

**North Dakota Department of Human Services
Medicaid Expansion
Overview of Risk Sharing Arrangement
Health Care Reform Review Committee
March 19, 2014**

From August 5, 2013 Request for Proposal:

J. Financial Considerations/Per Member Payment/Risk Sharing

Offerors are encouraged to thoroughly review Subpart J (Finance and Payment) of Attachment B (*CMS Checklist for Managed Care Contract Approval*). The Checklist is an internal document used by the Centers for Medicare and Medicaid Services in reviewing contracts between state Medicaid programs and Managed Care Organizations. The Checklist is dated 2003 and remains in “draft”; however, STATE is providing the Checklist to offer guidance. Offerors are encouraged to thoroughly review the Checklist as applicable provisions of the Checklist will be included in the contract(s) that result from this RFP. If an Offeror has objections to any requirement in the Checklist, they must raise the objection by the date noted in Section 1.03 RFP Schedule. Offerors are also cautioned that the Checklist does not contain all requirements that may have been enacted since the Checklist was issued as draft in 2003. **It is important for offerors to note that the eventual contract(s) must comply with all applicable federal and state requirements outlined in law, statute, regulation, and policy.**

A successful offeror must allow STATE and/or the United States Department of Health and Human Services to inspect and audit any financial records, including records of its subcontractors.

Offerors must submit a cost proposal for the fixed monthly per member payment in calendar year 2014. Bids are required for both urban and rural regions. (**Exception:** An offeror submitting a coverage proposal for Burleigh and Cass counties only (Metropolitan Statistical Areas) are not required to submit a rural Price Bid). STATE will establish a confidential rate range for both rural and urban areas prior to submission of the bids.

Each rating cohort within each region has its own actuarially sound rate range and, therefore, each rate must fall within the range specific to the cohort. To the extent that the proposed rate at the region/cohort level falls outside of the actuarially sound rate range, STATE and STATE-contracted actuaries will review the assumptions supplied in the Cost Proposal and will have further discussions with all the offerors at the same time. After the discussions, the offerors will be allowed to submit a revised Cost Proposal based on the guidance provided by STATE and STATE-contracted actuaries. If that proposed rate still results in a proposed rate that is below the lower bound, the proposed rate will be reset to the lower bound of the rate range developed by STATE-contracted actuary. Alternatively, if the cost proposal contains a proposed

rate that is above the upper bound of the rate range developed by STATE-contracted actuary, the proposed rate will be reset to the midpoint, which is defined as the average of the upper and lower bounds of the rate range developed by STATE-contracted actuary.

Once the rates are either accepted or reset as described above, the offeror's cost proposal will be scored accordingly.

The capitation (rates) paid to the Successful Offeror(s) must be certified by a qualified actuary who is a member of the American Academy of Actuaries. This is a requirement of the Centers for Medicare and Medicaid (CMS).

STATE may, at its option, utilize plan claims experience data in the bid for 2015, 2016, and 2017, or may subsequently require a new per member per month bid for those years.

Because STATE recognizes the uncertainty of the number of covered lives and the healthcare services to be used by the Medicaid expansion population, STATE will employ a risk corridor mechanism to adjust the final payments to the successful offeror(s). Due to the unknown characteristics of underlying acuity of the expansion population, the risk corridor will protect both the successful offeror(s) as well as STATE. The successful offeror(s) and STATE will share the financial risk both in terms of any potential losses or gains for medical expenditures for Calendar Year 2014 based on a calculation of the Adjusted Medical Expenditures for all enrollees.

Adjusted Medical Expenditures shall be determined by STATE and STATE-contracted actuary based on Encounter Data and plan financial data submitted by the successful offeror(s) pursuant to the requirements of MCO Reporting Template (MRT), located in the Quality, Reports, Encounter Data, External Quality Review and Sanction 'Reports' section below. Adjusted Medical Expenditures excludes Non-State Plan services.

STATE reserves the right to audit medical expenditures. The data used by STATE and STATE-contracted actuary for the reconciliation will be the routine Encounter Data. STATE and the successful offeror(s) agree that, to the extent there are differences between medical expenditures as reflected in the encounter data and the financial data submitted by the successful offeror(s), STATE and the successful offeror(s) will confer and make a good faith effort to reconcile those differences before the calculation of the Final Settlement as described below in Risk Sharing Final Settlement.

The risk sharing procedures may include a review of the successful offeror(s) Routine Encounter Data and an audit, to be performed by STATE or its authorized agent, to verify that all paid claims for the Enrollee by the successful offeror(s) are reimbursed in amounts that do not exceed the amounts allowed in the Medicaid fee schedule.

The administrative percentage is multiplied by the adjusted medical expenditure. The administrative percentage will be consistent with the percentage used for setting the Total Capitation Rates for the Calendar Year 2014 period.

Risk Sharing Final Settlement

STATE shall perform a settlement of the payments made by the successful offeror(s) to STATE or by STATE to the successful offeror(s). The settlement is the calculated gain or loss determined as the Total Capitation Rates paid to the successful offeror(s) less the Total Adjusted Expenditures (sum of the Adjusted Medical Expenditure plus the administrative amount). This amount is subjected to the risk-sharing corridor to determine the final settlement amount.

Within 180 days following the end of the Calendar Year 2014, the successful offeror(s) shall provide STATE with a complete and accurate report of Actual Medical Expenditures, by category of service, for enrollees, based on claims incurred for Calendar Year 2014 including 5 months of claims run-out, and its best estimate of any claims incurred but not reported (IBNR) for Claims run-out beyond 5 months, and any applicable IBNR completion factor. The report will be a detailed claim-level record.

Prior to 10 months following Calendar Year 2014, STATE shall provide the successful offeror(s) with a final reconciliation under the risk share program for Calendar Year 2014. Any balance due between STATE and the successful offeror(s), as the case may be, will be paid within 60 days of receiving the final reconciliation from STATE.

In the event the successful offeror(s) may require risk mitigation efforts before the end of Calendar Year 2014, STATE may consider interim financial arrangements to ensure solvency and continued successful operation of the successful offeror(s).

From Attachment F of the Contract between Sanford Health Plan and the Department:

The Risk Corridor Percentage is calculated as a blended statewide figure for total Adjusted Medical Expenditures divided by one (1) minus _____ percent for the MCO to cover administrative costs, divided by the Total Capitation Rate, for the Contract Year 2014 period.

The Risk Sharing Corridor Percentage is calculated as follows:

$$\text{(Adjusted Medical Expenditures)/(1-Administrative Percentage)} / \text{(Total Capitation Rate)}$$

The Risk Corridor Percentage calculation begins at 100% and move either up or down until it reaches the Risk Corridor Percentage.

The Risk Sharing Corridor is defined as follows:

Risk Corridor Minimum Percentage		Actual Risk Corridor Percentage		Risk Corridor Maximum Percentage	MCO share	State/Federal Share
	<		<	__%	—	__%
__%	≤		<	__%	__%	__%
__%	≤		<	__%	__%	__%
__%	≤		<	__%	__%	__%
__%	≥			-	__%	__%

Note: Certain information has been redacted as it is proprietary to the Sanford Health Plan and confidential under North Dakota Century Code section 44-04-18.4.