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 an 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, and the associated claims within that period for the non-ABD population. Retroactive enrollees are identified by contract type Q. Med-QUEST has an approved Section 1902(e)(14)(A) waiver that authorizes them to temporarily reinstate eligibility effective on the individual's prior termination date for individuals who were disenrolled based on a procedural reason and are subsequently redetermined eligible for Medicaid during the reconsideration period. This may lead to members being assigned a retroactive contract type "Q" when they do not meet the intended use of this designation and corridor. Members who have no gap in enrollment preceding the period where they have contract type Q will not be included in this corridor and instead part of the aggregate gain/loss share calculation.

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 2024. 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 attributed to the retroactive coverage period. 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 using contract type Q limited to members who have a gap in enrollment preceding the period. 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.
- Revenue includes the full amount of withhold regardless of how much was earned. Assumed administrative load is as follows:
  - Expansion 8.85%
  - Family & Children (F&C) 8.85%
- 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 2024. 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.

Methodology Summary

The risk corridor applies to Family & Children, Expansion, and ABD Medicaid-Only populations.

Revenue is calculated using CY 2024 enrollment based on eligibility data from Med-QUEST and the high cost drug specific PMPM loaded into the CY 2024 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 Family & Children 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 2024 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 Family & Children and 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 2024 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	$136.79
Family and Children	$5.77
Expansion	$19.81

- 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

There is a significant amount of volatility in 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 2024.

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 2024 Family & Children newborn enrollment (excluding retroactive enrollment) based on eligibility data and the high risk newborn pool PMPM loaded into the CY 2024 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 Family & Children 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 2024, 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 Family & Children and 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 2024 rates is $309.05. 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 Family & Children 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 2024, 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 settlement 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 within one year after the end of the contract period.

4. Delivery Case Rate Settlement

Background

Maintenance of eligibility (MOE) has caused a noticeable drop in the average pregnancy-related expenditures as pregnant women have maintained eligibility much longer than the historical normal of 2 months postpartum. Additionally, Med-QUEST has an approved SPA to extend postpartum coverage from two months to 12 months postpartum, effective January 2023. Due to the uncertainty introduced by changes in eligibility and previous observed differences in pregnancy-related expenditures between MCOs, Med-QUEST introduced a delivery case rate settlement in CY 2023 and is continuing to implement it in CY 2024.

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 2024 enrollment based on eligibility data from Med-QUEST and the Deliveries/1000 loaded into the CY 2024 rates.

Actual deliveries will be identified in CY 2024 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. The difference in the assumed and actual deliveries will be multiplied by the average cost per delivery (case rate) assumed in the CY 2024 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 2024 rates of $7,797.07 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 (CIS) have been provided by the CCS program for several years and were added to QI beginning in 2020, however the guidance and requirements have changed over time and the ramp up and adoption by CIS providers has been slow. To avoid overfunding the CIS benefit during this ramp up but still encourage adoption, Med-QUEST put in place a CIS corridor for CY 2023 and is continuing to implement it for CY 2024.

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 must be paid as encounters and follow the guidelines outlined in provider memo QI2314A[1] 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 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.

[1] https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2023/QI-2314A,%20CCS-2303A%20CIS%20IMPLEMENTATION%20UPDATED%20GUIDELINES_CIS%20ASSESSMENT%20AND%20CIS%20ACTION%20PLAN_Final%20(part%201)%20-%20signed.pdf

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 corridors and pools described so far 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.

Since CY 2022 we have made adjustments to the revenue used in the calculation to mitigate the disruption of MOE on the enrollment levels. The pause in enrollment redeterminations has led to significant growth in Medicaid enrollment, and now that the redeterminations have resumed a sizeable number of members who are currently included in our rate setting snapshots may be disenrolled during CY 2024. Given the potential large fluctuations in enrollment levels and member mix we will adjust the Family & Children and Expansion revenue amounts using risk scores that have been reweighted using actual CY 2024 enrollment and the ABD revenue amounts using a blend of non-LTSS/LTSS rates based on actual CY 2024 proportion of non-LTSS/LTSS members. The change in revenue will be included along with the final settlement amount calculated using the adjusted revenue.

As described in the retroactive settlement corridor section, the retroactive restatement of eligibility may result in members being assigned a retroactive contract type Q when they do not meet the intended use of this designation of the retroactive settlement corridor. To address this, members who have no gap in enrollment preceding the period where they have contract type Q will have their revenue adjusted as if they had been paid the standard capitation rate and will be included in the aggregate gain/loss share calculation.

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 and the delivery case rate settlement. 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 is assumed to be 94.35% for ABD, and 91.15% for Family & Children and Expansion based on the target medical loss ratios (MLRs) in the capitation rates.

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, and recoveries. 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

- Risk score adjustment
  - Capitation rates will be paid using an initial risk score consistent with historical methodology.
  - Risk scores will be reweighted using actual CY 2024 enrollment data.

  - This change will only address relative risk between MCOs, not the overall acuity of the members and will be revenue neutral to Med-QUEST overall.

- 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 2024 for each MCO will be applied to the rates above to calculate an adjusted revenue amount.
- Members who have no gap in enrollment preceding the period where they have contract type Q will have their revenue adjusted as if they had been paid the standard capitation rate and will be included in the aggregate gain/loss share calculation.
- Other risk protections from the main QI capitation rate 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, high risk newborn pool, and the delivery case rate settlement. 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. Similarly, delivery case rate revenue and claims will be included in the settlement, but revenue will be adjusted for the settlement that takes place. Revenue from the separate CIS capitation rate and associated claims are not included.
- 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 8.85%
  - Aged, Blind, and Disabled (ABD) 5.65%
  - Family and Children 8.85%
- 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, high risk newborn pool, and delivery case rate settlements have been finalized.