Missouri Medicaid Access to Physician Services (MO MAPS) Program

Operations Manual

Contents

Missouri Medicaid Access to Physician Services (MO MAPS) Program

Operations Manual

Updated: September 2018

Scope of Manual:

This document provides a detailed description of Missouri's implementation of the Missouri Medicaid Access to Physician Services (MO MAPS) within the Missouri Medicaid program. This program is designed to improve access to primary care services for Medicaid beneficiaries.

This manual describes MO HealthNet's approach, details the payment methodology and program funding, and provides guidelines for continuing implementation of the Program.

This CMS-approved payment methodology for the Program is consistent with 42 CFR 438.6(c) and was designed with technical assistance from CMS.

Introduction:

The overarching goal of the MO MAPS Program is to increase access to primary and specialty care services for MO HealthNet Managed Care members by the state's essential Medicaid providers—the University of Missouri Health System (MU Health), Truman Medical Centers (TMC), and University Physician Associates (UPA)—while minimizing the administrative burden on the health plans, providers, and MO HealthNet.

The MO MAPS Program is a payment arrangement intended to supplement, not supplant, the base managed care rates negotiated between health plans and providers. This program will operate as a pool, in which a set dollar amount is established before the start of the fiscal year that MO HealthNet will distribute to the health plans. Health plans use the pool to increase reimbursement to providers based on actual utilization and the reimbursement is distributed according to predetermined criteria memorialized in agreements between them and the providers.

The plans will not be at-risk for the MO MAPS program. Under this arrangement, the plans will not be incentivized to shift utilization or under-value their base negotiated provider payment rates.

Program Operations:

Eligible Providers
The MO MAPS Program applies to physician and certain non-physician practitioners affiliated with the University of Missouri Health System and Truman Medical Centers because these practitioners are key providers of primary and specialty care services to Medicaid beneficiaries. These entities are:

- University of Missouri Health System
- Truman Medical Centers
- University Physician Associates (UPA)

Practitioners eligible for payments under this Program are either employed by or affiliated with these entities.

Qualified Practitioners
Under the MO MAPS Program, payments are limited to the following practitioner types:

- Doctors of Medicine
- Doctors of Osteopathy
- Doctors of Podiatry
- Doctors of Dentistry
- Doctors of Chiropractic
- Certified Registered Nurse Anesthetists
- Certified Registered Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Optometrists
- Clinical Nurse Specialists
- Board Certified Behavioral Analysts
- Physical Therapists
- Occupational Therapists
- Speech Therapists
- Audiologists
- Licensed Professional Counselors

NOTE: *Please see* ***Appendix B*** *for a list of all Qualified Practitioners for each eligible provider by Taxpayer Identification Number (TIN).*

Services Covered
The patient care services provided by the eligible practitioners listed above that are deemed professional services shall be eligible for payments from the pool under this program.

Services provided to enrolled members who are dually eligible for Medicaid and Medicare services are excluded from this program. Services provided under sub-capitated arrangements between health plans and the eligible providers are also excluded. Sub-capitation is defined as when a Health Plan pays a network healthcare practice/provider a set monthly fee that covers all of the administrative and medical expenses of a defined population.

Services paid for under a case rate or bundled rate are also excluded. Case rate/bundled payment is defined here as either a payment of a single rate for a defined group of procedures and services (some

of which may even be inpatient or outpatient) or as the reimbursement of health care providers based on expected costs for clinically-defined episodes of care.

Payment Approach:

Establishing the Average Commercial Rate (ACR)
The state followed the fee-for-service CMS guidance "Medicaid Qualified Practitioner Services – Methodologies for Enhanced Payment Made to Physicians and Practitioners Associated with Academic Medical Centers and Safety Net Hospitals and Upper Payment Calculation" in calculating the average commercial rate (ACR). The commercial allowed amounts by CPT were collected for the top 5 payers by payment volume and averaged to reach a single ACR as a percent of Medicaid statistic.

Setting the Separate Payment Term Pool
For the MO MAPS Program, the state defines separate payment term in their contracts with health plans, which is also referred to as a pool. A separate payment term pool will be established that will contain a set dollar amount to be paid to the eligible providers throughout the year based on actual utilization.

The total dollar amount in the separate payment term pool will be determined as follows:

1. Calculate a statewide Average Commercial Rate (ACR) (see below). The uniform percentage rate increase will be commensurate with the statewide ACR.
2. Estimate projected utilization by using historical utilization plus any necessary trend factors.
3. Multiply estimated projected utilization by the statewide ACR to determine the target payment level.
4. Estimate base rate payments at the negotiated rates for projected utilization.
5. The separate payment term pool will be set as the difference between the target payment level (3) and base rate payments at the negotiated rates (4).

The separate payment term pool will be described in the rate certification with the following elements:

1. The total amount of the payment;
2. The providers that will be receiving the payment;
3. The distribution methodology;
4. An indication that the directed payment is being made under an approved §438.6(c) payment arrangement.

Barring any spikes in utilization or other special circumstances, the size of the separate payment term pool will remain constant over the year. Any increases to the separate payment term pool will require the State to notify and seek approval from CMS.

SFY 2019	The statewide ACR as a percent of Medicaid for SFY 19 (the period from July 1, 2018 to June 30, 2019) is **201% of managed care Medicaid**. The Separate Payment Term is set at **$27,000,400**.

NOTE: *For more information on how the Separate Payment Term Pool was set, see* ***Appendix C****.*

Calculation of Quarterly Payments and Annual Reconciliation
Under this payment approach, MO HealthNet seeks to minimize the administrative burden to execute the billing and payment process for the eligible providers, the Health Plans, and the state.

For the first three quarters of each rate year, the distribution of the quarterly payments from the pool to the providers from the Health Plans will remain static. After the fourth quarter of the rate year, an annual reconciliation will be conducted.

For the first three quarters of the fiscal year, providers will receive enhanced payments under this program based on relative distribution percentages of a provider's contribution towards the overall pool as determined using claim data from prior years.

At the end of the fourth fiscal quarter, interim provider payments shall be reconciled based on utilization. The reconciliation will look at claim data for the current year (all fiscal quarters), based on date of service, to ascertain each health plans' utilization and each providers' share of the pool revenue. Providers' share of the pool shall be based on total Medicaid payments for Medicaid services as a ratio against all participating providers' total Medicaid payments for Medicaid services. A respective providers' fourth quarter payment will be off-set adjusted against any variance found between a provider's share of the pool and total program payments to date. Consensus among the Operations Workgroup shall be reached prior to completion of reconciliation.

> ***NOTE:*** *For more information on the Reconciliation Process and the Operations Workgroup, see* ***Appendix D****.*

Quarterly MO HealthNet Payments to Health Plans
For the first three quarters of the fiscal year, MO HealthNet shall distribute payments to the Health Plans based on the historical utilization and payer mix data for the time period used to determine the ACR and set the separate payment term pool.

Health Plan Payments to Providers
For the first three quarters of a fiscal year, providers will receive pool payments under this program based on relative distribution percentages of a provider's contribution towards the overall pool as determined using claim data from prior years. At the end of the fourth fiscal quarter, interim provider payments shall be reconciled based on utilization.

Health Plans will continue to pay their negotiated base rates to eligible providers throughout the year.

Health Plans will pay the supplemental payment amount calculated by MO HealthNet to the providers in a lump sum within 10 calendar days of receiving the funds from MO HealthNet.

Funding Approach:

The MO MAPS Program is entirely funded by Intergovernmental Transfers (IGTs) from the eligible public providers.

The IGTs from the eligible providers to fund the MO MAPS Program is equal to the cost of the state share to MO HealthNet to finance the program. In general, on a quarterly basis, IGTs equal the quarterly separate payment term pool payment needed to fund the state share of the MO MAPS Program based on projected enrollment and utilization. The IGTs from the eligible providers for the year are locked into three quarterly identical transferred amounts per institution for the first three quarters. In the fourth quarter, MO HealthNet shall issue IGT guidance in alignment with the fourth quarter reconciliation process.

Program Evaluation:

Overview
The supplemental payments will help to support the Qualified Practitioners and their affiliated hospitals to continue to serve a significant share of MO HealthNet managed care members.

This will be accomplished by an increase in the number of qualified practitioners providing primary and specialty care services and the number of outpatient visits relative to the Missouri Medicaid managed care population.

MO HealthNet will review the percentage increase on an annual basis to ensure funds are appropriate to support the professional services provided by these integral Qualified Practitioners.

Access Metrics
The two metrics that will be collected and evaluated in the MO MAPS Program are:

- The **number of Qualified Practitioners** providing primary care services relative to the Missouri Medicaid managed care population, and
- The **number of outpatient visits** relative to the Medicaid managed care population.

Contacts:

State Contacts
If you have questions about the MO MAPS Program, please contact:

Tony Brite
Deputy Director of Finance
573-751-1092
tony.brite@dss.mo.gov

Health Plan Contacts
Each Health Plan has designated a contact for any questions related to the MO MAPS Program:

Home State	Ryan Litteken	RLITTEKEN@homestatehealth.com	855-694-4663
MO Care	Pam Victor	Pamela.Victor@wellcare.com	573-876-1557
United Health Care	Carey Merzlicker	carey_merzlicker@uhc.com	314-592-5937

Eligible Providers Contacts
Each eligible provider has designated a contact for any questions related to the MO MAPS Program:

MU Health	Vic Arnold	arnoldv@health.missouri.edu	573-882-1612
Truman Medical Centers	Marga Hoelscher	Marga.Hoelscher@tmcmed.org	816-404-3540
University Physician Associates	Tom Syverson	tsyverson@upamed.org	816-218-2571

Appendices:

Appendix A

Key Dates for Program Year 1 (PY1)

Appendix A: List of Key Dates SFY 2019

July 1, 2018	Program Implementation Begins
October 2, 2018	Intergovernmental Transfers
October 12, 2018	Quarterly Payments to Providers
January 2, 2018	Intergovernmental Transfers
January 14, 2018	Quarterly Payments to Providers
April 2, 2019	Intergovernmental Transfers
April 12, 2019	Quarterly Payments to Providers
July 1, 2019	Q4 Reconciliation Process Begins
July 1, 2019	SFY 2020 MO MAPS Program Year Begins
October 28, 2019	Intergovernmental Transfers
November 7, 2019	Quarterly Payments to Providers

Appendix B

List of Eligible Providers by Taxpayer Identification Number (TIN)

Missouri Medicaid Access to Physician Services (MO MAPS) Program		
Appendix B: List of Eligible Providers by Taxpayer Identification Number (TIN)		
TIN	GROUP NAME	ENTITY
90-0294051	University Physicians Specialty Care Associates	University of Missouri Health System
90-0294053	University Physicians Inpatient Care Associates	University of Missouri Health System
43-6003859	The Curators of the University of Missouri	University of Missouri Health System
43-1009163	University Physician Associates	University Physician Associates
44-0661018	Truman Medical Centers	Truman Medical Centers

Appendix C

Pool Setting Memorandum

Date: June 18, 2018

From: Sellers Dorsey

To: MO HealthNet

Subject: Calculation of Separate Payment Term for Missouri Medicaid Access to Physician Services (MO MAPS) Program

---

The purpose of this memo is to describe how the separate payment term ("pool") was set for the Missouri Medicaid Access to Professional Services (MO MAPS) Program, a MO HealthNet managed care physician supplemental payment program that was designed in compliance with 42 CFR 438.6(c) and technical assistance provided by CMS.

Background

The overarching goal of the MO MAPS Program is to increase access to primary care services for MO HealthNet Managed Care members by the state's critical Medicaid providers—the University of Missouri Health System (MU Health), Truman Medical Centers (TMC), and University Physician Associates (UPA)—while reducing the administrative burden on the health plans, providers, and MO HealthNet.

The MO MAPS Program is a payment arrangement intended to supplement, not supplant the base managed care rates negotiated between health plans and providers. This program will operate as a pool, in which a set dollar amount is established before the start of the fiscal year that MO HealthNet will initially distribute to the health plans. Health plans use the pool to increase reimbursement to providers based on actual utilization and the reimbursement is distributed according to predetermined criteria memorialized in agreements between them and the providers.

The plans will not be at-risk for the MO MAPS program. Under this arrangement the plans would not be incentivized to shift utilization or under-value their base negotiated provider payment rates.

The pool is generally determined by:

1. Calculating the average commercial rate (ACR)
2. Estimating utilization for the SFY
3. Estimating payments at the ACR for anticipated utilization

Calculation of Average Commercial Rate (ACR)

MO HealthNet followed the fee-for-service CMS guidance "Medicaid Qualified Practitioner Services – Methodologies for Enhanced Payment Made to Physicians and Practitioners Associated with Academic Medical Centers and Safety Net Hospitals and Upper Payment Calculation" in calculating the average commercial rate (ACR). The commercial allowed amounts by CPT were collected for the top 5 payers by payment volume and averaged to reach a single ACR as a percent of Managed Medicaid statistic.

Because MU Health treats a robust commercial patient population across the state, in virtually every county, its data was considered to be most representative of a statewide ACR. TMC and UPA however predominantly serve Medicaid and the uninsured from a smaller state geographic area and have significantly less commercial utilization. As a result their commercial bargaining power is not representative of statewide average commercial rates.

Further information may be found in the MO MAPS Operations Manual.

Setting the Pool

In establishing the ACR and determining Medicaid managed care volume for the eligible providers, Sellers Dorsey used a full year of historical utilization data from July 1, 2015 to June 30, 2016 given to us from providers. In May 2017, however, the state of Missouri expanded Medicaid managed care statewide. TMC, UPA, and MU Health each expected to experience an increase in managed care volume due to this statewide rollout.

Sellers Dorsey calculated this percentage increase by examining historical utilization data from the fiscal years prior to the statewide rollout of managed care and comparing payment volume from those years to payment volume annualized for the current fiscal year (the only time period of data available after the implementation of the statewide rollout of managed care).

Based on the metric used to measure volume (i.e. unique patients, encounter/invoices, payments, etc.) the percentage increases ranged from 8% to 13%. After discussions with MO HealthNet, Mercer, and the providers, Sellers Dorsey opted to use the percentage increase of payments as the trend factor to size the pool. MU Health's data reflected a 10.7% increase in managed care volume. Table 1 below summarizes the calculations used to determine the 10.7% trend factor used to account for the increase in Medicaid managed care volume.

Table 1:

Net Payments	FY 16	FY 17	FY 18 (Q1 - Q3) Annualized	% change 16 to 18
Fee-For Service Medicaid	$ 38,530,224.70	$ 36,085,294.13	$ 33,035,407.47	-16.6%
Managed Medicaid	$ 13,556,665.39	$ 14,665,316.66	$ 15,179,557.64	**10.7%**

To account for this increase in volume in determining the size of the separate payment term, Sellers Dorsey applied a similar methodology as that used to set the ACR and applied this 10.7% trend factor to its prior calculations for each of the three providers to determine a total supplemental payment and separate payment term pool of **$27,000,400**.

Table 2:

	Estimated payment arrangement size using SFY 2016 data	MU trend factor '16-'18 payments from Health Plans	Projections utilizing an expected 10.7% increase
MU Health	$14,514,495	10.7%	$16,067,546
Truman Medical Center	$2,921,911	10.7%	$3,234,555
UPA	$6,954,199	10.7%	$7,698,298
Total Pool			**$27,000,400**

Appendix D

Program Operations Workgroup and Reconciliation

Appendix D: Missouri Medicaid Access to Physician Services (MO MAPS) Program Operations Workgroup (Operations Process and Planning)

The purpose of this appendix is to define the objectives of the Operations Workgroup and to delineate the process for quarterly reconciliation of claims and payments.

Overview

The overarching goal of the MO MAPS Program is to increase access to primary care services for MO HealthNet Managed Care members by the state's critical Medicaid providers—the University of Missouri Health System, Truman Medical Centers, and University Health Physicians. The MO MAPS Program is a supplemental payment program intended to supplement, but not supplant any portion of the base managed care rates negotiated between health plans and providers.

A more thorough description of MO MAPS can be found in the MO MAPS Operations Manual. In summary, this program will operate as a separate payment term or "pool", in which a set dollar amount is established for the contract year. MO HealthNet will distribute the separate payment term to the health plans outside of the regular capitation rates. Health plans in turn would forward funds received under this payment arrangement to providers based on utilization, as discussed further below.

The set dollar amount pool will be allocated among providers based on actual provider utilization. The plans are at 0% risk for the additional funding and thus it is expected that plans would not be incentivized to shift utilization or under-value their base negotiated provider payment rates.

MO HealthNet is empowering an Operations Work Group comprised of health plan and provider representatives to reach conclusion and work through any differences in data and to promote partnership and reduce the overall administrative burden on the health plans, providers, and MO HealthNet.

Principles

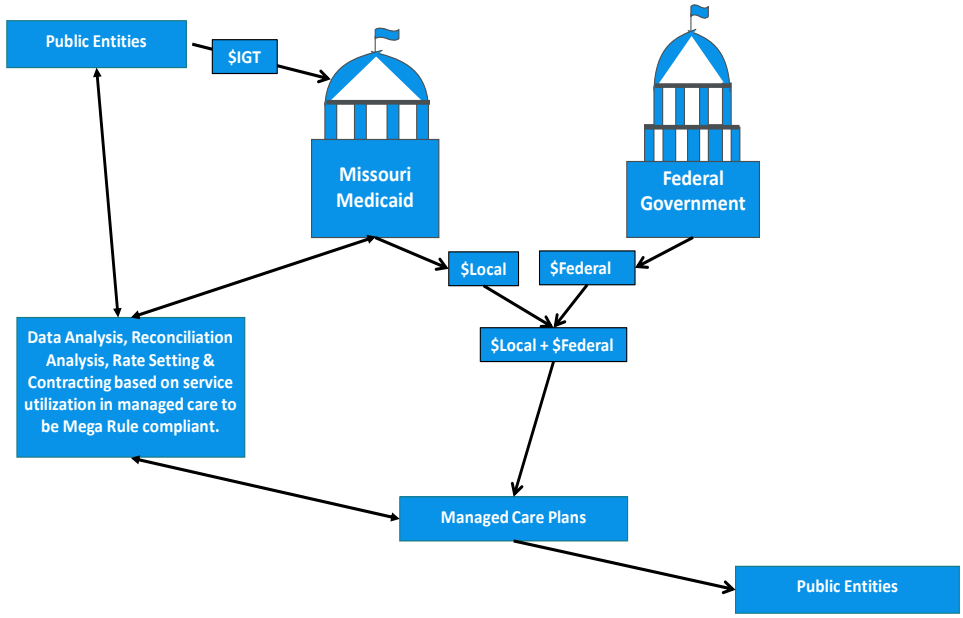
1. Providers and Health Plans will work together to reach agreement on the utilization data required for pool distribution calculations.
2. Providers and Health Plans will need to work collaboratively to achieve programmatic objectives for beneficiaries, ensure open communication lines and to ensure data accuracy.
3. Workgroup Members – The Operations Workgroup is comprised of representatives from the Eligible Providers and the Health Plans.

Annual Reconciliation Process Framework Summary

Fiscal Quarters 1 through 3 – Interim Payments

For the first three quarters of a fiscal year, providers will receive enhanced payments under this program based on relative distribution percentages of a provider's contribution towards the overall pool as determined using claim data from prior years.

The State will be provided with a distribution percentage worksheet prior to the start of a fiscal year; on a pre-determined schedule, the State will then issue Intergovernmental Transfer (IGT) guidance documentation to providers based on this information. Upon the State receiving all IGTs from program participants, the State shall issue highly targeted technical guidance to health plans who shall then issue payments to participating providers based on the guidance documentation provided by the State.



Fiscal Quarter 4 – Payment and IGT Reconciliation Based on Utilization in Actuality

At the end of the fourth fiscal quarter, interim provider payments shall be reconciled based on utilization. The reconciliation will look at claim data for the current year (all fiscal quarters), based on date of service, to ascertain each providers' share of the pool revenue. Providers' share of the pool shall be based on total Medicaid payments for Medicaid services as a ratio against all participating providers' total Medicaid payments for Medicaid services. A respective providers' fourth quarter payment will be off-set adjusted against any variance found between a provider's share of the pool and total program payments to date. The fourth quarter annual reconciliation shall be based on data provided by program providers. A data request shall be sent to providers and unanimous consensus between provider entities shall be reached prior to completion of reconciliation. Rate certification shall be completed approximately six months after initial reconciliation and shall be based on data submitted by the Medicaid health plans to the state and/or state actuary directly. In the event a consensus is not agreed

between the parties, the State shall decide on final reconciliation amounts based on state encounter data.

Data Request Template

The purpose of this section is to define the data request process and parameters necessary to conduct preliminary and final annual reconciliation analysis. This section (Data Request Template) will be extracted into a separate document and sent on a quarterly basis, along with the data request template spreadsheet document.

Objectives:

A) Acquire claim data from participating provider organizations for the purpose of conducting a utilization analysis.
B) Provide assurance to provider stakeholders that MAPS funds are being accurately distributed based on actual utilization.

Statement of Scope: Data Request and Data Utilization Analysis:

A) Professional component claims only (no institutional component claims)
B) Preliminary Analysis to occur quarterly, with final "live" reconciliation occurring after 4th quarter dates of service.
C) Each quarterly and annual data request will define date of service and date of payment range: [place holder]
D) Procedure code range inclusive of all professional claims: (**All acute care claims and behavioral health carve out**)
E) Provider types to be included:

- **Doctors of Medicine**
- **Doctors of Osteopathy**
- **Doctors of Podiatry**
- **Doctors of Dentistry**
- **Certified Registered Nurse Anesthetists**
- **Certified Registered Nurse Practitioners**
- **Physician Assistants**
- **Certified Nurse Midwives**
- **Clinical Social Workers**
- **Clinical Psychologists**
- **Optometrists**
- **Clinical Nurse Specialist**

- **Assistant Physicians**
- **Chiropractors**
- **Board Certified Behavioral Analyst**
- **Physical Therapist**
- **Occupational Therapist**
- **Speech Therapist**
- **Audiologists**
- **Licensed Professional Counselors**
- **Respiratory Therapy**
- **Acupuncturist**
- **Registered Behavioral Technician**

Limitations and Conditions:

A) Is not intended as a health plan (or provider) financial audit or contract compliance audit
B) Is not intended as a forum on overall rates paid by Medicaid Managed Care Organizations (MCOs) to providers
C) Is not a formal financial or accounting analysis and no financial or accounting guidance is implied or intended
D) Is not an actuarial analysis or rate certification document
E) Is not a legal document; no legal advice is implied or intended

Concept of Operations

MO MAPS is an enhanced Medicaid rate initiative intended to incentivize providers and provider organizations to participate in the Missouri Medicaid program so that beneficiaries can maintain or improve access to vital services. The program is based on a uniform percent rate increase to participating provider organizations. Based on prior year analysis of provider data, an estimated projection of total annual payments under the program was calculated using an average commercial rate assumption. The total annual projection amount has been divided into four equal amounts that will be distributed to participating provider organization according to relative distribution factors for each provider organization based on their relative payment amounts showing as due under the annual projection. There is also a relative distribution factor by health plan calculated as part of the projections. For the first three quarterly payments of the program, 25 percent is to be distributed to providers based on the relative distribution factors by provider organization and by health plan. In the fourth quarter distribution cycle, a precise utilization analysis will occur which will look at health plan and provider data to ascertain a precise utilization distribution factor for participating providers. This fourth quarter utilization analysis will then apply a reconciling off-set between actual utilization versus theoretical projection. The providers will have an opportunity to review data against their own records and to provide feedback.

Methodology

Fourth Quarter Analysis: The fourth quarter reconciliation analysis will analyze *aggregated* claim records as they appear according to provider entity claim records. A data request template will be sent in an excel spreadsheet to be completed by providers. The fields shall include items noted below under "Information Required From Providers (Data Extract)."

Preliminary Analysis: There shall be preliminary reconciliation analysis performed in the first three quarters of the program to identify issues with data or business processes; the intent of the preliminary analysis is to identify significant variance between pro rata amounts in the projection versus actual. A data request template will be sent in an excel spreadsheet to be completed by providers. The fields shall include items noted below under "Information Required From Providers (Data Extract)."

Primary Metric for Distribution Factors: Providers' share of the pool shall be based on total Medicaid payments for Medicaid services as a ratio against all participating providers' total Medicaid payments for Medicaid services. A respective providers' fourth quarter payment will be off-set adjusted against any variance found between a provider's share of the pool and total program payments to date. Consensus among the Operations Workgroup shall be reached prior to completion of reconciliation.

Information Required From Providers (Data Extract)

On request from Sellers Dorsey, providers will extract the following claim data and place into an excel spreadsheet template that will be provided with the data request quarterly. The claims shall be identified using scope information defined under "scope" above.

Item#	Field Description	Summary	Purpose/Use
A	Billing NPI	Unique Key ID – Organizational Level (CMS Type 2)	10-digit numeric string to be used for matching selected encounters among organizational silos e.g. Health Plan to Provider (and potentially to state encounter data)
B	Federal Employer Identification Number (FEIN/TIN)	Unique Key ID – Organizational Level (IRS assigned key)	9-digit numeric string to be used for matching selected encounters among organizational silos e.g. Health Plan to Provider (and potentially to state encounter data)
C	Unique Count of Procedure Codes	Count (unique) of CPT4 codes appearing within eligible date of service and date of payment range	Numeric string- to be used for comparative statistics for comparing data between organizational silos
D	Health Plan Paid Amount	Total Medicaid rate paid to provider by health plan, not inclusive of this supplemental payment program.	Numeric string (currency) – to be used for comparative statistics for comparing data between organizational silos and for establishing distribution ratios between providers
E	Charges	Amount charged by provider to plan	reconciliation item between organizational silos
F	BNF enrolled health plan ID - voluntary	Plan ID number	To correctly identify eligible claims and ensure different organizational silos correctly identify eligible claims for reconciliation.

G	BNF enrolled health plan ID - involuntary	Plan ID number	To correctly identify eligible claims and ensure different organizational silos correctly identify eligible claims for reconciliation.
H	BNF enrolled health plan name	Plan Name	To correctly identify eligible claims and ensure different organizational silos correctly identify eligible claims for reconciliation
I	Billed Units	Number of units billed to plan for respective service	reconciliation item between organizational silos
J	Unique count of claims	Unique count of claims (inclusive of all lines)	reconciliation item between organizational silos
K	Unique count of BNF ID's	Unique count of Beneficiary IDs	reconciliation item between organizational silos
L	Date of Payment Range	Define date of payment cut-off	Used to limit claim run-off period to ensure uniform definition of study period
M	Date of Service Range	Define date of service range	Used to ensure uniform definition of study period

Figure 1 - Example of Annual Reconciliaiton Report

MO MAPS - Reconciliation Analysis Worksheet -Template Example					
9/4/2018					
Serial	**Item Description**	**Provider A**	**Provider B**	**Provider C**	**Total**
A.	Projected Base Payments	$100.00	$150.00	$200.00	$450.00
B.	Actual Base Payments (DERIVED FROM PLAN DATA)	$140.00	$110.00	$205.00	$455.00
C.	Projected Distribution Factor	0.2222	0.3333	0.4444	1.00
D.	Projected Supplementals Distribution	$222.22	$333.33	$444.44	$1,000.00
E.	Q1-Q3 Dist (Quarterly)	$55.56	$83.33	$111.11	$250.00
F.	Q1 - Q3 Dist. (Total)	$166.67	$250.00	$333.33	$750.00
G.	Q1-Q3 IGT (Quarterly)	$19.66	$29.49	$39.32	$88.48
H.	Q1-Q3 IGT (Total)	$58.98	$88.48	$117.97	$265.43
I.	Actual Distribution Factor	0.3077	0.2418	0.4505	1.00
J.	Actual Supplementals Distribution	$307.69	$241.76	$450.55	$1,000.00
K.	Actual IGT	$108.89	$85.56	$159.45	$353.90
L.	4Q18 Final Amount Due From/TO State	$141.03	($8.24)	$117.22	$250.00
M.	IGT Due From/TO (credit off-set) State	$49.91	($2.92)	$41.48	$88.48
N.	Risk Retention (provider Holds)	$25.00	$37.50	$50.00	$112.50
O.	4Q18 Final Provider Realized Amount	$166.03	$29.26	$167.22	$362.50

Projected Total Base	**$450.00**
Actual Total Base	**$540.00**
ACR Projected Total Net Payments	**$1,000.00**
ACR Projected Total Local	**$353.90**

FMAP
0.6461

Annual Reconciliation Process Framework

For the first three quarters of each rate year, the distribution of the quarterly payments from the pool to the providers will remain static. During the fourth quarter of the rate year, an annual reconciliation will be conducted.

Quarter 1 – Tracking

Task #	Description	Start Date	Due Date	Responsible Party	Deliverable
Intergovernmental Transfer (IGT)					
1a	State issues IGT Guidance		Sep. 21	State	IGT – Fixed Distribution
1b	Providers issue IGT to State	Sep. 21	Oct. 2	Providers	IGT – Fixed Distribution
1c	State distribution to Plans with supporting instructions for distribution to Providers	Oct. 2	Oct. 5	State	Medicaid Payment
Payments to Providers & Report					
2a	Payment distribution to Providers	Oct. 5	Oct. 10	Plans	Revenue Distribution to Providers
2b	Providers report amount received from plans to Sellers Dorsey	Oct. 10	Oct. 19	Providers	Receipt Report to Sellers Dorsey
Payment Tracking					
3a	Sellers Dorsey compares expected vs. actual payment amounts	Oct. 19	Oct. 26	Sellers Dorsey	Variance Report (Expected Payments vs. Actual Payments)
3b	Providers & Plans review payment variance report and submit any corrective action taken to Sellers Dorsey.	Oct. 26	Nov. 9	Plans & Providers	Variance Report Review + Corrective Action Plan (if needed)
Utilization Tracking					
4a	Plans & Providers submit utilization data to Sellers Dorsey on request.	Oct. 15	Nov. 9	Plans & Providers	Utilization Data Request
4b	Sellers Dorsey produces comparative utilization analysis report	Nov. 9	Nov. 21	Sellers Dorsey	Utilization Report & Analysis

4c	Operations Workgroup meets to review utilization analysis and discuss any corrective action	Nov. 26	Dec. 14	Plans & Providers	Plans & Providers provide feedback on report

Quarter 2 – Tracking

Task #	Description	Start Date	Due Date	Responsible Party	Deliverable
Intergovernmental Transfer (IGT)					
1a	State issues IGT Guidance		Dec. 17	State	IGT – Fixed Distribution
1b	Providers issue IGT to State	Dec. 17	Jan. 2, 2019	Providers	IGT – Fixed Distribution
1c	State distribution to Plans with supporting instructions for distribution to Providers	Jan. 2	Jan. 7	State	Medicaid Payment
Payments to Providers & Report					
2a	Payment distribution to Providers	Jan. 7	Jan. 10	Plans	Revenue Distribution to Providers
2b	Providers report amount received from plans to Sellers Dorsey	Jan. 10	Jan. 22	Providers	Receipt Report to Sellers Dorsey
Payment Tracking					
3a	Sellers Dorsey compares expected vs. actual payment amounts	Jan. 22	Jan. 28	Sellers Dorsey	Variance Report (Expected Payments vs. Actual Payments)
3b	Providers & Plans review payment variance report and submit any corrective action taken to Sellers Dorsey.	Jan. 28	Feb. 8	Plans & Providers	Variance Report Review + Corrective Action Plan (if needed)
Utilization Tracking					
4a	Plans & Providers submit utilization data to Sellers Dorsey on request.	Jan. 18	Feb. 8	Plans & Providers	Utilization Data Request
4b	Sellers Dorsey produces comparative utilization analysis report	Feb. 8	Feb. 22	Sellers Dorsey	Utilization Report & Analysis

4c	Operations Workgroup meets to review utilization analysis and discuss any corrective action	Feb. 22	Mar. 8	Plans & Providers	Plans & Providers provide feedback on report

Quarter 3 - Tracking

Task #	Description	Start Date	Due Date	Responsible Party	Deliverable
Intergovernmental Transfer (IGT)					
1a	State issues IGT Guidance		Mar. 15	State	IGT – Fixed Distribution
1b	Providers issue IGT to State	Mar. 15	Apr. 2	Providers	IGT – Fixed Distribution
1c	State distribution to Plans with supporting instructions for distribution to Providers	Apr. 2	Apr. 5	State	Medicaid Payment
Payments to Providers & Report					
2a	Payment distribution to Providers	Apr. 5	Apr. 10	Plans	Revenue Distribution to Providers
2b	Providers report amount received from plans to Sellers Dorsey	Apr. 10	Apr. 19	Providers	Receipt Report to Sellers Dorsey
Payment Tracking					
3a	Sellers Dorsey compares expected vs. actual payment amounts	Apr. 19	Apr. 26	Sellers Dorsey	Variance Report (Expected Payments vs. Actual Payments)
3b	Providers & Plans review payment variance report and submit any corrective action taken to Sellers Dorsey.	Apr. 26	May 10	Plans & Providers	Variance Report Review + Corrective Action Plan (if needed)
Utilization Tracking					
4a	Plans & Providers submit utilization data to Sellers Dorsey on request.	Apr. 19	May 10	Plans & Providers	Utilization Data Request
4b	Sellers Dorsey produces comparative utilization analysis report	May 10	May 24	Sellers Dorsey	Utilization Report & Analysis

4c	Operations Workgroup meets to review utilization analysis and discuss any corrective action	May 24	Jun. 7	Plans & Providers	Plans & Providers provide feedback on report

Quarter 4 – Annual Reconciliation

Task #	Description	Start Date	Due Date	Responsible Party	Deliverable
Utilization Data Review					
1a	Sellers Dorsey requests detailed utilization data from providers;		**Jul. 1**	Sellers Dorsey	Data Request
1b	Providers send utilization data on request, to Sellers Dorsey.	Jul. 1	**Jul. 15**	Providers	Utilization Data following template
1c	Sellers Dorsey produces analytics (reconciliation report)	Jul. 15	**Jul. 29**	Sellers Dorsey	Reconciliation Report
1d	Providers review comparison analysis & report back any corrective action taken to Sellers Dorsey.	Jul. 29	**Aug. 12**	Providers	Review utilization report & implement corrective action plan as needed & report back to workgroup
1e	Operations Workgroup Meets	Aug. 12	**Sep. 9**		In-person Operations Workgroup meeting
Operations Workgroup Consensus					
2a	Upon workgroup consensus, Sellers Dorsey sends reconciliation report to State reflecting IGT amounts due (inclusive of reconciled IGT's)	Sep. 9	**Oct. 7**	Sellers Dorsey	IGT Guidance to State
Intergovernmental Transfers (IGT)					
3a	State issues IGT guidance to providers, based on agreed upon reconciliation amounts.	Oct. 7	**Oct. 14**	State	IGT guidance to Providers

3b	Providers issue IGT to state	Oct. 14	**Oct. 28**	Providers	IGT remitted to State
3c	Upon receipt of all IGTs, state issues payment & supporting documentation to plans	Oct. 28	**Oct. 31**	State	Payment Remitted to Plans
Payments to Providers and Report					
4a	After plans receive payments, plans then remit payments to providers.	Oct. 31	**Nov. 5**	Plans	Payment remitted to providers
4b	Providers report amount received from plans to Sellers Dorsey.	Nov. 5	**Nov. 15**	Providers	Providers submit receipt amounts to Sellers Dorsey
Payment Reporting					
5a	Providers & Plans review payment variance report and submit any corrective action taken to Sellers Dorsey.	Nov. 15	**Nov. 22**	Plans & Providers	Variance Report Review + Corrective Action Plan (if needed)

Example of Process 1A From Schedule Matrix – Provider IGT Guidance (to be accompanied by IGT calculation spreadsheet each quarter)

[DATE], 2018

Pursuant to authority granted under Title XIX of the Social Security Act and the specific Provider Access Agreements made between the individual MISSOURI Medicaid Health Plans (Health Plans) and qualifying Public Entities identified in [agency abbreviation] Bulletin [insert bulletin number], the Health Plans will make supplemental payments for eligible claims to **[insert public entity name]** in the amount of **$[enter total payment amount]**. The **total** payment is composed of:

- **$[enter amount of any corrections (place holder)]** is for retroactive adjustments for [enter SFY quarter] State Fiscal Year respective to the BASE MAPS Rate Component.
- **$[enter amount payment]** is for adjustments for practitioner services for [enter sfy quarter] State Fiscal Year respective to the BASE MAPS Rate Component.

The attached spreadsheet indicates the amount that will be paid to **[public entity name]** by each of the Health Plans. To ensure these transactions proceed, **[public entity name]** has volunteered to make a payment to the State in the amount of **$[enter igt base amount]; $[enter agency admin fee if applicable]** of this total is for the Administrative fee charged to maintain this program and will be withheld by [insert agency abbreviation]. Please remit this payment no later than **[enter IGT remit deadline]**. **Please be advised, failure to meet this deadline will result in suspension of this distribution until the state match is received by the State of Missouri pursuant to the voluntary agreement.** Please send a reply to all recipients of this message indicating the exact amount to be remitted, the date that funds will be sent and the means by which this transaction will occur.

Please submit any questions or concerns about this transaction to **[insert agency project manager name]** at [insert agency PM email].

Please remit this payment in accordance with the following information:

Funds shall be sent via EFT to the following bank & account #:
Bank Name: xx.
Name of Account: State Treasurer, Missouri
Bank Routing Number: x
Account Number: x
ROUTING NUMBER FOR **WIRES**: x

Checking or Savings: EFT's should include a message or comment: " xx ".

Example Process 1A – Provider IGT Guidance Spreadsheet

MO MAPS Local Calculation FOR 1Q18 Rate Year							
				FMAP 1 (Regular)	FMAP 2 (enhanced categories)	admin fees	
				0.6461	0	0	
	Total Distribution Amount with IGT Liability		Total Actual Distribution w/ all program categories including enhanced match eligible categories	Local Match (regular FMAP)	Local Match (enhanced FMAP)	1Qtr2018 Admin Fees Total	cLocalAmt (Base + enhanced + admin)
University of Missouri Health System	$4,016,886.50		$4,016,886.50	$1,421,576.13	0	0	$1,421,576.13
Truman Medical Centers	$808,638.75		$808,638.75	$286,177.25	0	0	$286,177.25
University Health Physicians (UHP)	$1,924,574.50		$1,924,574.50	$681,106.92	0	0	$681,106.92
Total	**$6,750,099.75**		**$6,750,099.75**	**$2,388,860.30**	**$0.00**	**$0.00**	**$2,388,860.30**
Fund account balance	$0.00						

Payment Instructions

Due date: upon receipt

Please remit payment as follows

State of Missouri
Attn: x /Program ID Code
Mail 1
Mail 2
Mail 3
Billing NPI:
Federal Employer ID: x

Example Process 1C From Schedule Matrix – Health Plan Distribution Guidance From State (to be accompanied by distribution spreadsheet each quarter)

[DATE], 2018

Pursuant to authority granted under Title XIX of the Social Security Act and the specific Provider Access Agreements made between the individual MISSOURI Medicaid Health Plans (Health Plans) and qualifying Public Entities identified in [agency abbreviation] Bulletin [insert bulletin number], [insert health plan name] will make supplemental payments for eligible claims for the respective amounts indicated for each entity in the attached spreadsheet**. The capitation amount remitted to your health plan for this program shall be adjusted based on a year-end analysis and utilization report.**

The attached spreadsheet indicates the amount that will be paid to **each entity.** Please remit this payment no later than **[health plan remit deadline]**. Payment instructions are included in the attached spreadsheet.

Please send a reply to all recipients of this message indicating the exact amount to be remitted to each entity, the date that funds will be sent and the means by which this transaction will occur.

Please submit any questions or concerns about this transaction to **[insert agency project manager name]** at [insert agency PM email].

Example Process 1C From Schedule Matrix – Health Plan Distribution Guidance Spreadsheet

Aggregate 1Q18 MAPS Health Plan Remittance Advice					
Healthplan ID#	**Healthplan**	**University of Missouri Health System**	**Truman Medical Centers**	**University Health Physicians (UHP)**	**Total**
x	Home State	$1,606,754.60	$323,455.50	$769,829.80	$ 2,700,039.90
x	MO Care	$2,008,443.25	$404,319.38	$962,287.25	$ 3,375,049.88
x	United Community Plan	$401,688.65	$80,863.88	$192,457.45	$ 675,009.98
Totals		**$4,016,886.50**	**$808,638.75**	**$1,924,574.50**	**$ 6,750,099.75**

Payment Instructions
Due date: upon receipt

Please remit payment as follows

University of Missouri Health System
Attn: x
EFT Account#
EFT Routing#

Billing NPI:
Federal Employer ID: x

Truman Medical Centers
Attn: x
EFT Account#
EFT Routing#

Billing NPI:
Federal Employer ID: x

University Health Physicians (UHP)
Attn: x
EFT Account#
EFT Routing#

Billing NPI
Federal Employer ID: x

Example Process 2b From Schedule Matrix – Provider Receipt Report to Sellers Dorsey

Aggregate1Q18 MAPS Distribution					
Healthplan ID#	**Healthplan**	**Provider Entity Revenue Expected 1Q18**	**Provider Entity ACTUAL Received as of xx/xx/xxxx**	**Variance**	
x	Home State	$ 2,700,039.90		$ 2,700,039.90	
x	MO Care	$ 3,375,049.88		$ 3,375,049.88	
x	United Community Plan	$ 675,009.98		$ 675,009.98	
Totals		**$ 6,750,099.75**		**$ 6,750,099.75**	
Provider Organization: Please enter your MO MAPS received amount as of today, in colum D and return to bmcclellan@sellersdorsey.com					

Appendix E

Health Plan Contract Language

PLACEHOLDER

Additional Attachments

Missouri Medicaid Access to Professional Services

(MO MAPS)

DRAFT Methodology FOR Annual Reconciliation

1. **Objectives:**
   A) Acquire Medicaid Managed Care encounter claim data from Missouri Medicaid Health Plans for the purpose of conducting a utilization analysis sufficient for rate certification purposes by State Actuary (compliance).
   B) Provide assurance to provider stakeholders that MAPS funds are being accurately distributed based on actual utilization.

2. **Statement of Scope: Data Request and Data Utilization Analysis:**
   A) Professional component claims only (no institutional component claims)
   B) Annual Request and utilization analysis
   C) Year 1 reconciliation: Date of Service July 1, 2017 through June 30, 2018; Date of Payment through June 30, 2018
   D) Procedure code range inclusive of all professional claims
   E) Must identify rate cell components (see data request template attachment A)
   F) Data request must be sufficiently specific to allow uniform analysis among health plans and providers, without containing protected health information (PHI) of beneficiaries

3. **Limitations and Conditions:**
   A) Is not intended as a health plan (or provider) financial audit or contract compliance audit
   B) Is not intended as a forum on overall rates paid by Medicaid Managed Care Organizations (MCOs) to providers
   C) Is not a formal financial or accounting analysis and no financial or accounting guidance is implied or intended
   D) Is not an actuarial analysis or rate certification document
   E) Is not a legal document; no legal advice is implied or intended

4. **Concept of Operations**

MO MAPS is an enhanced Medicaid rate initiative to incentivize providers and provider organizations to participate in the Missouri Medicaid program so that beneficiaries can maintain or improve access to vital services. The program is based on a uniform percent rate increase to participating provider organizations. Based on prior year analysis of provider data from participating provider organizations, an estimated projection of total annual payments under the program was calculated using an average commercial rate assumption. The total annual projection amount has been divided into four equal amounts that will be distributed to participating provider organization according to relative distribution factors for each provider organization based on their relative payment amounts showing as due under the annual projection. There is also a relative distribution factor by health plan calculated as part of the projections. For the first three quarterly payments of the program, 25% percent is to be distributed to providers based on the relative distribution factors by provider organization and by health plan. In the fourth quarter distribution cycle, a precise utilization analysis will occur which will look at health plan and provider data in order to ascertain a precise utilization distribution factor for participating providers.

This fourth quarter utilization analysis will then apply a reconciling off-set between actual utilization versus theoretical project. In order to conduct this analysis, managed care organizations must provide sellers Dorsey with data sufficient to conduct the analysis. Attachment A contains a template of claim data needed in order to conduct the analysis. The providers will have an opportunity to review the health plan submitted data against their own records and to provide feedback. In the event significant variance occurs between health plan provided data and provider data, iterative discussions shall occur between the plans and providers in order to ascertain the cause of such variances to create, where appropriate, corrective action plans to address the issue (s) in a timely fashion.

Methodology

Fourth Quarter Analysis: The fourth quarter reconciliation analysis will analyze *aggregated* claim records as they appear according to Medicaid health plan claim records of system. A data request template shall be provided to Medicaid health plans in a timely manner that shall allow ample time to provide the requested data according to project timelines. Attachment A contains the data request template.

Preliminary Analysis: There shall be preliminary reconciliation analysis performed in each of the first three quarters of the program in order to identify issues with data or business processes; the intent of the preliminary analysis is to identify significant variance between provider data and health plan data, *before* disruption occurs in the fourth quarter due to significant differences as such an unexpected event occurring in the fourth quarter would have potential to affect multiple stakeholders and negatively impact timely payments of program revenue and therefore potentially restrict movement towards reaching program objectives.

Order of Operations**:** Sellers Dorsey will first request and review data from the MCO's. A report will be provided to the PEs and if needed (at request of PEs) a data extract will be submitted by the PEs for purposes of comparison with the MCO extracts. For preliminary reconciliation analysis and fourth quarter reconciliation analysis, the PE's shall submit data according to the data request template.

Primary Metric for Distribution Factors: Providers' share of the pool shall be based on total Medicaid payments for Medicaid services as a ratio against all participating providers' total Medicaid payments for Medicaid services. A respective providers' fourth quarter payment will be off-set adjusted against any variance found between a provider's share of the pool and total program payments to date. Consensus among the Operations Workgroup shall be reached prior to completion of reconciliation.

Figure 1 Example of 4th Quarter Reconciliation

Serial	Item Description	Provider A	Provider B	Provider C	Total
A.	Projected Base Payments	$100.00	$150.00	$200.00	$450.00
B.	Actual Base Payments (DERIVED FROM PLAN DATA)	$140.00	$110.00	$205.00	$455.00
C.	Projected Dist. Factor	0.2222	0.3333	0.4444	1.00
D.	Projected Supplementals	$222.22	$333.33	$444.44	$1,000.00
E.	Q1-Q3 Dist (Quarterly)	$55.56	$83.33	$111.11	$250.00
F.	Q1 - Q3 Dist. (Total)	$166.67	$250.00	$333.33	$750.00
G.	Actual Dist. Factor	0.3077	0.2418	0.4505	1.00
H.	Actual Pool Dist.	$307.69	$241.76	$450.55	$1,000.00
I.	4Q18 Amount Due	$141.03	($8.24)	$117.22	$250.00
J.	Risk Retention (provider or State Holds)	$25.00	$37.50	$50.00	$112.50
K.	4Q18 Final Amount Due	$166.03	$29.26	$167.22	$362.50

Projected Total Base	**$450**
Actual Total Base	**$540**
ACR Projected Total Net Payments	$1,000.0

Potential for Scope Expansion into an Encounter Data Quality Initiative: At request of the Medicaid program, the project could be expanded at some point to include a comparison between health plan reported data, provider reported data, and the state encounter data system FOR certain selected claim samples that could become more granular than the initial scope; such an expansion may be of significant use as an encounter quality initiative. Comparing data in this manner has potential to produce a robust validation system because it will allow stakeholders to view a "complete picture" of the Medicaid managed care data universe between multiple silos.

Such a scope expansion may qualify for enhanced matching rates from CMS in order to fund the scope expansion.

Public Provider Entities (PEs):

On request, the PE's shall provide a primary point of contact for the MO MAPS program.

Sellers Dorsey will first request and review data from the MCO's. A report will be provided to the PEs and if needed (at request of PEs) a data extract will be submitted by the PEs for purposes of comparison with the MCO extracts. For preliminary reconciliation analysis and fourth quarter reconciliation analysis, the Pes shall submit data according to the data request template

Medicaid Managed Care Organizations:

On request, MCO's shall provide a primary point of contact for the MO MAPS program.

For preliminary reconciliation analysis and fourth quarter reconciliation analysis, the MCO's shall submit data according to the data request template (attachment A). Subsequent to the utilization analysis reports, the MCO's shall review the report and engage in stakeholder discussions regarding any concerns raised in the report. Specific dates and deadlines for operations of the program are highlighted in the operations manual **Appendix D**.

Plan Reported Data

Billing NPI	FEIN (TaxID)	Unique Count of Procedure Codes	Charges	Health Plan Paid Amount	BNF Enrolled Health Plan ID (Health Plan ID assigned by state -voluntary assigned)	BNF Enrolled Health Plan ID (Health Plan ID assigned by state -involuntary assigned)	BNF Enrolled Health Plan Name	Billed Units	Unique Count of Claims	Unique Count of BNF ID's	Date of Service Range	Date of Payment Range	Region (state to provide region crosswalk)	Program Description (state to provide program category crosswalk)	Age Band (state to provide age band cross walk)	Gender
*10 digit numerical	*9-digit numerical	*numerical	*numerical	*numerical	*numerical	*numerical	*text data	*numerical	*numerical varcha	*numerical varchar 30	please populate wi	please populate with DC	See Crosswalk Tab	See Crosswalk Tab	See crosswalk tab	See crosswalk tab

FOR Date of Service 10/1/2017 throuh 9/30/2018
with date of payment through 9/30/2018

FOR all professional component Medicaid claims, all service-based procedure codess (no supply)

Please include only FINAL adjudicated claims

COA	DESCRIPTION	AGE BAND	GENDER
1 - All Regions	MO HealthNet for Families, Children and Refugees	<1 (Newborns)	M & F
		Children <21	M & F
		Adults 21+	M & F
2 - All Regions	MO HealthNet for Pregnant Women	All Ages	F
4 - Central, East and Southwest	Foster Care Children	0-25 year olds	M & F
4 - West Region OSJC	Foster Care Children	0-25 year olds	M & F
4 - West Region JC	Foster Care Children	0-25 year olds	M & F
5 - All Regions	State CHIP	0-18 year olds	M & F
1, 2, 4 and 5 - All Regions	Delivery Payment	All ages	F
1 - All Regions	NICU Birth Payment	Newborns	M & F

REGIONAL GROUPS

Separate rates are developed for each of the four MO HealthNet Managed Care regions. In the Central, East and Southwest Regions, there are four risk -adjusted capitation rates, plus a regional delivery payment and a regional NICU birth payment, as well as s ingle regional capitation rates for pregnant women and COA 1 eligibles less than one year old. Note that the West Region includes an additional risk -adjusted rate due to the COA 4 — OSJC (outside of Jackson County) and COA 4 — JC (Jackson County) rating gr oup distinction. Counties that make up the rate regions outlined below represent region mappings effective July 1, 2018.

Central Region

Central — Previous

The MO HealthNet Managed Care Program began in the Central Region in March 1996. The Central Region originally included Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Randolph and Saline counties. Effective January 1, 2008, the Central Region was expanded to includ e Benton, Laclede, Linn, Macon, Maries, Marion, Phelps, Pulaski, Ralls and Shelby counties.

Central — Extension

Effective May 1, 2017, the Central Region expanded to include Adair, Andrew, Atchison, Bollinger, Buchanan, Butler, Caldwell, Cape Girardeau, C arroll, Carter, Clark, Clinton, Crawford, Daviess, DeKalb, Dent, Dunklin, Gentry, Grundy, Harrison, Holt, Iron, Knox, Lewis, Livingston, Mercer, Mississippi, New Madrid, Nodaway, Pemiscot, Putnam, Reynolds, Ripley, Schuyler, Scotland, Scott, Stoddard, Sull ivan, Wayne and Worth counties.

The Central Region capitation rates described in this memorandum include all 68 counties of the previous region and the extension region.

East Region

The MO HealthNet Managed Care Program began in the East Region in Septembe r 1995. Originally, the East Region consisted of Franklin, Jefferson, St. Charles, St. Louis City and St. Louis counties. Beginning in December 2000, the East Region was expanded to include Lincoln, St. Francois, Ste. Genevieve, Warren and Washington count ies. Effective January 1, 2008, the East Region was further expanded to include Madison, Perry and Pike counties. The counties included in the East Region for this procurement are unchanged from the current 13 counties.

West Region

The MO HealthNet Managed Care Program began in the West Region in February 1997. Originally, the West Region included Jackson County (JC) and the counties outside Jackson County (OSJC) (Cass, Clay, Henry, Johnson, Lafayette, Platte, Ray and St. Clair). Effective January 1, 2008, the West Region was expanded to include Bates, Cedar, Polk and Vernon counties. The counties included in the West Region for this procurement are unchanged from the current 13 counties.

Southwest Region

The MO HealthNet Managed Care Program began in the S outhwest Region in May 2017. The Southwest Region includes Barry, Barton, Christian, Dade, Dallas, Douglas, Greene, Hickory, Howell, Jasper, Lawrence, McDonald, Newton, Oregon, Ozark, Shannon, Stone, Taney, Texas, Webster and Wright counties.

Provider Reported Data															
Billing NPI	FEIN (TaxID)	Unique Count of Procedure Codes	Charges	Health Plan Paid Amount	BNF Enrolled Health Plan ID (Health Plan ID assigned by state -voluntary assigned)	BNF Enrolled Health Plan ID (Health Plan ID assigned by state - involuntary assigned)	BNF Enrolled Health Plan Name	Billed Units	Unique Count of Claims	Unique Count of BNF ID's	Date of Service Range	Date of Payment Range	Region (state to provide region crosswalk)	Program Description (state to provide program category crosswalk)	Age Band (state to provide age band cross walk)
*10 digit numerical	*9-digit numerical	*numerical	*numerical	*numerical	*numerical	*numerical	*text data	*numerical	*numerical varchar 30	*numerical varchar	please populate with DOS range	please populate with D	See Crosswalk Tab	See Crosswalk Tab	See crosswalk tab

MO MAPS - Reconciliation Analysis Worksheet -Template Example												
9/4/2018												
Serial	**Item Description**			**Provider A**		**Provider B**		**Provider C**		**Total**		
A.	Projected Base Payments			$100.00		$150.00		$200.00		$450.00		
B.	Actual Base Payments (DERIVED FROM PLAN DATA)			$140.00		$110.00		$205.00		$455.00		
C.	Projected Distribution Factor			0.2222		0.3333		0.4444		1.00		
D.	Projected Supplementals Distribution			$222.22		$333.33		$444.44		$1,000.00		
E.	Q1-Q3 Dist (Quarterly)			$55.56		$83.33		$111.11		$250.00		
F.	Q1 - Q3 Dist. (Total)			$166.67		$250.00		$333.33		$750.00		
G.	Q1-Q3 IGT (Quarterly)			$19.66		$29.49		$39.32		$88.48		
H.	Q1-Q3 IGT (Total)			$58.98		$88.48		$117.97		$265.43		
I.	Actual Distribution Factor			0.3077		0.2418		0.4505		1.00		
J.	Actual Supplementals Distribution			$307.69		$241.76		$450.55		$1,000.00		
K.	Actual IGT			$108.89		$85.56		$159.45		$353.90		
L.	4Q18 Final Amount Due From/TO State			$141.03		($8.24)		$117.22		$250.00		
M.	IGT Due From/TO (credit off-set) State			$49.91		($2.92)		$41.48		$88.48		
N.	Risk Retention (provider Holds)			$25.00		$37.50		$50.00		$112.50		
O.	4Q18 Final Provider Realized Amount			$166.03		$29.26		$167.22		$362.50		
	Projected Total Base	**$450.00**										
	Actual Total Base	**$540.00**										
	ACR Projected Total Net Payments	**$1,000.00**										
										FMAP		
	ACR Projected Total Local	**$353.90**								**0.6461**		

Pilot Project - Comparison of Basic Descriptive Statistics Between Organizational Data Silos											
		PLAN A		Provider A		State Encounter Data		Plan: Provider		Plan to State Encounter Data	
Line Count		5,005		4,490		3,000		515		2,005	
Unique BNFID Count		1,294		1,195		1,127		99		167	
Unique Claim ID Count		2,713		2,832		2,244		(119)		469	
Lines w/ NULL Claim ID Number		675		0		0		675		675	
Total Charges		807,869		747,000		590,274		60,869		217,595	
Total Billed Units		7,401		6,600		13,410		801		(6,009)	
Unique Procedure Codes		400		353		322		47		78	
Count Unique FEIN (TaxID)		2		2		8		0		(6)	

[DATE], 2018

Pursuant to authority granted under Title XIX of the Social Security Act and the specific Provider Access Agreements made between the individual MISSOURI Medicaid Health Plans (Health Plans) and qualifying Public Entities identified in [agency abbreviation] Bulletin [insert bulletin number], the Health Plans will make supplemental payments for eligible claims to [insert public entity name] in the amount of **$[enter total payment amount]**. The **total** payment is composed of:

- **$[enter amount of any corrections (place holder)]** is for retroactive adjustments for [enter SFY quarter] State Fiscal Year respective to the BASE MAPS Rate Component.

- **$[enter amount payment]** is for adjustments for practitioner services for [enter sfy quarter] State Fiscal Year respective to the BASE MAPS Rate Component.

The attached spreadsheet indicates the amount that will be paid to **[public entity name]** by each of the Health Plans. To ensure these transactions proceed, **[public entity name]** has volunteered to make a payment to the State in the amount of **$[enter igt base amount]**; **$[enter agency admin fee if applicable]** of this total is for the Administrative fee charged to maintain this program and will be withheld by [insert agency abbreviation]. Please remit this payment no later than **[enter IGT remit deadline]**. **Please be advised, failure to meet this deadline will result in suspension of this distribution until the state match is received by the State of Missouri pursuant to the voluntary agreement.** Please send a reply to all recipients of this message indicating the exact amount to be remitted, the date that funds will be sent and the means by which this transaction will occur.

Please submit any questions or concerns about this transaction to **[insert agency project manager name]** at [insert agency PM email].

Please remit this payment in accordance with the following information:
Checks should be made payable to: State of Missouri
Checks should be sent to:
[agency address- Cashier's Unit]
Program identifying name or code
Address 1
Address 2
Address 3

Funds may also be sent via EFT to the following bank & account #:
Bank Name: xx.
Name of Account: State Treasurer, Missouri
Bank Routing Number: xx
Account Number: xx
ROUTING NUMBER FOR **WIRES**: xx

Checking or Savings: Checks and EFT's should include a message or comment: " xx ".

Aggregate1Q18 MAPS Distribution						
Healthplan ID#	**Healthplan**	**University of Missouri Health System**	**Truman Medical Centers**	**University Physician Associates (UPA)**	**Total**	
x	Home State	$1,606,754.60	$323,455.50	$769,829.80	$ 2,700,039.90	
x	MO Care	$2,008,443.25	$404,319.38	$962,287.25	$ 3,375,049.88	
x	United Community Plan	$401,688.65	$80,863.88	$192,457.45	$ 675,009.98	
Totals		**$4,016,886.50**	**$808,638.75**	**$1,924,574.50**	**$ 6,750,099.75**	

MAPS Pool Healthplan Distribution Factors 2018 Rate Year	
Home State	0.4000
MO Care	0.5000
United Community Plan	0.1000
Total	**1.0000**

MAPS Pool Provider Distribution Factors 2018 Rate Year	
University of Missouri Health System	0.5951
Truman Medical Centers	0.1198
University Physician Associates (UPA)	0.2851
Total	**1.0000**

MO MAPS Local Calculation FOR 1Q18 Rate Year								
				FMAP 1 (Regular)	FMAP 2 (enhanced categories)	admin fees		
				0.6461	0	0		
	Total Distribution Amount with IGT Liability		Total Actual Distribution w/ all program categories including enhanced match eligible categories	Local Match (regular FMAP)	Local Match (enhanced FMAP)	1Qtr2018 Admin Fees Total	cLocalAmt (Base + enhanced + admin)	
University of Missouri Health System	$4,016,886.50		$4,016,886.50	$1,421,576.13	0	0	$1,421,576.13	
Truman Medical Centers	$808,638.75		$808,638.75	$286,177.25	0	0	$286,177.25	
University Physician Associates (UPA)	$1,924,574.50		$1,924,574.50	$681,106.92	0	0	$681,106.92	
Total	**$6,750,099.75**		**$6,750,099.75**	**$2,388,860.30**	**$0.00**	**$0.00**	**$2,388,860.30**	
Fund account balance	$0.00							
Payment Instructions								
Due date: upon receipt								
Please remit payment as follows								
State of Missouri								
Attn: x /Program ID Code								
Mail 1								
Mail 2								
Mail 3								
Billing NPI:								
Federal Employer ID: x								

Health plan ID#	Healthplan	University of Missouri Health System	Truman Medical Centers	University Physician Associates (UPA)	Total	Program Fiscal Quarter
x	Home State	$1,606,754.60	$323,455.50	$769,829.80	$ 2,700,039.90	1Q2018
x	MO Care	$2,008,443.25	$404,319.38	$962,287.25	$ 3,375,049.88	1Q2018
x	United Community F	$401,688.65	$80,863.88	$192,457.45	$ 675,009.98	1Q2018

[DATE], 2018

Pursuant to authority granted under Title XIX of the Social Security Act and the specific Provider Access Agreements made between the individual MISSOURI Medicaid Health Plans (Health Plans) and qualifying Public Entities identified in [agency abbreviation] Bulletin [insert bulletin number], [insert health plan name] will make supplemental payments for eligible claims for the respective amounts indicated for each entity in the attached spreadsheet**. The capitation amount remitted to your health plan for this program shall be adjusted based on a year-end analysis and utilization report.**

The attached spreadsheet indicates the amount that will be paid to **each entity.** Please remit this payment no later than **[health plan remit deadline]**. Payment instructions are included in the attached spreadsheet.

Please send a reply to all recipients of this message indicating the exact amount to be remitted to each entity, the date that funds will be sent and the means by which this transaction will occur.

Please submit any questions or concerns about this transaction to **[insert agency project manager name]** at [insert agency PM email].

Aggregate 1Q18 MAPS Health Plan Remittance Advice					
Healthplan ID#	**Healthplan**	**University of Missouri Health System**	**Truman Medical Centers**	**University Physician Associates (UPA)**	**Total**
x	Home State	$1,606,754.60	$323,455.50	$769,829.80	$ 2,700,039.90
x	MO Care	$2,008,443.25	$404,319.38	$962,287.25	$ 3,375,049.88
x	United Community Plan	$401,688.65	$80,863.88	$192,457.45	$ 675,009.98
Totals		**$4,016,886.50**	**$808,638.75**	**$1,924,574.50**	**$ 6,750,099.75**
Payment Instructions					
Due date: upon receipt					
Please remit payment as follows					
University of Missouri Health System					
Attn: x					
Mail 1					
Mail 2					
Mail 3					
Billing NPI:					
Federal Employer ID: x					
Truman Medical Centers					
Attn: x					
Mail 1					
Mail 2					
Mail 3					
Billing NPI:					
Federal Employer ID: x					
University Physician Associates (UPA)					
Attn: x					
Mail 1					
Mail 2					
Mail 3					
Billing NPI					
Federal Employer ID: x					

Aggregate1Q18 MAPS Distribution					
Healthplan ID#	**Healthplan**	**Provider Entity Revenue Expected 1Q18**	**Provider Entity ACTUAL Received as of xx/xx/xxxx**	**Variance**	
x	Home State	$1,606,754.60		$1,606,754.60	
x	MO Care	$2,008,443.25		$2,008,443.25	
x	United Community Plan	$401,688.65		$401,688.65	
Totals		**$4,016,886.50**		**$1,924,574.50**	