

# MO HEALTHNET MANAGED CARE RATE DEVELOPMENT JULY 1, 2015 – JUNE 30, 2016

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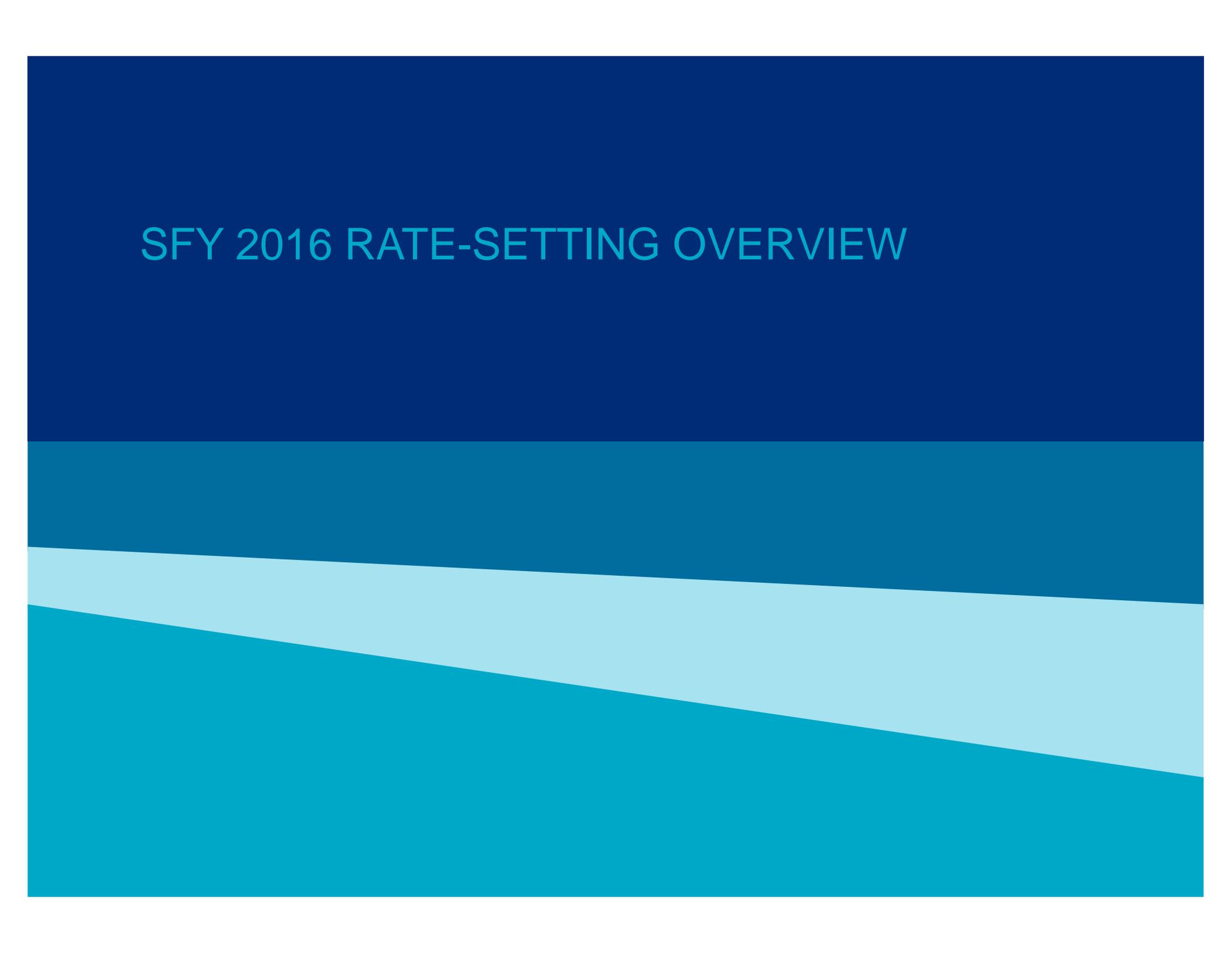
**November 10, 2014**

Government Human Services Consulting

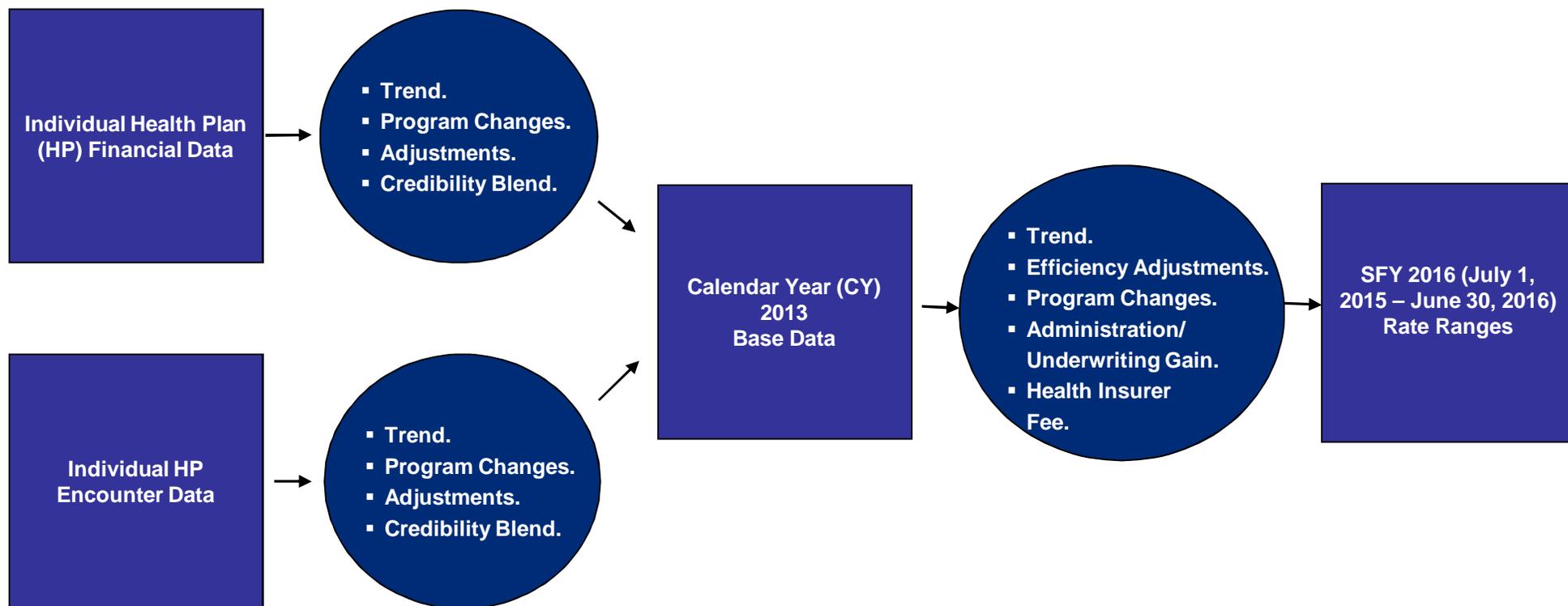
# Agenda

- State Fiscal Year (SFY) 2016 Rate-Setting Overview.
- Base Data Development.
- SFY 2016 Rate Range Development.
- Other SFY 2016 Payment Considerations.
- Questions.

# SFY 2016 RATE-SETTING OVERVIEW

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# SFY 2016 Rate-Setting Overview



## SFY 2016 Rate-Setting Overview

### Documentation Materials Available

- SFY 2016 Data Book:
  - Full description of data sources and adjustments.
  - Description of rate-setting methodology and program changes.
  - Methodologies for efficiency adjustments.
  - Details on risk adjustment models.
- Template for Health Plan Financial Reporting Form (Formerly Attachment 10).

## SFY 2016 Rate-Setting Overview

### Changes from SFY 2015 Rates

- Full rebase of base data to use more recent HP financial data and encounter data.
- Added Pregnant Women rate cell.
- Program and contract changes effective during SFY 2016:
  - Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) reimbursement requirements effective July 1, 2015.
  - Community Mental Health Center (CMHC) reimbursement effective July 1, 2015.
  - Former Foster Care Youth benefit changes effective July 1, 2015.

# BASE DATA DEVELOPMENT



## Base Data Development

### HP Financial Data

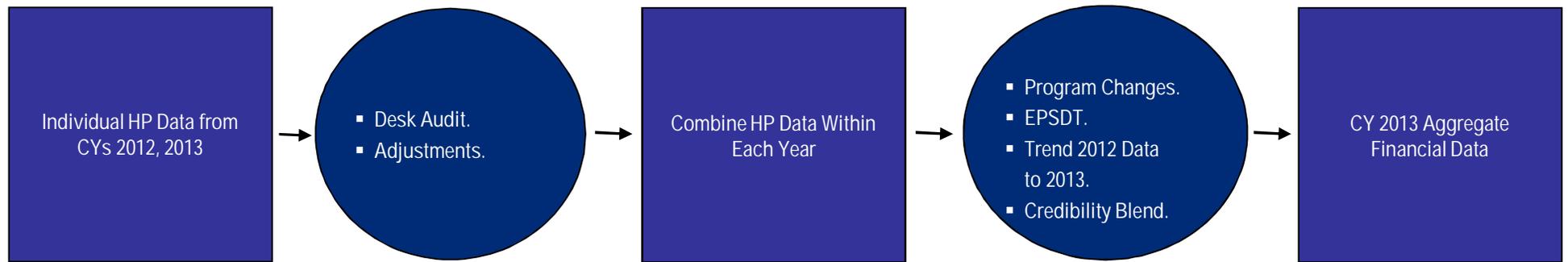
- Non-delivery and delivery data for CYs 2012 and 2013 from May 2014 Health Plan Financial Reporting Form financial submissions.
- Desk audit:
  - Check for completeness, consistency, and reasonability.
  - Review of outstanding claims.
    - Analyze lag triangles.
    - Adjust reported incurred but not reported up or down, as necessary.
  - Compare to Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) filings.
- Sent data review letter to HPs and confirmed adjustments.

## Base Data Development

### HP Financial Data (cont.)

- Apply historical program changes with effective dates through CY 2013:
  - Primary care physicians (PCP) payment change for Affordable Care Act (ACA) effective January 1, 2013.
  - Ambulance fee schedule and mileage reimbursement effective July 1, 2013.
  - Former Foster Care Youth coverage up to age 26 effective August 28, 2013.
- Reflect 80% Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) presentation rate.
- Trend CY 2012 data to CY 2013 (0.0% to 10.0% by category of service [COS]).
- Blend two years of data placing 80% weight on CY 2013 data and 20% weight on CY 2012 data.

## Base Data Development HP Financial Data (cont.)



## Base Data Development

### HP Encounter Data

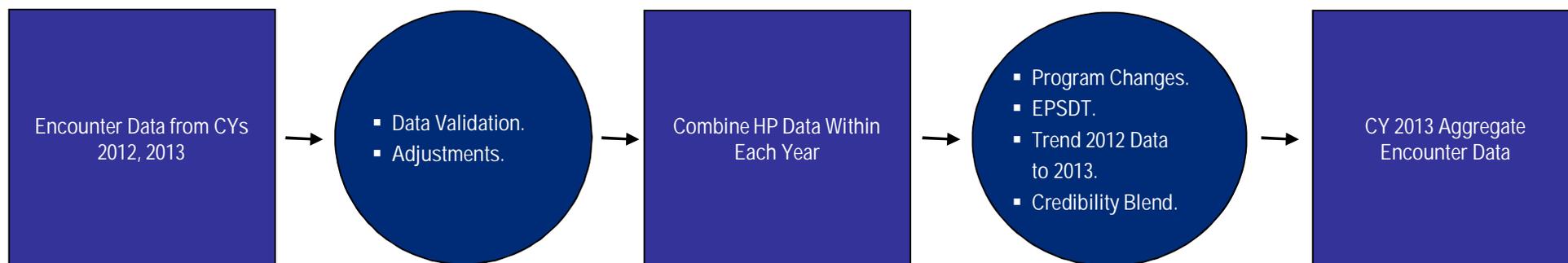
- Non-delivery and delivery data for CYs 2012 and 2013.
- Validation analysis:
  - Compare to Health Plan Financial Reporting Form financial data submission.
  - Check for data completeness and accuracy.
  - Review for historical consistency, consistency within HP and consistency across HPs and regions.
- Data adjustments:
  - Reallocated costs into consistent COS and rate cells among HPs.
  - Adjusted for cases where costs were not reasonable and/or consistent with HP financials.
  - Applied completion factors based on completion patterns seen in lag triangles.
- Based on validation, Inpatient – Physical Health, Outpatient – Physical Health, Emergency Room (ER), Physician Services, and Family Planning data were used in the rate-setting process.

## Base Data Development

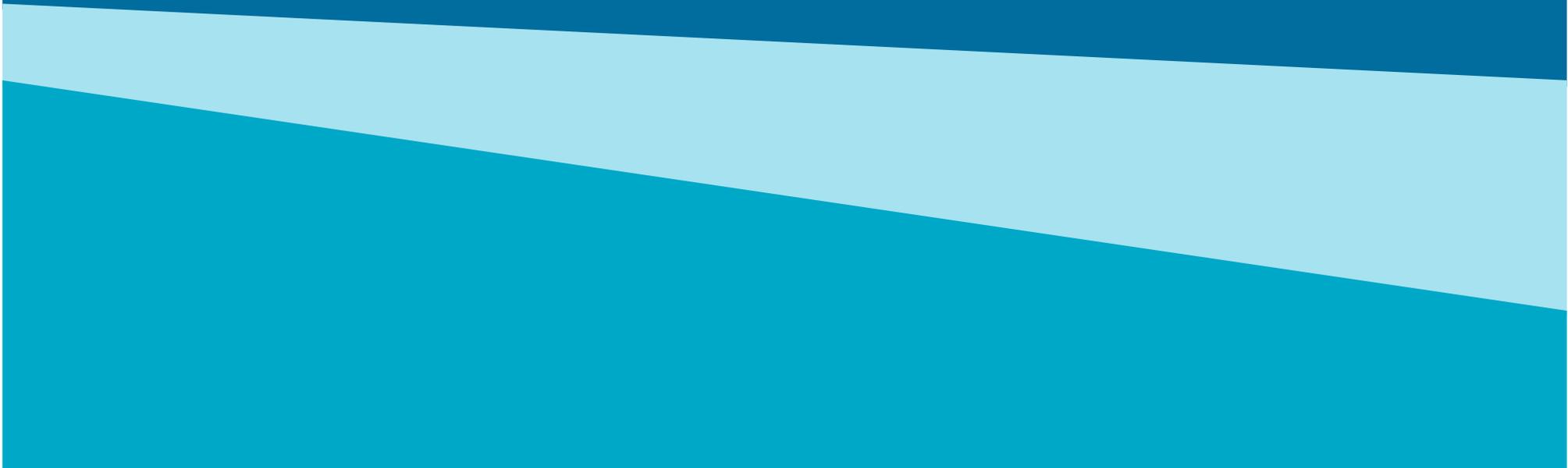
### HP Encounter Data (cont.)

- Apply historical program changes with effective dates through CY 2013:
  - PCP payment change for ACA effective January 1, 2013.
  - Former Foster Care Youth coverage up to age 26 effective August 28, 2013.
- Reflect 80% EPSDT presentation rate.
- Trend CY 2012 data to CY 2013 (0.0% to 10.0% by COS).
- Blend two years of data placing 80% weight on CY 2013 data and 20% weight on CY 2012 data.

## Base Data Development HP Encounter Data (cont.)



# SFY 2016 RATE RANGE DEVELOPMENT



## SFY 2016 Rate Range Development Credibility Blending of Data Sources

- Place most weight on HP financial data.

COS	Financial Weight	Encounter Weight
Inpatient – Physician Health	85% all regions	15% All Regions
Emergency Room	80% Central and East 85% West	20% Central and East 15% West
Outpatient – Physical Health	80% Central and East 85% West	20% Central and East 15% West
Physician Services	85% all regions	15% all regions
Family Planning	50% all regions	50% all regions
All Other Services	100% all regions	0% all regions

- Considerations:
  - Centers for Medicare & Medicaid Services requirements on detailed data source.
  - HP financial reporting.
  - Encounter data validation.

## SFY 2016 Rate Range Development Trend

- Medical trend is the projection of utilization and unit cost changes over time.
- Trend sources:
  - HP reported financial data.
  - HP responses to financial data desk audit questions.
  - Other state Medicaid programs and national indices.
- Trend varies by COS:

	Central	East	West
Non-Delivery Trend	1.5% to 5.1%	2.5% to 4.0%	2.0% to 4.5%
Delivery Trend	1.0% to 2.5%	1.0% to 2.0%	1.0% to 2.5%
Overall Annual Trend	3.7%	3.2%	3.3%

- Apply 30 months of trend from midpoint of base data year (July 1, 2013) to midpoint of contract year (January 1, 2016).

## SFY 2016 Rate Range Development Prospective Program Changes

- Routine circumcision effective June 15, 2014:
  - Routine circumcisions no longer require prior authorization for newborns up to 28 days after birth.
  - Relied on CY 2012 and CY 2013 data provided by the HPs.
  - Annual financial impact for the Newborn, Physician COS:

COS	Central	East	West
Physician	3.7%	3.6%	2.4%

- Ambulance reimbursement changes effective July 1, 2014:
  - Reimbursement levels for procedure codes A0427 and A0429 will be increased by \$45.00.
  - Relied on utilization from SFY 2013 encounter data.
  - Annual financial impact by COS:

COS	Central	East	West
Transportation	15.3%	17.1%	14.3%

## SFY 2016 Rate Range Development Prospective Program Changes (cont.)

- Enhanced PCP payments as required by the ACA effective January 1, 2015:
  - Medicaid programs are no longer required to reimburse eligible PCPs for eligible services at a rate of at least 100% of Medicare payment rates.
  - Removed the enhanced payments from the CY 2013 base data.
  - Annual financial impact by COS:

COS	Central	East	West
Physician	-11.6%	-11.3%	-20.6%
Family Planning	-4.9%	-2.3%	-7.1%

- Breast cancer surgery:
  - Prior authorizations for a breast procedure related to a history of breast cancer are no longer required.
  - Since prior authorizations are currently being approved, no adjustment was necessary.

## SFY 2016 Rate Range Development Prospective Program Changes (cont.)

- Early elective deliveries effective September 30, 2014:
  - MO HealthNet will no longer reimburse for early elective deliveries, or deliveries prior to 39 weeks gestational age that are not medically indicated.
  - No adjustment necessary.
- CMHC reimbursement effective July 1, 2015:
  - HPs will be required to reimburse CMHCs at the fee-for-service (FFS) State Plan rate of 1.36 times the Medicare rate for such services.
  - CMHCs must be Medicare certified as a CMHC and approved by the Department of Mental Health as a CMHC.
  - The annual financial impact to the Mental Health COS is 22% for all regions, which varied by rate cell.

## SFY 2016 Rate Range Development Prospective Program Changes (cont.)

- FQHC/RHC reimbursement change effective July 1, 2015:
  - Currently HPs are allowed to negotiate a plan-specific rate with a FQHC/RHC provider.
  - Changes to health plan reimbursement requirements are as follows:
    - FQHCs and Provider Based RHCs (PBRHC) shall be reimbursed at 90% of their allowable Medicaid billed charges.
    - Independent RHCs (IRHCs) shall be reimbursed at 90% of their Medicare/Medicaid interim rate per visit.
  - Increased provider base:
    - State anticipates a more significant increase in the number of qualifying FQHC facilities during the contract period compared to previous years.
  - Annual financial impact by COS:

COS	Central	East	West
Dental	27.8%	27.8%	27.8%
Physician	14.3%	13.6%	16.6%
Other	12.5%	11.9%	14.4%

## SFY 2016 Rate Range Development Prospective Program Changes (cont.)

- Former Foster Care Youth benefit change effective July 1, 2015:
  - Per the ACA, Foster Care coverage was extended up to age 26 effective January 1, 2014.
  - Effective July 1, 2015, the benefits for Former Foster Care Youth will be modified per CMS direction to exclude EPSDT screenings.
  - Relied upon enrollment projections provided by MO HealthNet to determine acuity benchmarks for the newly eligible group.
  - The financial impact to COA 4 is -0.01% for all regions.

## SFY 2016 Rate Range Development

### Efficiency Adjustments

- Background:
  - First implemented during SFY 2011 rate setting.
  - Effective cost-containment strategies to reduce health care inefficiencies and support the State's strategy for value-based purchasing.
  - Successful management can reduce overall health care costs and improve patients' quality of medical care.
- Efficiency adjustments:
  - Low-Acuity Non-Emergency (LANE).
  - Potentially Preventable Hospital Admissions (PPA).
  - Risk-Adjusted Efficiency (RAE).

## SFY 2016 Rate Range Development

### LANE Adjustment Process

- LANE adjustment reflects expectation that the HP should manage a portion of low-acuity ER visits in a less acute setting.
- CY 2013 encounter data examined for ER visits with diagnosis codes indicating potential low acuity.
- Assumptions of percentage of LANE visits preventable for each diagnosis were applied to each HP's encounters.
- No encounters with 99284 or 99285 CPT codes were removed.
- For each encounter removed, \$82.50 was added back to costs to represent the primary care visit that could have occurred instead of the LANE visit.

## SFY 2016 Rate Range Development LANE Adjustment Results

- LANE visits accounted for 54% to 61% of total financial ER costs.
- Approximately 24% of LANE visits removed for each HP; a few of the conditions with the most visits removed were removal of ear infections, respiratory infections, and other infections.
- Applied a targeted efficiency level (TEL) of 60% to adjustment.
- Results were applied to the total medical portion of regional rate development.

Region	60% TEL
Central	-0.9%
East	-1.4%
West	-1.6%

## SFY 2016 Rate Range Development PPA Adjustment Process

- PPA adjustment reflects expectation that a certain portion of Inpatient admissions could have been avoided or reduced in duration through alternative services and high-quality care management.
- CY 2013 encounter data examined for The Agency for Healthcare Research and Quality guidelines (PDI and PQI) for PPAs.
- PPA visits were not included as part of adjustment if:
  - Member met clinical global exclusion criteria.
  - Member had not met criteria for enrollment duration prior to admission; criteria varied by PDI/PQI and ranged from two to 12 months.
  - These exceptions apply to 19% to 22% of PPA visits.
- For each encounter removed, 6% was added back to costs to represent alternative treatment costs instead of the PPA visit.

## SFY 2016 Rate Range Development PPA Adjustment Results

- Child PPA dollars (after duration and risk adjustments) accounted for 0.4% to 0.7% of total Child financial costs.
- Adult PPA dollars accounted for 0.5% to 0.8% of total Adult financial costs.
- Applied a targeted efficiency level of 75% to adjustment.
- Results were applied to the total medical portion of regional rate development.

Region	75% TEL
Central	-0.2%
East	-0.4%
West	-0.4%

## SFY 2016 Rate Range Development RAE Process

- Addresses differences in claim levels among HPs within a region after adjusting for the underlying risk level of their enrolled population.
- Risk scores assigned for each eligible person, then aggregated for each regional HP.
- Summarize CY 2013 HP financial claim per member per months (PMPMs) on a rate cell and constant case mix basis.
- CY 2013 HP financial claim PMPMs were adjusted using risk scores to develop comparable costs for a 1.0 risk population.
- Risk scores and HP experience were evaluated on a rate cell and constant case mix basis separately.

## SFY 2016 Rate Range Development RAE Process (cont.)

- Most efficient “health plan” may be the combined experience of multiple plans to account for a minimum of one-third of the regional member months.
- Costs over the most efficient health plan (or plans) PMPM (adjusted to 1.0 risk factor) were removed from other HPs in the region:
  - Health Plan A: \$210 PMPM @ risk 1.05 → \$200 @ risk 1.0.
  - Health Plan B: \$215.60 PMPM @ risk 0.98 → \$220 @ risk 1.0.
    - At 100% targeted efficiency level, Health Plan B claims would be reduced by 9% (\$20/\$220) before developing regional rates.
- Applied a targeted efficiency level of 50% to the Central and West Regions and 40% to the East Region.
- Impact calculated after accounting for LANE/PPA adjustments.

## SFY 2016 Rate Range Development RAE Results

- Results will be applied to the total medical portion of regional rate development.

Region	TEL	Adjustment
Central	50%	-1.5%
East	40%	-2.2%
West	50%	-3.2%

## SFY 2016 Rate Range Development Neonatal Intensive Care Unit (NICU) Payment

- The State pays a supplemental HP payment for higher than average costs experienced in the first year of life for Missouri HealthNet managed care eligibles that meet a low birth weight criterion (birth weight less than 1500 grams).
- NICU payment assumptions were updated in the SFY 2015 rate development to reflect the most recent HP experience.
- Assumptions used in the NICU payment development:

Region	Prevalence Factor	NICU Relative Cost Factor
Central	1.25%	2021%
East	1.88%	1924%
West	1.27%	1628%

- NICU relative cost factor represents the relativity of the additional first year of costs for NICU births compared to the first year costs in the newborn rate cell in COA 1 for the non-NICU births.

## SFY 2016 Rate Range Development

### Pregnant Women Rate Cell

- Rate cell encompasses all expenses and membership related to individuals identified with ME Codes 18, 43, 44, 45, and 61.
- Relied on HP experience along with detailed encounter and FFS data to develop this rate cell:
  - Shifted costs from COA 1 child and adult rate cells to the Pregnant Women rate cell.
  - Allocated the Pregnant Women costs across applicable service categories.
  - Targeted a PMPM for Pregnant Women consistent with current cost experience submitted by the HPs.
- Overall, it is a cost neutral adjustment to match payment to risk.

## SFY 2016 Rate Range Development Administration/Underwriting Gain Load

- Evaluate administration on percent of revenue and PMPM basis.
- Sources and considerations for administrative load development:
  - HP financial data.
  - DIFP filings.
  - Risk-based capital requirements.
  - Contractual requirements.
  - Other state Medicaid program experience.

## SFY 2016 Rate Range Development Administration/Underwriting Gain Load (cont.)

- Consideration given for target HP underwriting gain to provide for the cost of capital:

	Central	East	West
Administration	10.0%	10.0%	9.5%
Underwriting Gain	2.0%	2.0%	2.0%
Total	12.0%	12.0%	11.5%

## SFY 2016 Rate Range Development

### Health Insurer Fee

- Health insurer fee assessed for qualifying health insurers based on their respective share of premium revenue in the previous year.
- Health insurer fee was effective January 1, 2014.
- Fee is considered a cost of doing business in the State of Missouri.
- Fee is an increasing annual assessment determined by the federal schedule.
- Applied a 2.5% adjustment factor for the SFY 2016 rate ranges.
- Potential retroactive adjustment to capitation rates based on the final HP assessments from the IRS.

## SFY 2016 Rate Range Development Capitation Rates by Region

	Central	East	West
Base Data	\$198.20	\$206.36	\$222.64
Annual Trend (apply for 2.5 years)	3.7%	3.2%	3.3%
Program Changes	3.2%	3.0%	1.9%
• Circumcision	0.2%	0.2%	0.1%
• Ambulance Reimbursement	0.2%	0.3%	0.2%
• ACA PCP	-2.3%	-2.0%	-3.1%
• FQHC/RHC	4.5%	4.0%	4.2%
• CMHC	0.7%	0.6%	0.6%
• Former Foster Care Youth	0.0%	0.0%	0.0%
Efficiency Adjustments	-2.5%	-3.9%	-5.1%
Administration/Underwriting Gain Load	12.0%	12.0%	11.5%
Health Insurer Fee	2.5%	2.5%	2.5%
<b>Average Total Capitation Rate</b>	<b>\$254.23</b>	<b>\$257.69</b>	<b>\$270.46</b>

- Based on average risk of the regional population (no risk adjustment).

# OTHER SFY 2016 PAYMENT CONSIDERATIONS

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## SFY 2016 Risk Adjustment

### What is Risk Adjustment?

- A process to estimate health care expenses based on the disease conditions attributed to the population.
- Captures adverse or positive selection without using experience rating by plan (health status, not cost based).
- Rate allocation, not rate setting.
- Addresses the real and imagined perceptions of fairness:
  - “Cherry picking” low-risk individuals.
  - Attracting high-risk individuals.
- Better matching of payment to risk — documented to be a significantly better predictor of risk variation versus traditional age/gender rating.

## SFY 2016 Risk Adjustment

### How Risk Adjustment Works

- Uses historical diagnosis codes and/or national drug codes (NDCs) available on detailed claim/encounter records as basis for risk assessment.
- Certain conditions (AIDS, asthma, diabetes, etc.) and use of particular pharmaceuticals have strong link to future health care costs.
- Statistical models correlate historical diagnoses/pharmaceutical utilization to likelihood of future health care cost.
- Relative values are assigned to members based on their associated disease profile.
- Plan risk scores are developed and applied to capitation rates based on the aggregated risk of their enrolled members.

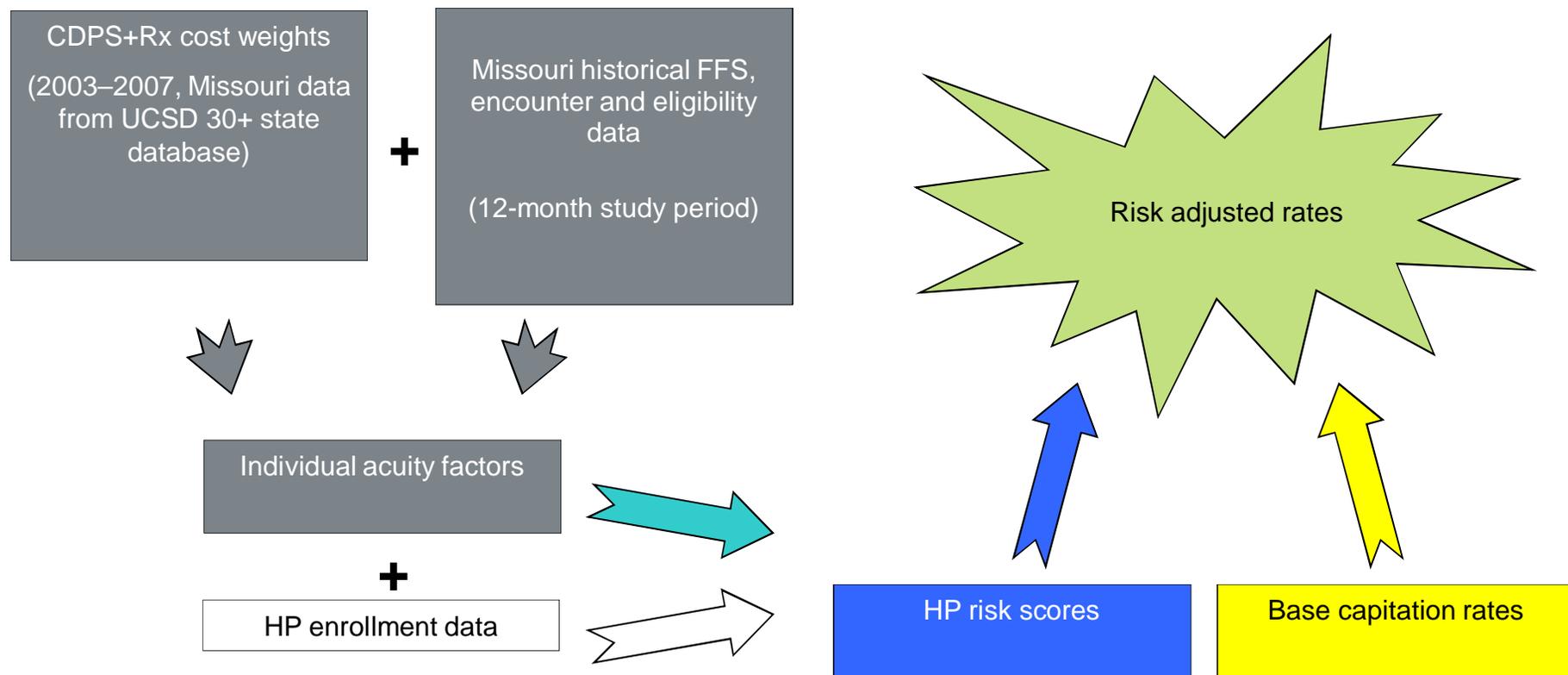
## SFY 2016 Risk Adjustment MO HealthNet Managed Care

- MedicaidRx (MedRx) was used for the implementation of risk adjustment for MO HealthNet Managed Care in January 2013 due to the following:
  - Limitations of complete diagnosis information for some HPs.
  - Availability of accurate and complete Pharmacy data.
  - MedRx had been evaluated in the past for efficiency adjustments in rate setting.
  - Model was in the public domain and did not require model fees for use by the State or HPs.
- The consistency in the level of reporting among the HPs has improved.
  - A blended MedRx and Chronic Illness and Disability Payment System and Pharmacy (CDPS+Rx) risk adjustment approach is applied to rates effective January 1, 2014 through June 30, 2015.
  - CDPS+Rx risk adjustment approach will be applied to the rates effective July 1, 2015.

## SFY 2016 Risk Adjustment General Overview

- Steps for periodic risk assessment:
  - Collect data (eligibility, claims, and encounters).
  - Assess individual acuity (risk score).
  - Determine HP health risk (case mix).
  - Perform budget neutrality.
  - Calculate HP-specific capitation rates.

# SFY 2016 Risk Adjustment Risk Adjustment Process – Flowchart



## SFY 2016 Risk Adjustment Data Collection

- The CDPS+Rx model relies mainly on diagnosis information taken from HP reported encounter and FFS claims data:
  - Accurate reporting is critical.
  - Captures up to five diagnosis codes per claim/encounter.
  - Reporting encounters is contractually required.
  - Only one diagnosis is necessary for CDPS classification.
  - Position of diagnosis on claim is irrelevant.
- Twelve months of data are used to classify recipients into CDPS categories:
  - Anticipated study period for risk scores effective July 1, 2015 would be no older than February 1, 2013 – January 31, 2014.

## SFY 2016 Risk Adjustment Assess Individual Acuity

Category (Examples)	Cost Weights
<u>Demographics</u>	
Age 15 to 25, male	0.213
Age 15 to 25, female	0.548
<u>Disease Categories</u>	
Asthma/chronic obstructive pulmonary disease	0.191
Burns	0.212
Depression/anxiety	0.281
Cardiac	0.286
Diabetes	0.602
Human immunodeficiency virus	2.040
Psychotic illness/bipolar	0.852
Pain	0.113

- Relative values for disease and demographic conditions compared to average cost.
- Cost weight values are “additive”.
- Each individuals’ cost weights were aggregated to develop an acuity factor.

## SFY 2016 Risk Adjustment

### Assess Individual Acuity (cont.)

- Individual acuity factors are developed for each scored enrollee:
  - Minimum Medicaid eligibility threshold of six months (not required to be continuous) must be met for individuals to be scored.
  - Using six months of Medicaid eligibility allows members the time necessary to receive applicable service related to their conditions.
  - Members that do not meet the six-month scoring criteria will receive the average risk of the region and rating group (risk score of 1.00).

## SFY 2016 Risk Adjustment Plan Risk Score Development

- HPs are assigned their enrollees' individual acuity factors as part of their risk score calculation.
- Each HP's risk score is computed as the *average* of the individual acuity factors of all of their assigned, scored enrollees.
- A HP's risk score indicates the *relative* health risk of its enrollees to the other plans.
- Enrollment will be assigned using the month three months prior to the first month of the contract cycle, and will be updated on a quarterly basis to account for membership shifts.

**Managed care provider: XYZ Health Plan**

Total scored enrollees: 6

Enrollee	Individual Acuity Factors
Recipient 1	0.780
Recipient 2	1.048
Recipient 3	0.929
Recipient 4	0.964
Recipient 5	1.009
Recipient 6	0.814
<b>XYZ Plan Risk Score</b>	<b>0.924</b>

## SFY 2016 Risk Adjustment Plan Risk Score Development (cont.)

- Members that did not have six months of enrollment during the study period or have newly joined the program since the end of the study period are referred to as “unscored”.
- Unscored enrollees are incorporated into the overall plan risk score as follows:
  - For each plan, members that did not meet the six-month scoring criteria receive a 1.0 risk score, or the average risk of the region and rating group.
  - This reflects the growing enrollment in smaller HPs that may not be reflective of current HP enrollment, the potential of new HPs entering the program, and member shifting due to auto-assignment.

## SFY 2016 Risk Adjustment Budget Neutrality

- Budget neutrality will be calculated for each region and rate cell separately.
- Anticipated rate structure and associated model:

Category of Aid	Model
COA 1 (< 1 Newborns)	Not risk adjusted
COA 1 (Child < 21)	MAF Child
COA 1 (Adults 21+)	MAF Adult
COA 2 (Pregnant Women)	Not risk adjusted
COA 4 (All < 21)	MAF Child
COA 5 (All < 19)	MAF Child
<ul style="list-style-type: none"> <li>• Maternity delivery payments</li> <li>• NICU payments</li> </ul>	Not risk adjusted

## SFY 2016 Risk Adjustment Capitation Rates

- The total population average risk score is normalized to 1.000:
  - This ensures that the risk adjustment process is budget neutral.
  - These normalized risk scores are called the budget neutral plan risk scores.
- Plan-specific rates are then calculated as:
  - (CDPS+Rx budget neutral plan risk score) \* (base rate).

### Assumed base capitation rate of \$200.00

	XYZ Health Plan	Top Notch Health	A+ Health Care	All Plans
<u>Scored enrollees</u>				
Member months	6	16	28	50
Plan risk score	0.924	0.980	1.089	1.034
<u>Unscored enrollees</u>				
Member months	14	4	7	25
Assumed risk score	1.000	1.000	1.000	1.000
<u>Planwide</u>				
Member months	20	20	35	75
Composite risk score	0.977	0.984	1.071	1.023
Budget neutral plan risk score	0.955	0.962	1.047	1.000
Risk adjusted rate	\$191.00	\$192.40	\$209.40	\$200.00

## SFY 2016 Performance Withhold Program

### Performance Withhold

- Aggregate 2.5% withhold applied to capitation payments.
- Not applied to delivery or NICU payments.
- Initial contract year performance metrics administrative in nature and expected to be met by HPs.
- No rate adjustment made as requirements reflected in administrative component of capitation rates.

## SFY 2016 Performance Withhold Program Performance Metrics in Initial Contract Year

Performance Metric	Application	Frequency	Withhold
1. Encounter data acceptance rate	Regional	Quarterly	0.50%
2. Provider Panel	Regional	Months 1-6	0.25%
a. Directory accuracy/completeness	Regional	Months 7-12	0.25%
b. Wait times	Regional	Months 7-12	0.25%
3. EPSDT participant rate Ages 0-6	Statewide	Semi-annual	0.50%
4. Case management	Statewide	Semi-annual	0.25%
a. Initial needs assessment for Pregnant Women	Statewide	Semi-annual	0.25%
b. Follow-up timeframes for children with elevated blood levels	Statewide	Semi-annual	0.25%
5. Medicaid Reform	Regional	Annual	0.17%
a. Member incentive programs	Regional	Annual	0.17%
b. Provider incentive programs	Regional	Annual	0.17%
c. LCCCP application and approval	Regional	Annual	0.17%

## SFY 2016 Performance Withhold Program

### Withhold Return

- Withhold returned for meeting a metric with no prorating for partially meeting a metric.
- Withhold returned for metrics met within 30 days of evaluation (per metric frequency schedule).
- Changes to performance metrics, populations and individual withhold percentages in Renewal Year 1 and 2 to be made in consultation with workgroup and final determinations made by State in the form of a contract amendment.
- Aggregate withhold of 2.5% expected for all three years of contract.

# QUESTIONS





Services provided by Mercer Health & Benefits LLC.