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Prepaid inpatient health plan reconciliation process State of Connecticut

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Prepaid inpatient health plan background

Information

- On November 29, 2007, the State of Connecticut (State) received Centers for Medicare & Medicaid Services (CMS) approval to amend its managed care organization (MCO) waiver to a prepaid inpatient health plan (PIHP) waiver with non-risk contracts
- The PIHP period spanned December 1, 2007 – January 31, 2009
- During this time period, various MCOs phased into the non-risk PIHP arrangement, then exited the program entirely or phased back into the full risk-capitated Healthcare for Uninsured Kids and Youth (HUSKY) program
- During this time period, HUSKY members were given the choice of receiving services administered fee-for-service
- The reconciliation required the acceptance, validation and processing of a significant amount of data:
 - Unique claims: 3,262,432
 - Claim lines: 9,248,431
 - Invoiced paid amount: \$619,828,000
 - Number of fee schedules: 35

Prepaid inpatient health plan background

Assumptions

- The upper payment limit (UPL) reconciliation analysis determined how the actual MCO paid expenditures compared to an equivalent UPL developed based upon repricing the PIHP utilization at the Medicaid fee schedules
- The reconciliation analysis may result in submitting a prior period adjustment to federal claiming
- The State incorporated these results and determined the appropriate prior period adjustment amount to be applied for federal claiming purposes
- Any administrative reconciliation was handled separately from the PIHP medical reconciliation
- The UPL reconciliation was completed for the HUSKY A population. The HUSKY B population was not held to a UPL test

Non-risk prepaid inpatient health plan contracts

- The non-risk contractor:
 - Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits (UPL) specified in §42 CFR 447.362
 - May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits
- The contractors may be paid interim payments. After services are delivered, the contractor and State reconcile to ensure that total payment is no greater than the non-risk UPL per 42 CFR 447.362
- Non-risk UPL equals actual utilization priced at Fee-for-Service (FFS) fee schedule, plus an administration fee
- Centers for Medicare and Medicaid Services (CMS) matches the administrative portion of the payment at an administrative match rate
 - Service costs are matched at a services match rate

Risk contracts

- The contractor is paid a monthly insurance payment equal to the expected utilization of the Medicaid services, plus administration related to Medicaid
- Payments must be actuarially sound per 42 CFR 438.6(c)
- CMS matches the entire payment at a services match

Calculation of non-risk upper payment limit

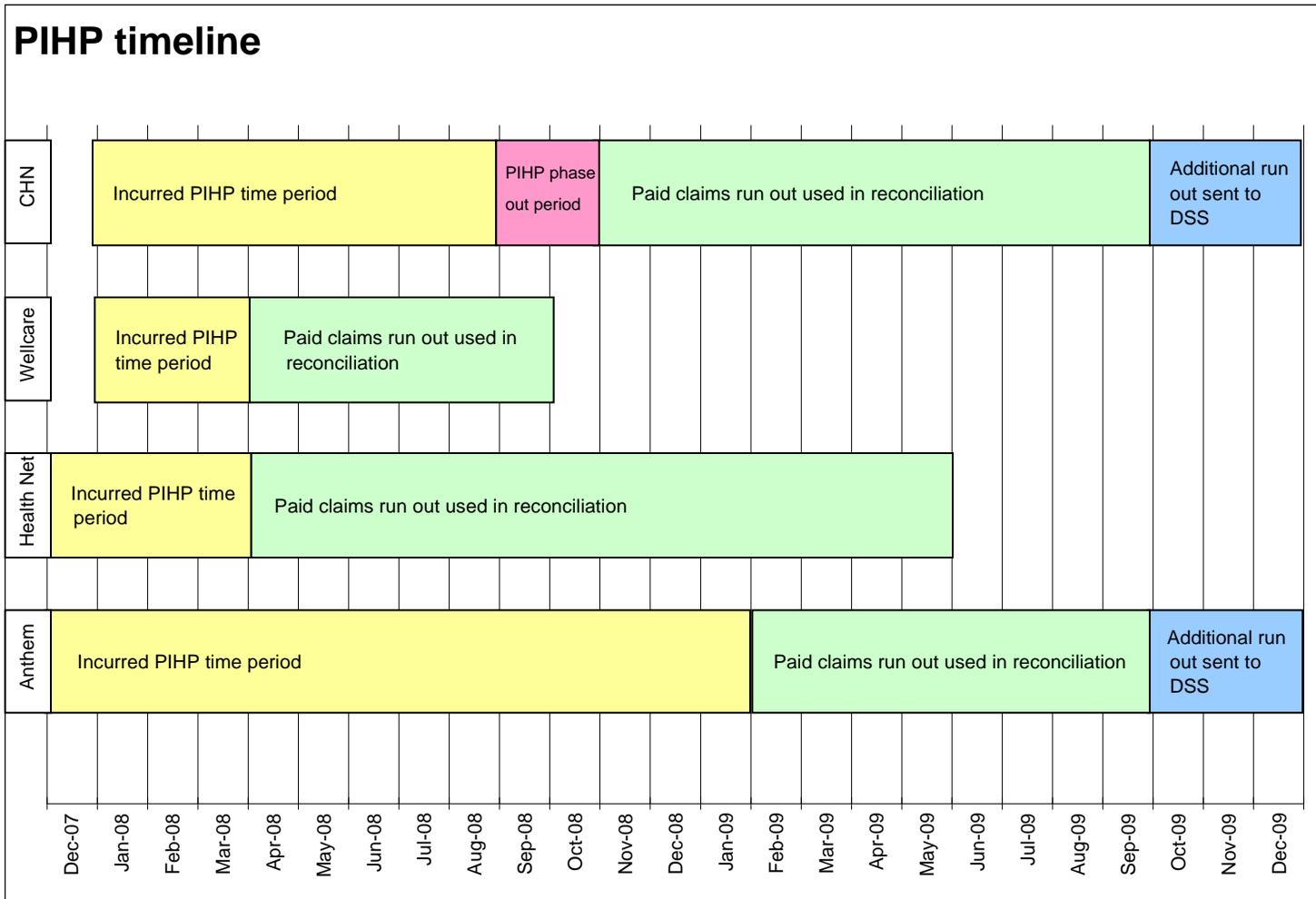
- Under a non-risk contract, Medicaid payments to the Contractor may not exceed:
 - What Medicaid would have paid, on a FFS basis, for the services actually furnished to recipients
 - The net savings of administrative costs the Medicaid agency achieves by contracting with the plan instead of purchasing the services on a FFS basis
- The UPL is calculated by pricing the services rendered by the health plan at the Medicaid FFS fee schedule, plus an amount for administration
 - The calculation of administration costs of a non-risk plan is often operationalized using the Medicare cost plan cost principles, set as a percentage of the medical service costs or as a per-member-per-month (PMPM) fee
 - The services portion is calculated using HIPAA-compliant paid claims data and encounter data submitted by the plan, priced using FFS fee amounts

Reconciliation process

- After the non-risk UPL has been created, the payments to the health plans are compared to the UPL
- CMS will match plan payments up to the non-risk UPL for each contract
- The reconciliation is performed at a contract level for all enrollees within a plan
- CMS is repaid any amounts that each contract's payments exceed the non-risk UPL
- The State of Connecticut has chosen to use all-state funds to reimburse non-risk health plans for amounts above the Medicaid non-risk UPL
- Payments are not subject to actuarial soundness

Prepaid inpatient health plan background

PIHP time period

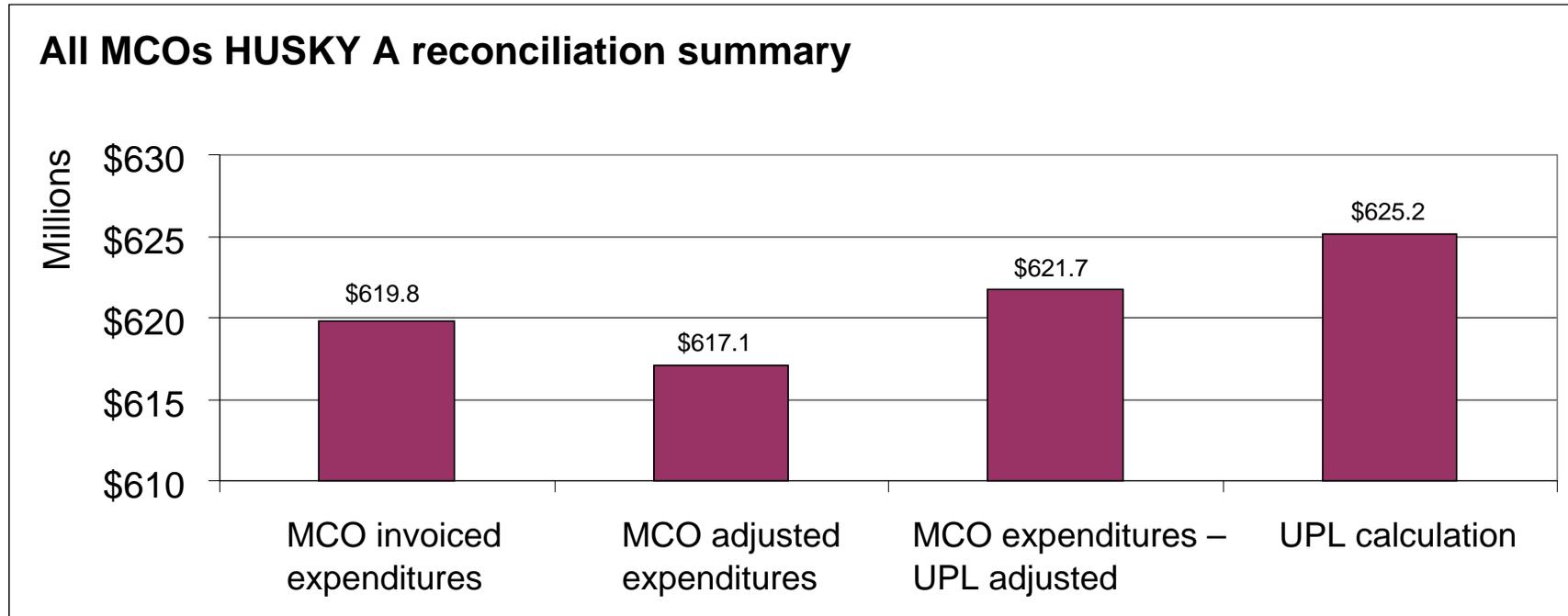


Summary

PIHP reconciliation

Incurred period: *December 1, 2007 – January 31, 2009*

Paid through: *September 30, 2009*



Adjustments to managed care organization invoiced expenditures

- Adjustments applied to the MCO invoiced expenditures
 - Claims which failed critical edits
 - Claims data which differed from reported invoiced expenditures
 - Retroactive claims payment adjustments
 - Interest payments

Upper payment limit adjustments

- The CMS UPL comparison requires additional adjustments to the MCO invoiced expenditures:
 - Exclude non-federally-funded abortions
 - Re-classify non-emergent transportation as an administrative expense
 - Include the provider supplemental fees
 - Include supplemental orthodontia payments

Prepaid inpatient health plan managed care organization cash reconciliation

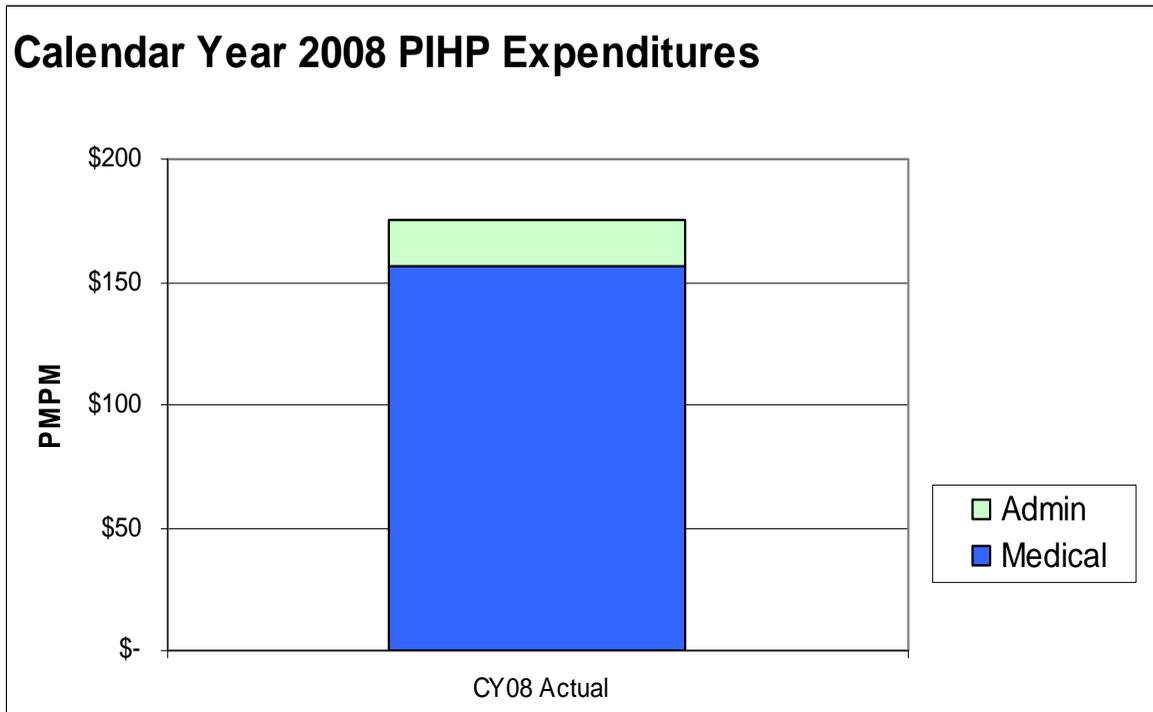
	HUSKY A	HUSKY B	Combined
<i>Member months</i>	3,514,718	146,041	3,660,759
MCO adjusted revenue	\$ 576,033,274	\$ 23,026,628	\$ 599,059,902
MCO adjusted expenditures	\$ 617,134,998	\$ 19,533,917	\$ 636,668,915
Net amounts due (to)/from MCOs	\$ (41,101,724)	\$ 3,492,711	\$ (37,609,013)
Payments (to)/from MCOs			(40,178,998)
Balance due (to)/from MCOs			2,569,985

Note:

This summary reflects final cash reconciliation amounts due to or from the MCOs based upon monthly PIHP payments to the MCOs as compared to their adjusted medical expenditures. This does not provide a comparison of expenditures during the PIHP period and a capitated managed care environment.

Summary

Calendar year 2008 reported PIHP expenditures



CY08 PIHP*	
Medical	\$ 156.84
Admin	\$ 18.24
Total	\$ 175.08

*Notes:

For the purpose of developing PIHP baseline expenditures to compare against MCO reported expenditures, amounts reflecting carved out dental and pharmacy services are excluded from the reported PIHP expenditures.

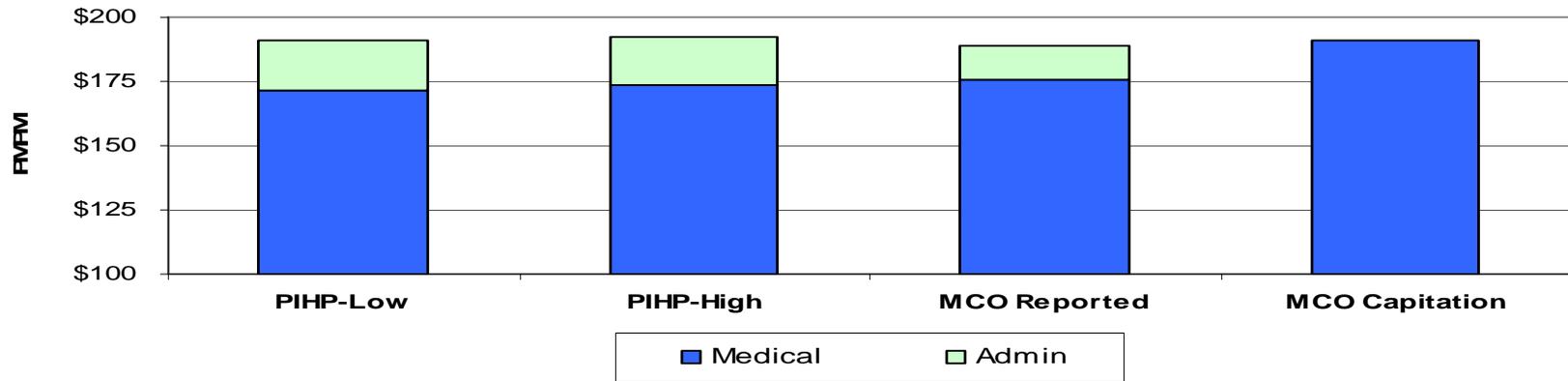
The administrative PMPM reflects the negotiated \$18.18 fee with the PIHP contractors plus reported nurseline expenditures.

The weighted average PMPM utilizes CY08 PIHP HUSKY A enrollment.

Comparison

Projected PIHP expenditures versus managed care expenditures

**Calendar Year 2009:
PIHP projections and reported managed care costs**



	PIHP-Low	PIHP-High	MCO Reported	MCO Capitation
Medical	\$ 171.86	\$ 173.75	\$ 175.58	
Admin	\$ 18.78	\$ 18.78	\$ 13.31	
Total	\$ 190.64	\$ 192.54	\$ 188.89	\$ 190.97

-All weighted average PMPM's are normalized based on calendar year 2009 enrollment.

- PIHP projections incorporate assumptions to reflect the policies in place for the HUSKY A program in CY09 including the reimbursement policy to pay no less than the Medicaid floor.

- The PIHP-Low and PIHP-High estimates vary because a range of trends are utilized in this comparison.

- MCO costs/capitation exclude amounts withheld or accrued for pay-for-performance. MCO capitation reduced for certain home infusion expenditures paid by DSS.

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