retroactive period an enhanced premium (premiums are higher than for non-retroactive members of the same rate code) is paid on behalf of the enrollee. This enhanced payment is paid for only during the retroactive period. All prospective periods of enrollment are paid at the standard capitation rates and are subject to the risk share program described below in “5 - Aggregate Gain/Loss Share.”
- Revenue includes the full amount of withhold regardless of how much was earned. Assumed administrative load is as follows:
  - Expansion 8.8%
  - Family & Children (F&C) 8.8%
  - Note that MCOs who do not participate on all islands will have administration reduced by 0.50%. The MCO specific administrative assumption will be used for that calculation.
- Expenses include all high cost drug costs during the retroactive period.
- Expenses for a member will be adjusted to be consistent with any pricing adjustments included in the rate development. Specifically, if there are unit cost issues with a plan such that repricing was required for the rate development material, that same repricing would be applied to the claims before application of the retroactive settlement.
- Transition of Care
  - If a retroactive member remains admitted in a facility after being assigned to a MCO then facility costs continue to be associated with the retroactive period.
  - Costs will be excluded from the retroactive settlement and will be covered by the non-retroactive capitation rate after a transition of care occurs, based on the transition of care rules as included in the contract. This is consistent with how costs are transferred from one MCO to another when a member in a facility changes MCOs.
  - Professional fees and enabling services (e.g. meals, transportation, and lodging) are considered prospective once the member is enrolled in the MCO. During the retroactive period these costs are associated with the retroactive settlement.
- The settlements will be calculated separately for each population and MCO.
  - If there are gains/losses exceeding 2.5%, Med-QUEST would share equally in the gain/loss between 0% and 2.5%.
  - Med-QUEST will recover/reimburse all gains/losses exceeding 2.5%.

Timing

The settlement will take place within one year after the end of the contract period.

2. High Cost Drug Risk Corridor

Background

Some Medicaid members have conditions requiring very expensive drug treatments. These members are infrequent and not evenly distributed among the MCOs. To mitigate the MCO's risk, Med-QUEST introduced a high cost drug corridor in CY 2018 and will continue to implement this corridor in CY 2023. For the purpose of the drug corridor, drugs are defined as 10-digit GPIs or J-code HCPCS. High cost drugs include drugs in excess of $125,000 per member per code while enrolled with an MCO for the rate setting period. Zolgensma is not included in this corridor as the financial liability of this drug lies with Med-QUEST. For CY 2022, all costs for Aduhelm were included in this corridor due to uncertainty around utilization rates and coverage by Medicare. Given the cost of the drug has decreased substantially and Medicare covers it in clinical trial setting we expect low expenditures for the Medicaid program. For CY 2023, Aduhelm is no longer included in the corridor and therefore Dual-Eligible members are also no longer included.

Methodology Summary

The risk corridor applies to F&C, Expansion, and ABD Medicaid-Only populations for CY 2023.

Revenue is calculated using CY 2023 enrollment based on eligibility data from Med-QUEST and the high cost drug specific PMPM loaded into the CY 2023 rates. The revenue is net of premium tax and assumed drug rebates.

Expenses are net of any rebates and retroactive high cost drug expenses for the F&C and expansion populations.

Gain/loss is calculated separately for each MCO and population. If an MCO's calculated net gain/loss exceeds 3% of revenue for health care expenses, Med-QUEST will share equally in the gain/loss between 3% and 6%; Med-QUEST will recover/reimburse all gains/losses exceeding 6%. The premium tax assumed for rate development will be applied to positive or negative settlements.

Items needed from the MCOs

MCOs will provide a validation of data from Med-QUEST's data warehouse intended to be included in the settlement and rebates received for high cost drugs.

Detailed Mechanics

- Eligible Claims
  - The standard corridor is specific to drug costs exceeding $125,000 per member per drug while enrolled with an MCO during CY 2023 and excludes Dual-Eligible members. Supplemental rebates are included in the total costs.
  - According to the "Affordable Care Act Medicaid Prescription Drug Rebate Provision" memo "Health plans are required to provide NDC information for all J code reimbursement." Consistent with this memo, to be an eligible claim, the claims must be an accepted claim with an NDC in Med-QUEST's data warehouse.
- For F&C and the Expansion populations, there is a retroactive settlement corridor in place. Drug costs incurred during a retroactive enrollment period are excluded for this settlement. For the Medicaid-only ABD population, all drug costs unless otherwise noted are included in this settlement since there is no retroactive settlement corridor.
- Table 10-1 summarizes the high cost drug PMPM loaded into the CY 2023 rates. The actual costs from the MCOs will be compared to these costs for the final settlement calculation.

TABLE 10-1: QUEST INTEGRATION – HIGH COST DRUG CORRIDOR PMPMS

POPULATION	TOTAL PMPM
ABD Medicaid-Only	$111.48
Family and Children	$5.59
Expansion	$17.76

- For the gain/loss calculation, the net gain or loss percentage will be computed for each MCO and population separately.
  - If there is MCO-specific gain/losses exceeding 3%, Med-QUEST will share equally in the gain/loss between 3% and 6%.
  - Med-QUEST will recover/reimburse all gains/losses exceeding 6%.

Timing

The settlement will take place once the retroactive settlement corridor has been finalized.

3. High Risk Newborn Risk Pool

Background

In recent years, Med-QUEST has become increasingly aware of the volatility of newborn costs between MCOs and the resulting impact on MCO performance. In many cases, the MCOs are automatically assigned a newborn or a late-term pregnant mother, not enabling them to manage the care in order to reduce costs. In response to this concern, Med-QUEST introduced a High Risk Newborn Pool (HRNBP) to protect MCOs with high risk newborns in CY 2019, and will continue to implement this pool in CY 2023.

Methodology Summary

The pool applies to all newborns (defined as being in an 'Ages < 1' rate code) except those who are dual-eligible.

The risk pool amount is calculated using CY 2023 F&C newborn enrollment (excluding retroactive enrollment) based on eligibility data and the high risk newborn pool PMPM loaded into the CY 2023 rates. The risk pool is initially allocated to each MCO on a PMPM basis, and then re-allocated based on each MCO's share of high risk newborn expenditures.

The allocation of the pool is determined by the actual costs for non-retroactively enrolled F&C newborns and all Medicaid-Only ABD newborns with eligible APR Diagnosis-Related Groups (DRGs): neonates with a birthweight below 1,500 grams (588, 589, 591, 593, 602, 603, 607, 608), neonates above 1,500 grams with major procedure (609, 630, and 631), and neonates with ECMO (583). An MCO's share of the pool is the ratio of the MCO's eligible costs and the sum of eligible costs across the entire QI program for the calendar year.

Regardless of the actual high risk newborn claims paid out in CY 2023, the total amount paid out of the risk pool is no less/greater than the amount loaded into the risk pool. This settlement is budget-neutral from Med-QUEST's perspective, simply shifting funding between MCOs. The redistributed revenue is calculated by taking each MCO's share of the pool minus the amount of funding they initially received. The premium tax assumed for rate development will be applied to positive or negative settlements.

Items needed from the MCOs

MCOs will provide a validation of data from Med-QUEST's data warehouse intended to be included in the pool and IBNP assumptions and documentation for eligible claims.

Detailed Mechanics

- Eligible Claims
  - High risk newborns will be determined using APR Diagnosis-Related Groups (DRGs) version 37.1. Eligible DRGs include neonates with a birthweight below 1,500 grams (588, 589, 591, 593, 602, 603, 607, 608), neonates above 1,500 grams with major procedure (609, 630, and 631), and neonates with ECMO (583). Only costs associated with these DRGs are eligible for the risk pool.
  - Eligible claims will be determined based on admission date. If a claim crosses between multiple years, the dollars will be included in the year corresponding to the admission date of the claim.
  - Claims must be an accepted claim in Med-QUEST's data warehouse, but will allow for an incomplete claim adjustment with supporting documentation of outstanding claims.
  - For F&C and the Expansion populations, there is a retroactive settlement corridor in place. Costs incurred during a retroactive enrollment period are excluded for this settlement.
- The risk pool amount is based on a PMPM calculated using eligible claims in the base year multiplied by the current period's newborn member months. The PMPM loaded into the CY 2023 rates is $269.32. MCOs hold this funding as a placeholder but final revenue will be based on this settlement.
- To minimize cash flow issues, this risk pool amount will initially be allocated to each MCO on a PMPM basis based on their number of newborns from the F&C population during the rate setting period. This funding is not guaranteed revenue for each MCO but will instead be re-allocated to the appropriate MCOs once the high risk newborn settlement takes place after the rate setting period.
- The risk pool will be budget-neutral from Med-QUEST's perspective, simply shifting money between MCOs based on which MCOs get a larger share of high risk newborns. The pool will be allocated between MCOs

based on their actual costs for eligible newborns with eligible DRGs costs, including transfers, identified as members discharged and admitted within one day. An MCO's share of the pool will be the MCOs eligible costs / the sum of eligible costs across the entire QI program for the rate setting period. Regardless of the actual high risk newborn claims paid out in CY 2023, the total amount paid out of the HRNBP will be no less than/greater than the amount loaded into the risk pool.

- IBNP for Open claims
  - For claims that are still open when the final settlement is calculated, an MCO will be required to provide an Incurred-But-Not-Paid (IBNP) estimate for the remainder of the claim. MCOs must provide detailed documentation of IBNP assumptions.
  - Once reviewed and approved, IBNP estimates related to eligible claims will be included with eligible costs.
- The settlements will be calculated in total across populations and MCOs.

Timing

- Semi-Annual Updates
  - Med-QUEST will provide semi-annual updates to the MCOs showing their current share of the pool relative to the rest of the QI program.
  - These updates are informational only and no money will be paid out with these updates.
- Final Settlement
  - A final settlement will take place once the retroactive and high cost drug risk corridor settlements have been finalized.

4. Delivery Case Rate Settlement

Background

Maintenance of eligibility (MOE) has caused a noticeable drop in the average pregnancy-related expenditures as pregnant women who would normally be disenrolled after 2 months postpartum will maintain eligibility. At the time of rate certification, it's unclear when MOE will end, and we do not expect the average pregnancy-related expenditures to go back to their pre-MOE levels due to post-partum expansion. Due to the uncertainty introduced by changes in eligibility and previous observed differences in pregnancy-related expenditures between MCOs, Med-QUEST is introducing a delivery case rate settlement in CY 2023.

Methodology Summary

The settlement applies to all deliveries covered under female rate cells for the Family & Child and Expansion populations; it is not applicable to the ABD population.

Deliveries assumed in rate development is calculated using CY 2023 enrollment based on eligibility data from Med-QUEST and the Deliveries/1000 loaded into the CY 2023 rates.

Actual deliveries will be identified in CY 2023 claims data using the HCPCS and APR-DRGs v37.1 in tables 10-2 and 10-3.

TABLE 10-2: HCPCS CODES FOR DELIVERIES

HCPCS* CODE	CODE DESCRIPTION
59400	Obstetrical care
59409	Obstetrical care
59410	Obstetrical care
59610	Vbac delivery
59612	Vbac delivery only
59614	Vbac care after delivery
59510	Cesarean delivery
59514	Cesarean delivery only
59515	Cesarean delivery
59618	Attempted vbac delivery
59620	Attempted vbac delivery only
59622	Attempted vbac after care

TABLE 10-3: APR-DRG CODES FOR DELIVERIES

APR DRG**	CODE DESCRIPTION
539	Cesarean Section with Sterilization
540	Cesarean delivery without sterilization
541	Vaginal delivery with sterilization
542	Vaginal delivery with complicating procedures
560	Vaginal delivery

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The settlement is calculated separately for each MCO and population. The difference in the assumed and actual deliveries will be multiplied by the average cost per delivery (case rate) assumed in the CY 2023 rates. The premium tax assumed for rate development will be applied to positive or negative settlements.

Items needed from the MCOs

MCOs will provide validation of data from Med-QUEST's data warehouse, which is intended to be relied upon for the settlement.

Detailed Mechanics

- Eligible Deliveries
  - Deliveries will be determined using the HCPCS and APR-DRGs v37.1 in tables 10-2 and 10-3.

  - Includes one delivery per member in a 9-month period based on the first month the code appears.
  - Claims must be an accepted claim in Med-QUEST's data warehouse.
  - Deliveries that occur in a retroactive enrollment period are excluded as there is a retroactive settlement corridor in place.
- The average cost per delivery assumed in the CY 2023 rates of $7,515.26 is used as the case rate for the settlement, not actual costs.
  - Includes the HCPCS and APR-DRG codes used to identify deliveries, as well as the HCPCS in table 10-4:

TABLE 10-4: HCPCS CODES FOR DELIVERIES

HCPCS* CODE	CODE DESCRIPTION
59412	Antepartum manipulation
59414	Deliver placenta
01960	Anesth, vaginal delivery
01961	Anesth, cs delivery
01967	Anesth/analg, vag delivery
01968	Anes/analg cs deliver add-on

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  - All eligible claims within the month of delivery are included in the delivery case rate
- The settlements will be calculated separately for each population and MCO.

Timing

The settlement will take place within one year after the end of the contract period.

5. Community Integration Services Corridor

Background

Community integration services have been provided by the CCS program for several years and added to QI beginning in 2020, however the memo Community Integration Services (CIS) Implementation Guidelines: Overview, Member Eligibility, Service Delivery, Coordination, & Reimbursement (CIS Memo) was issued in April 2021 with new guidance and requirements above the services provided historically. A separate CIS capitation rate was developed to fund the majority CIS services based on the guidance of the CIS Memo in CY 2022, however adoption by CIS providers has been slow and we anticipate a ramp up period over the next one to two years. To avoid overfunding the CIS benefit during this ramp up but still encourage adoption, Med-QUEST is proposing a CIS corridor for CY 2023.

Methodology Summary

The corridor applies to the separate CIS capitation rate outlined in Appendix 11. Revenue is net of premium tax and the administrative load assumed for rate development. Expenses include those provided to members who have a CIS status of H5 (Housing Pre-Tenancy) or H6 (Housing Tenancy). Expenses incurred before or after a member has a CIS status of H5 or H6 such as outreach and follow-up are not included. Expenses must be paid as encounters and follow the guidelines outlined in the CIS Memo to be considered valid.

Gain/loss is calculated separately for each MCO across populations. If an MCO's calculated net gain/loss exceeds 2.5% of revenue for CIS expenses, Med-QUEST will share equally in the gain/loss between 0% and 2.5%; Med-QUEST will recover/reimburse all gains/losses exceeding 2.5%. The premium tax assumed for rate development will be applied to positive or negative settlements.

Detailed Items needed from the MCOs

MCOs will provide detailed CIS claims data.

Detailed Mechanics

- Revenue is calculated based on actual payments made based on CIS statuses H5 and H6 as outlined in Appendix 11. Tax and admin expenses are removed.
- Expenses are calculated based on detailed claims data for valid CIS services.
- The net gain or loss percentage will be computed for each MCO separately.
  - If there are gains/losses exceeding 2.5%, Med-QUEST would share equally in the gain/loss between 0% and 2.5%.
  - Med-QUEST will recover/reimburse all gains/losses exceeding 2.5%.

Timing

The settlement will take place within one year after the end of the contract period.

6. Aggregate Gain/Loss Share

Background

Beginning in CY 2017, Med-Quest implemented a two-sided aggregate gain/loss sharing arrangement with the MCOs to account for unexpected significant difference between the total revenue and actual expenses realized. The retroactive, high cost drug, high risk newborn, and community integration services corridor address unknown risks specific to certain populations or services while the aggregate gain/loss program considers the financial health of the MCO as a whole.

Methodology Summary

The aggregate gain share population applies to all populations.

For CY 2023, there will be an adjustment to the revenue used in the calculation to mitigate the disruption of the COVID-19 public health emergency (PHE) on the enrollment levels. The pause in enrollment redeterminations has led to significant growth in Medicaid enrollment, and once the PHE ends and enrollment redeterminations recommence, a sizeable number of members who are currently included in our rate setting snapshots may be disenrolled during CY 2023. Given the potential large fluctuations in enrollment levels and member mix we will adjust the ABD revenue amounts using a blend of non-LTSS/LTSS rates based on actual CY 2023 proportion of non-LTSS/LTSS members. There will be no adjustment for F&C and Expansion revenue. The change in revenue will be included along with the final settlement amount calculated using the adjusted revenue.

Revenue is net of premium tax and the amount included in the retroactive and high cost drug corridors, and includes the revenue redistribution for the high risk newborn pool. Revenue from the separate CIS capitation rate is not included. Revenue includes the full amount of withhold regardless of how much was earned. The health care services portion of the capitation revenues for MCOs who participate on all islands is assumed to be 93.6% for ABD, and 90.8% for F&C and Expansion based on the target medical loss ratios (MLRs) in the capitation rates. MCOs who do not participate on all islands had target MLRs of 93.8% for ABD and 91.3% for F&C and Expansion.

Expenses are net of those included in the retroactive and high cost drug corridors. Expenses covered under the separate CIS capitation rate are not included. Expenses include incurred claims for medical, pharmacy, and long-term services and supports as well as other benefit costs including sub-capitation and care coordination/case management. Expenses are net of pharmacy rebates, recoveries, and expenses covered by the other settlements. Expenses for supplemental payments, hospital pay for performance pool, health insurance fee, and institution for mental disease state-funded expenses are not included.

Consistent with prior years, gain/loss is calculated for each MCO separately and determined across all populations. The total net gain/loss amount is calculated by taking Health Care Revenue minus Health Care Expenses. The percentage is then calculated by further dividing by the Health Care Revenue. If an MCO's calculated net gain/loss exceeds 3% of revenue for health care expenses across all populations, Med-QUEST will share equally in the gain/loss between 3% and 5%; Med-QUEST will recover/reimburse all gains/losses exceeding 5%. The premium tax assumed for rate development will be applied to positive or negative settlements.

Items needed from the MCOs

MCOs will provide a populated aggregate financials template and claim lag triangles.

Detailed Mechanics

- ABD LTSS blend adjustment
  - Capitation rates will be paid using a projected distribution of non-LTSS vs LTSS members consistent with historical methodology.
  - The non-LTSS and LTSS rates will be set prospectively for each MCO using respective population distributions. LTSS members include nursing facility, HCBS, and at-risk members.
  - The actual distribution of non-LTSS to the LTSS members in CY 2023 for each MCO will be applied to the rates above to calculate an adjusted revenue amount.

- Other risk protections will be accounted to ensure there is no overlapping of risk corridors. The other risk corridors include the retroactive enrollment corridor, high cost drug corridor, and the high risk newborn pool. High risk newborn pool revenue and claims will be included in the settlement, but revenue will be adjusted for the redistribution from the pool that takes place.
- Costs for a member will be adjusted to be consistent with any pricing adjustments included in the rate development. Specifically, if there are unit cost issues with a plan such that repricing was required for the rate development material, that same repricing would be applied to the claims before application of the aggregate gain/loss share settlement.
- Revenue includes the full amount of withhold regardless of how much was earned. Assumed administrative load is as follows:
  - Expansion 8.8%
  - Aged, Blind, and Disabled (ABD) 6.35%
  - Family and Children 8.8%
- Note that MCOs who do not participate on all islands will have administration reduced by 0.50% for the Family & Child and Expansion populations and 0.25% for ABD population, respectively. The MCO specific administrative assumption will be used for that calculation.
- For the gain/loss calculation, the net gain or loss percentage will be computed for each MCO separately across all populations.
  - If there is MCO-specific gain/losses exceeding 3%, Med-QUEST will share equally in the gain/loss between 3% and 5%.
  - Med-QUEST will recover/reimburse all gains/losses exceeding 5%.

Timing

The settlement will take place once the retroactive, high cost drug risk corridor, and high risk newborn pool settlements have been finalized.