Minnesota Department of Human Services

ACTUARIAL REVIEW OF MEDICAID MANAGED CARE RATE SETTING

March 28, 2013

Submitted By:

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March 28, 2013

Mr. Mark J. Hudson
Chief Rate Officer
Minnesota Department of Human Services
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RE: Actuarial Review of Managed Care Rate Setting

Dear Mark:

The Segal Company ("Segal") was engaged by the Minnesota Department of Human Services ("DHS") to conduct a review and analysis of the processes and methodologies used by prior consultants, actuaries, and departmental personnel to set managed care rates for State Fiscal Years 2003 through 2011 (July 1, 2002 through June 30, 2011). The report attached to this letter contains the results of our analysis.

Project Scope

Our review and analysis include the following:

- An independent expert's review and opinion. A report that includes an assessment of the rate setting process, including rates set, or determined, by prior actuaries, and recommendations made by other experts or actuaries in determining rates for PMAP, MNCare, and PGAMC.

- Based upon all of the information reviewed, a determination of whether the public program rates set from FY 2003 through FY 2011 were "actuarially sound". A determination of whether certifications to the Centers for Medicare & Medicaid Services (CMS) were appropriate.

- An identification of any procedures, analysis, and/or conclusions by DHS, consultants or prior actuaries that were inadequate, deficient, incomplete or that may have inappropriately impacted rate determination. A determination of any procedures identified as either deficient or incomplete that continue to be practiced in FY 2012. Recommendations for improving the process for setting PMAP rates.

Restrictions/Limitations

This report has been prepared for the State of Minnesota, Department of Human Services. To the extent that the information contained in this report is provided to third parties, this letter, the report and all appendices should be distributed in their entirety. Due to the technical nature of the subject matter, it is assumed that any user of the data possesses a certain level of expertise in actuarial science and is familiar with Minnesota's Medicaid programs and managed care rating principles in general. Parties receiving this report should consult with qualified professionals in drawing conclusions about the results contained herein.

Data Reliance

Segal relied upon information provided by DHS in the development of the results found in the disclosure section of this report. We did not check it for errors and/or omissions. Our reported results and conclusions may be inaccurate and/or inappropriate if this information contained errors and/or omissions.

* * *

Mark, please do not hesitate to contact either of us if you have any questions or need additional information.

Sincerely,

Kenneth C. Vieira, FCA, FSA, MAAA
Senior Vice President & Actuary

Howard Atkinson, Jr., FCA, ASA, MAAA
Vice President & Health Actuary

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Executive Summary

Segal was engaged by the Minnesota Department of Human Services ("DHS") to conduct a review and analysis of the processes and methodologies used by prior consultants, actuaries, and departmental personnel to set managed care rates for the Prepaid Medical Assistance Program ("PMAP"), MinnesotaCare ("MNCare"), Prepaid General Assistance Medical Care ("PGAMC") and Minnesota Seniors Health Options ("MSHO"). More specifically, the purpose of our review was to determine if: 1) Medicaid managed care rate setting produced capitation rates that were actuarially sound; 2) the Centers for Medicare and Medicaid Services ("CMS") regulations were adhered to; and 3) DHS staff followed acceptable procedures. The review covered State Fiscal Years 2003 through 2011 (July 1, 2002 through June 30, 2011). What follows is a brief summary of each of the elements reviewed; further analysis can be found in the "Detailed Findings" section of this report.

Actuarial Soundness

CMS requires that rates be actuarially sound for PMAP, MNCare and MSHO. It is our opinion that, in any given year, the rates developed and certified by Milliman, the State's actuary, met the definition of actuarial soundness and complied with the guidelines established by the American Academy of Actuaries.

Guiding regulations and practice standards mandate that each rate year stand on its own. Further, in contrast to National Association of Insurance Commissioners (NAIC) provisions, Federal requirements mandate that the Medicaid program rates stand on their own. It appears that the rates for each year fall within the upper bounds of broad guidance relating to soundness; however, if one were to consider the assumptions and results over time, there is an apparent lack of reasonableness that should have called into question the data and/or methods being utilized. Further, while not explicitly stated, a reasonable individual provided with the information Segal received would conclude that the State, the plans, and the actuary must have understood that the historic and forecasted losses on non-Medicaid programs would be covered by historic and forecasted profits on the Medicaid program. Without the "take one, take all" requirement in State statute, it is doubtful that any plan would have entered into any contract with the State to provide services under the non-Medicaid programs.

Plan Profitability

The Minnesota Supplemental Report #1 filed by each MCO with the Minnesota Department of Commerce annually identifies the MCO's profitability by product over the review period. We have looked at profitability from two main components—net income from operations (underwriting gain) and investment income.

Reviewing the self-reported experience for PMAP and MNCare for FY 2002 through 2011, the MCOs reported net operating income of $430.5 million. This is a 2.4% profit on $18.2 billion of premium over the period. It is difficult to isolate the investment income for each MCO during the period. Self-reported amounts were approximately $127 million during the same period,

contributing an addition 0.7% to profits. Combining both components would yield a profit of approximately 3.1% for these programs over the full period reviewed. The target operating margin in the actuarial rate development ranges from 0% to 1.75% in 2010, with the most prevalent being 1% and the overall average being 1.2%, calculated to be $223.6 million. Not considering the investment income, the actual profit was $206.9 million greater than expected for the entire period under review.

The profits received by the MCOs over the period are a good proxy for how the calculated rates have missed actual cost targets over time. If we consider the experience of PMAP and MNCare from 2004 to 2011 only, the period over which the actuarial soundness requirement applied, our review indicates the MCOs achieved on average 1.0% above targeted levels, or $161 million.

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Avg/Total 2002 – 2011	Avg/Total 2004 – 2011
PMAP & MNCare Revenue	$1,220,103	$1,378,732	$1,466,737	$1,606,823	$1,393,907	$1,626,532	$1,888,059	$2,290,822	$2,559,078	$2,762,275	$18,193,068	$15,594,233
Actual Net Income	$32,951	$64,687	$89,676	$28,572	-$67,657	-$19,674	$34,023	$112,195	$118,860	$36,868	$430,501	$332,863
Actual Profit Margin	2.70%	4.69%	6.11%	1.78%	-4.85%	-1.21%	1.80%	4.90%	4.64%	1.33%	2.37%	2.13%
Target Profit Margin	2.00%	2.00%	2.00%	0.50%	0.50%	0.50%	1.00%	1.00%	1.75%	1.18%	1.23%	1.10%
Expected Net Income	$24,402	$27,575	$29,335	$8,034	$6,970	$8,133	$18,881	$22,908	$44,784	$32,595	$223,615	$171,639

The consistent pattern of actual profits vs. targets is concerning. The results of 2.13% vs. 1.10% demonstrate a miss of nearly 94%, with the last three years well over 100%.

This variation or “surplus rate adjustment” was reviewed by the actuary annually and taken into account during their rate development. Although Milliman had this line item in their report, the variation appears to continue each year and was actually greatest in the last three years, 2009 to 2011, when Milliman changed methodology. Most of the excessive profits accumulated in these three years. Milliman consistently missed this assumption, causing rates to be excessive.

Two of the other larger programs should not be overlooked in the profitability analysis. MCOs were required (in the same contract that included MNCare and PMAP) to provide benefits to enrollees covered under the Prepaid General Assistance Medical Care (PGAMC) program in any county where the MCO covers PMAP and MNCare. This is problematic because the PGAMC program had significant losses during the same period, $191.7 million. This state-only funded program does not require certified or “actuarially sound” rates. Given that fact, the losses of PGAMC could not influence rates for PMAP and MNCare, which are required to be “actuarially sound”. Since this program was always projected to lose money, MCO management was required to make a business decision to participate in the entire program, anticipating that gains from PMAP and MNCare would more than offset losses from PGAMC.

The other major State program was the Minnesota Senior Health Options (MSHO) program. The supplement report shows a large gain for this program over the period of $290.4 million. This is an integrated program that contains revenues from both Medicare and Medicaid. It is difficult to isolate the source of the gain. Given the integration of funding, a component of the profits would be from Medicaid.

The combination of these two programs increased the MCO profitability by $98.7 million over the review period.

PGAMC Risk Adjustment Methodology

As indicated earlier in the profitability section, PGAMC had significant losses over the period. Because the rates were not certified at some point the rates overall were designed to generate losses for the plan. The distribution of the PGAMC enrollment in plans varied over time as the State began to reduce eligibility or attempt to have portions of the population enroll in other State programs which had either reduced benefits or some federal match. Starting in 2006, Milliman provided a letter annually describing the methodology to redistribute PGAMC revenue among the MCOs. In general, Milliman is spreading the losses of PGAMC as evenly as possible over the MCOs, since they were disproportionately affected by the program. PMAP experience was used as a basis to proportionally adjust the PGAMC rates. Only the PGAMC rates and MCO specific revenues were altered. Since these rates are not required to be actuarially sound, with no changes to PMAP or MNCare rates, there is not a "technical" issue with what Milliman was asked to do.

MCOs were required to participate in all the public programs, PMAP, MNCare & PGMAC (note that CMS approved these combined contracts). MCO executives will look at the contract covering all three programs in total and recognize the losses to be expected from PGAMC would be offset by gains in the other programs. Financially this approach worked well for the State since the MCO had no choice but to evaluate the programs together and it likely permitted the State to fund the PGAMC program at lower levels. Note that the federal government provides a match to the funds providing the gains, while the program proving the losses, PGAMC, was funded by the State only. The PGAMC program ended in 2010 and the MCOs no longer had the losses from this program.

With the certification likely sound and if profit targets were hit as projected, there would be no issue with this at all, since the MCOs would be having losses for that component of the business. The question is whether the rates for the other programs, matched by the federal government, were deliberately on the high end of the actuarial sound rate range in order to make up for anticipated losses from PGAMC.

Dependency on MCO Self-Reported Data for Rate Development

Appendix 2 shows the 10-year financial history for all Minnesota public programs taken from the state rate filings of the Managed Care Organizations ("MCOs"). We believe a major contributor to the volatility in year-to-year gains/losses is the fact that capitation rates and other relevant actuarial analyses were based upon MCOs' self-reported summary financial information. While this data is appropriate for financial reporting, it is unlikely to have the consistency or the level of detail required in actuarial analyses and rate setting. The best source for this is the detailed encounter data submitted by MCOs along with the associated cost data that would have been appropriately scrubbed and audited. Using encounter data would facilitate the desired building up of rates based on separate cost and utilization statistics by type of service for each program. This is the approach recommended by the Centers for Medicare and Medicaid Services ("CMS") and the American Academy of Actuaries in guidelines regarding the use of appropriate data in rate setting for Medicaid managed care programs. It is our understanding that the MCOs submit encounter data to the State, but not the associated cost data. With our limited review of the MCO contracts, it appears that DHS could have collected this information.

On October 19, 2011, Mathematica Policy Research produced a report entitled, "Collecting, Using and Reporting Medicaid Encounter Data: A Primer for States". In that report, they listed the nine states with extensive experience in collecting and using encounter data (Arizona, Delaware, Michigan, Minnesota, New Jersey, Oregon, Pennsylvania, Texas and Washington) during their review period between November 2010 and April 2011. Table III.1 in their report (see *Appendix 4*) showed that Minnesota was the only state in the study group that did not require plans to report cost (paid amount) data. We recommend that the State insist that MCOs report the required cost data necessary for the build-up approach to developing capitation rates.

Problematic Trend Methodology

We believe the methodology used by the actuary to analyze historical trends and, subsequently, to develop rating trends can be strengthened in a number of ways. First, we believe the analysis of historical experience-based trend should be based upon a detailed review of cost and utilization data that would best come from using the encounter data. Currently, this analysis is being carried out using MCO self-reported summary data. Secondly, we believe the encounter data is likely to produce more consistent (accurate) information and, therefore, the blending of experience-related trends could be shortened from the current three years to two years. This is likely to improve the accuracy of determining the experience-based trends and, ultimately, the rating trends. Thirdly, we believe that Milliman's benchmark trend is charge-based (as opposed to cost-based). This appears to be slightly higher than what we would expect in a managed care environment, primarily from the expected cost trend component. Since the final rating trend is a 50/50 blend of the experience and the benchmark trends, this is likely to overstate the needed premium capitation rates.

In general, we believe the Milliman trend methodology produced a systemic overstatement of the trend, causing the program to exceed targets over time. Segal recognizes that actuaries utilize a variety of acceptable and reasonable methods in developing trends. The issue is that over time an actuary should review and adjust the method as variances arise to remain close to actual market costs. We believe Milliman attempted to adjust the methodology in 2009 and after, but given the financial outcome of those years, it is evident that significant overstatement still existed. Having limited detailed data from which to do a trend study was obstructive to the work of the actuary and provided challenges for which Milliman tried to compensate.

Reliance on MCOs to Estimate Impact of Benefit Changes

Over the review period, Milliman was required to price the impact of many benefit changes. Because of the lack of detailed information, as identified above, they relied mostly upon the summary data from the MCOs for their analyses. In some cases, they relied upon external sources, such as the Milliman Cost Guidelines. Intuitively, we do not believe it is best actuarial practice to use self-reported data supplied by the MCOs for analyses that could directly affect their capitation revenue. We believe that the encounter data could have been used for at least some of the benefit changes, since they were highly dependent on estimating utilization impact only, which would not require the paid field. As a minimum, we would have expected some reasonableness check instead of almost full reliance on the self-report MCO impact.

Again, we believe that the best source for this analysis is the encounter data and recommend that the State work with the MCOs to report the level of detailed encounter and cost data that would facilitate these types of analyses.

Administrative Costs

We have reviewed the development of the administrative costs that were included in the rate development. The trend rate used is generally the average rate for the experience period, self-reported, trended at 2% to 4%, depending on the year. Annual loads vary from 7% to 10% over the period.

There did not seem to be any critical or diligent review of the administrative components going into the base rates. In our discussions with DHS, it appears that the reported administrative costs have elements included that should be pulled out from the development. We are aware that other audits have found similar issues in the administrative component so we will not go into greater detail in our review.

A targeted administrative load should be developed and stabilized. The rate should reflect the administrative load an efficient MCO needs to appropriately administer the programs and deliver the desired level of managed care. This could be expressed as a fixed price per contract or as an administrative percent load, but that assumption should not vary significantly over time.

Rate Worksheets from DHS

In the annual rate setting process, after Milliman provides their certification documentation, DHS inputs all the factors into their internal worksheet. The worksheet then calculates rates to be paid to each MCO for the applicable quarter. The rates are produced quarterly to reflect the lagged risk scores. The worksheet develops both the demographic and risk adjusted rates. Milliman certifies that they have reviewed the rate worksheets.

For the most part, Segal was able to cross check the Milliman certified factors into the worksheet and validate that the formulas appear appropriate. For 2009, we linked the Milliman factors to the rate sheet to the contract rates for a few MCOs. There are 30 to 40 tabs in each of these worksheets with thousands of formulas. A fully detailed review is beyond the scope of this review, but from our limited review of the spreadsheet, we believe there is a good faith effort to apply all the factors.

Given that all the years are “adjustments’ to prior years we went back to the first rate sheet for 2003. The starting point was an input that we were unable to verify. We discussed a few similar occurrences like this with DHS. Given the extensive amount of inputs, it is highly likely that there are minor errors, but we believe most would be insignificant. Segal is uncomfortable with the volume of inputs and believes this needs to be redesigned in the future to reflect the source for each of the starting numbers.

Risk Adjustment Recommendation

We believe the intent of the risk adjustment system was to have a fair approach to paying MCOs for the risk they are receiving relative to each other. It is also our opinion that the system attempts to meet the CMS requirements for actuarial soundness. Although the system appears to be budget neutral, over time we think it is likely that the financial appropriateness of this system does not adequately reflect relative risk of MCOs. With the variability of MCO financial performance, the retrospective review of the system comes into question.

The State is presently using a prospective risk adjustment system for analyzing the adequacy of premium rates. This approach works properly when enrollment levels are stable. However, enrollment has been increasing and the new entrants tend to be younger and less costly than the average. The current prospective system tends to overstate the required capitation rates in this growth environment. It is our belief that a retrospective risk adjustment system will more accurately reflect the required capitation rates. It is our understanding that DHS is already considering moving in this direction. A full review of the risk adjustment methodology is beyond the scope of this review.

Consider Alternative Managed Care Models

In addition to fee-for-service Medicaid, Minnesota provides Medicaid benefits on a risk basis approach through contracts with participating MCOs. The idea behind this type of arrangement is to hold the MCOs accountable for holding down costs through quality improvements and other incentive arrangements. Over time, it has been well documented that one of the areas of weakness with this approach has been in the monitoring and oversight by CMS.

According to a February 2012 Kaiser Family Foundation policy brief on Medicaid and the Uninsured, 31 states now operate Primary Care Case Management ("PCCM") programs, sometimes in addition to their MCO contracts. Using this model, states contract directly with primary care providers ("PCPs") who are responsible for direct and referral beneficiary care for a fee. States using the PCCM model have reported lower costs and higher beneficiary satisfaction compared to the MCO contracting approach. In addition, the PCCM model eliminates the potential for overpaying for care, as has been the case in Minnesota with higher than required capitation rates to MCOs.

There is also the possibility of using the PCCM model in the future as a means to more effectively integrate primary care and community-based services through an enhanced PCCM ("EPCCM") program or, patient-center medical home. This model has been used successfully in other states. We recommend that DHS review other emerging models.

Introduction

The purpose of an actuarial review of one actuary's work by another actuary is to ensure that actuarial calculations were performed correctly and that the methods and assumptions used were reasonable. The review should reveal whether procedures followed were technically sound and whether plan objectives were met.

Our review officially began on November 7, 2012 with an in-person meeting with DHS staff in St. Paul, Minnesota. At this meeting, it was agreed that the purpose of our review was to determine if: 1) Medicaid managed care rate setting produced capitation rates that were actuarially sound; 2) CMS regulations were adhered to; and 3) DHS staff followed acceptable procedures.

The following programs were reviewed:

PMAP	A federal/state funded managed care Medical Assistance (MA) program for children under the age of 21, parents and care takers of a dependent child, pregnant women, and certain low-income adults without a dependent child
MNCare	A federal/state funded managed care program for low and moderate income individuals and families who do not have access to employer-provided health insurance and have incomes above limits for MA and PGAMC
MSHO	A federal/state funded managed care program for seniors age 65 and over who are eligible for both Medicaid and Medicare benefits.
PGAMC	A state-funded program for low-income adults without children who did not qualify for federally funded health care programs. This program ended February 28, 2011 and enrollees were automatically moved to MA

Over the course of the next two months, Segal received hundreds of files from DHS, including but not limited to the following, for each year reviewed:

- CMS Rate Setting Checklists
- Milliman Actuarial Certifications
- Milliman Certification Support Letters—Trend & Surplus, Benefit Adjustments, Factors, etc.
- DHS Quarterly Risk Reports
- Minnesota Supplemental Report #1—Statement of Revenue, Expenses & Net Income
- DHS Rate Setting Worksheets
- Rate Setting Planning Document from DHS to the Managed Care Organizations ("MCOs").
- DHS Enrollment and Capitation Reports

A more detailed listing of the relevant files received can be found in *Appendix 1*.

In addition to our review of the information, we met with current DHS staff and had ongoing conversations to clarify the data received and to discuss questions encountered during the review. Many of the staff involved in the original rate development have either left the department or are no longer involved in rate development. The complex nature of the Minnesota rate setting process required more information than anticipated. We subsequently issued a request for more information from Milliman, the State's consulting actuary, during the review period. Our original work plan and timing had to be lengthened due to the volume and the timing of the various data requests, time spent awaiting Milliman's written response to our request, requests for additional information and/or points of clarification, supplemental data requests for new or missing information, and follow-up questions.

A review of the documents provided showed a host of significant changes to the various programs over the review period. Following is a brief chronology of the key events that had an impact on Medicaid managed care rates in Minnesota from 2003 – 2011 and that were communicated by DHS to the MCOs during the rate setting process:

2003

- A 5% withhold of capitation payments effective January 1.
- Demographic rates floor for the non-metro areas were established at 87% of the average metro (non-Hennepin) rates, representing a 2% reduction.
- A 0.5% legislative reduction in plan payments effective January 1.
- Preliminary estimates indicated the demographic trends for MA and PGAMC for 2003 were 5.1% and 7.7% respectively. The corresponding trends for the risk-adjusted component are estimated to be 3.8% and 2.5%.
- Plans that signed a two-year contract in 2002 received an additional 1% trend bonus in 2002 for both MA and PGAMC.
- An adjustment for double counting in the 2002 rates was incorporated into the 2003 rate development. A preliminary estimate of this overstated trend by 1.2% for MA and 4.8% for PGAMC.
- An adjustment for missing DHS's profit targets was included in the 2003 rates to attempt to hit a 1% surplus on State business.

2004

- A 1% ratable reduction in PMAP rates. This was in addition to the 0.5% already in place for 2003.
- Public program revenue no longer exempt from the 2% provider tax after January 1, 2004.
- An adjustment for missing DHS's profit targets was included in the 2004 rates to attempt to provide a reasonable surplus on State business.
- Demographic rates for the non-metro area increased from 90.5% to 91.5% of the metro (non-Hennepin) rates. Demographic rates for Hennepin area decreased from 109% to 106.9% of the metro rates.

2005

- An adjustment for missing DHS's profit targets was included in the 2005 rates to attempt to provide a reasonable surplus on State business. The profit target for 2005 was 1%. MCO surpluses were in excess of 3% in 2003.

2006

- An adjustment for missing DHS's profit targets was included in the 2006 rates to attempt to provide a reasonable surplus on State business. MCO surpluses were in excess of 3% in 2004.
- In 2004, the Department undertook a study to examine the appropriateness of the rating regions and geographic relativities. These new relativities were partially incorporated into the 2005 rate structure and fully reflected in 2006.
- Under Medicare Part D, Medicare now covers most drug costs for dual-eligible enrollees. This carve out had a major impact on SeniorCare rates, a minor impact on the rest of MA, and no effect on either PGAMC or MNCare rates.
- For MA and MNCare, a 6% reduction in hospital rates was enacted, effective July 2005. Beginning in January 2006, managed care rates for these programs were reduced to reflect the lower hospital costs MCOs could anticipate.

2007

- An adjustment for missing DHS's profit targets was included in the 2007 rates to attempt to provide a reasonable surplus on State business.
- Losses on PGAMC business the past few years were unevenly distributed among the MCOs. In an effort to redistribute the losses more fairly among the MCOs, an adjustment factor based on PGAMC volume and loss ratios was incorporated into the 2006 rates.

2008

- Inpatient hospital cost rebasing occurred in 2007 for fee-for-service. The preliminary change in hospital costs due to rebasing was 7.8% for MA and 16.2% for PGAMC. This was incorporated into the 2007 trend analysis. However, after rates were finalized in 2007, the actual increase due to rebasing was substantially higher than initially projected. Since DHS underestimated the effect of rebasing, an additional adjustment for 2008 was made in the trends. The new figures for hospital rebasing were 26.1% for MA and MNCare and 24.2% for PGAMC.
- An adjustment for missing DHS's profit targets was included in the 2008 rates to attempt to provide a reasonable surplus on State business.

2009

- Minnesota Session Laws 2008, Chapter 364, Section 3 limited MA and PGAMC managed care aggregate administrative expenses generally to 5% above spending in the previous calendar year. It also established a penalty for excesses, allowed DHS to waive the penalty in certain circumstances, and limited what may be counted as administrative expenses.

- Minnesota Session Laws 2008, Chapter 363, Article 18, Section 3, Subdivision 5, Paragraph (b) mandated that aggregate administrative costs paid to managed care plans be limited to 6.6% of total contract payments for each calendar year.
- An audit of managed care rates conducted by the Office of the Legislative Auditor (OLA) recommended that DHS include investment income in its rate setting methodology.
- Rebates received by the MCOs were explicitly recognized in trend analysis.
- DHS withheld an additional 3% of managed care plan payments under prepaid MA and PGAMC. This brought the total amount withheld to 8% in these two programs.
- An adjustment for missing DHS's profit targets was included in the 2009 rates to attempt to provide a reasonable surplus on State business.
- Basic Care ratable reduction—reduced payment rates for basic care services by 3% for MNCare and 4.5% for MA and PGAMC.
- Inpatient Ratable Reduction—reduced MA and PGAMC fee-for-service payment rates for inpatient hospital admissions occurring on or after July 1, 2009, by 1% and managed care rates proportionately effective October 1.

2010

- An adjustment for missing DHS's profit targets was included in the 2010 rates to attempt to provide a reasonable surplus on State business.
- Based on the area factor/rate cell study completed in 2009, DHS incorporated changes in the geographic and rate cell relativity relationships into the 2010 rates.
- PGAMC was discontinued effective April 1, 2010. It was estimated that 75% (approximately 18,000 new enrollees) would enroll in MNCare. The encounter data for the new enrollees won't show up in the risk assessment until 2011 and not be fully reflected until 2012. The new enrollees were expected to be higher-risk individuals. Adjustments to the demographic rates for the MNCare limited hospital were made to anticipate the conversion of PGAMC enrollees to MNCare.
- The managed care capitation withhold increased to 9.5% for all MA programs beginning in January 2010. For MNCare, the withhold percentage remained at 5%.
- Non-administrative managed care rates for services rendered from July 1, 2010 to December 31, 2013, MA and MNCare contract rates paid to managed care plans and county-based purchasing plans are reduced by 3% of the contract rate attributable to non-administrative services in effect on June 30, 2010. This rate reduction applied to all services, except Medicare cost sharing for dual eligible enrollees. Administrative costs represented approximately 8.2% of the basic care capitation. Thus, a 3% cut on non-administrative costs represented an effective 2.75% reduction applicable to the entire basic care rate. There was no separate administrative component included in the Nursing Facility (NF) and Elderly Waiver (EW) add-on rates for seniors. A full 3% reduction applied to these rates.

2011

- An adjustment for contribution to reserves were included in the 2011 rates to attempt to provide a reasonable surplus on State business.
- Based on the area factor/rate cell study completed in 2009, DHS phased in the geographic and rate cell relativity relationships in 2010 for the senior products. The phase-in of the factors was completed in 2011. For the PMAP and MNCare products, the factors were already fully reflected in the 2010 rates.
- With the elimination of the PGAMC program in April 2010, it was anticipated that a portion of the population would migrate to MNCare (adults without children). A rate adjustment was made to account for that. The encounter data for the migrants from PGAMC to MNCare will begin to show up in the risk assessment in 2011 but will not be fully reflected until 2012. Consequently, DHS did not risk adjust the MNCare limited hospital group in 2011.
- For services provided on or after January 1, 2011, an additional 3% of MNCare managed care payments was withheld.

Guidance from CMS and the American Academy of Actuaries

In conducting our actuarial review, we relied upon guidance from the American Academy of Actuaries contained in their August 2005 Actuarial Certification of Rates for Medicaid Managed Care Programs developed by the Medicaid Rate Certification Work Group (see *Appendix 8*). It is important to note that the guidance in this document is in the form of an Academy practice note, meaning that it does not carry the same weight as an official Actuarial Standard of Practice (ASOP). Presently, no official Academy ASOP exists pertaining to Medicaid rate setting. This practice note provides non-binding guidance for actuaries involved in Medicaid managed care rate setting and, therefore, the information in this practice note is not a definitive statement as to what constitutes generally accepted actuarial practice in this area. The Academy's Medicaid Work Group will be updating the 2005 practice note in the near future, with the intention of including more explicit references to the various ASOPs that apply to Medicaid work.

For the purpose of certifying rates to CMS, the Academy's Medicaid Work Group defines "actuarial soundness" as follows:

> ***Actuarial Soundness:*** *Medicaid benefit plan premium rates are deemed to be "actuarially sound" if, for the business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income, provide for all the reasonable, appropriate and attainable costs, including health benefits, health settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.*

For the purpose of certifying Medicaid managed care rates with CMS, Section AA.1.1 of the MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Rate-setting, known as the CMS Checklist (see *Appendix 7*) defines the criteria to which the actuarial certification of the capitation rates must adhere. Rates must be actuarially sound, meaning that

the rates were developed in accordance with generally accepted actuarial principles and practices and are appropriate for the population to be covered as well as the services to be furnished under the contract. In addition, the actuary providing the certification must meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

A workable assessment of "actuarial soundness" for certifications on behalf of state Medicaid agencies would usually take into account the following:

1. The data available to develop rates for populations with current coverage

2. The types of rate negotiation methods that may be in use by states

3. The financial condition and operations of participating MCOs.

We have relied upon these documents and our experience with Medicaid Managed Care Rate Setting to provide our best assessment of the Minnesota Managed Care Rate Setting process. The following section provides additional details from our review.

Detailed Findings

The following section discusses the items we reviewed in more detail. As discussed earlier, Segal received and reviewed hundreds of files related to the project. Key documents also included the final checklists submitted to CMS for each program (PMAP, MNCare, etc.) for each year of the review period; a detailed listing is included in *Appendix 1*. Below are the various key components of our review. When appropriate, we reference elements of the checklist or applicable actuarial standards.

1. Rate Setting Process and Methodology

Section AA.1.0 of the Checklist delineates the rate-setting methodology, which includes the specified payment rates, the identification of any risk-sharing mechanisms and the actuarial basis for rate determination. DHS followed a similar rate setting process each year. The general process and timing are detailed below:

Month	Activity
June	Discuss with MCOs the upcoming calendar year. Talk about key program changes, rating changes, data requests, etc.
July	Data received from MCOs
July – September	Actuary develops preliminary trends and benefit change impacts
September	Results presented to MCOs for comment
October	Review comments, provide additional analysis
November	HMO rate negotiations completed
December	Actuarial certification and CMS Checklist complete and filed with CMS

If there is legislative action, the schedule is adjusted accordingly. We concluded that the current process and timeframes shown above appear reasonable and follow standard practices among state Medicaid agencies.

The documentation also appears to address the requirements of CMS and is appropriate for each program.

Recommendation

Segal believes the process and timing are appropriate and recommends no changes.

2. Selection of Base Year Utilization and Cost Data

CMS provides the following guidance for the selection of base data in the development of actuarially sound capitation rates for Medicaid managed care contracts in Section AA.2.0 of the Checklist:

Base Year Utilization and Cost Data

The State must provide documentation and assurance that all payment rates are:

- Based only upon services covered under the State Plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration)
- Provided under the contract to Medicaid-eligible individuals

* In setting actuarially sound capitation rates, the State must apply the following element or explain why it is not applicable: Base utilization and cost data that are derived from the Medicaid population or if not, are adjusted to make them comparable to the Medicaid population. The base data used were recent and are free from material omission.

Base data for both utilization and cost are defined and relevant to the Medicaid population (i.e., the database is appropriate for setting rates for the given Medicaid population). States without recent FFS history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the highest degree of reliability, subject to Regional Office (RO) approval.

Examples of acceptable databases on which to base utilization assumptions are:

- Medicaid FFS databases,
- Medicaid managed care encounter data,
- State employees' health insurance databases, and
- low-income health insurance program databases.

NOTE: Some states have implemented financial reporting requirements of the health plans, which can be used as a data source in conjunction with encounter data and would improve on some of the shortcomings of these other specific databases used for utilization purposes. For example, some states now require the submission of financial reports to supplement encounter data by providing cost data. It would also be permissible for the State to supplement the encounter data by using FFS cost data. The State could also use the cost and utilization data from a Medicaid FFS database and would not need to supplement the data with plan financial information.

Utilization data is appropriate for a Medicaid program and the base data was reviewed by State for similarity with the covered Medicaid population. That is, if the utilization assumptions are not derived from recent Medicaid experience, the State should explain and document the source of assumptions and why the assumptions are appropriate to the Medicaid population covered by these proposed rates.

Service cost assumptions are appropriate for a Medicaid program and the base data was reviewed by the State for similarity with the Medicaid program's current costs.

The term "appropriate" means specific to the population for which the payment rate is intended. This requirement applies to individuals who have health care costs that are much higher than the average. Appropriate for the populations covered means that the rates are based upon specific populations, by eligibility category, age, gender, locality, and other distinctions decided by the State. Appropriate to the services covered means that the rates must be based upon the State plan services to be provided under the contract. There is no stated or implied requirement that entities be reimbursed the full cost of care at billed charges.

As referenced in the caption above, there are a number of data sources that would be acceptable to CMS. Given that managed care has been in place for many years, the FFS data would not be a reasonable option for the base year. For Minnesota, it would be appropriate to use the most recent encounter data. Encounter data are the detailed records of the health care services utilized by MCO claimants in the Medicaid managed care environment. In essence, they are equivalent to the paid claim records that MCOs create when they pay providers in the FFS Medicaid environment. In most states, the encounter data includes cost data, the amounts paid to providers. It has been determined that DHS did collect encounter data during the review period; unfortunately, that data did not include payment (cost) detail. The encounter data was primarily used internally for risk analysis, MCO performance metrics and other miscellaneous projects.

DHS or Milliman did not have access to detailed paid claims data for the entire period covered by this review. Since the detailed payment data was never collected, there has not been a reconciliation of the data used in the rates to determine whether the base information delivered in summary form from the MCOs accurately ties to financial statements reported. There are typically elements in the data that get pulled out as the actuary combs through the components. These were estimated by the MCO's actuary to be less than 0.1%, which seems very low. It is not uncommon for states to find that 2% to 4% of the encounter data is pulled out during the validation and quality check stage.

Milliman's Trend and Surplus documents include the base claims and enrollment data used in setting the historical and projected trends applicable to each product line for each rating year. The base data used by Milliman was summary claims data only; meaning, the detailed cost and utilization information Milliman needed to work with was not available for each type of service. In other states with large Medicaid managed care programs, such as exists in Minnesota, states prepare databooks with detailed costs and utilization components by type of service (Hospital Inpatient, Hospital Outpatient, Physician and Other Services, etc.) that the MCO's and state's actuaries can use in their analysis of cost and trends. In this case, Milliman relied on the self-reported summary data from the participating MCOs. Following the above guidelines, we are not aware that Milliman attempted to utilize the reported encounter data to develop detailed utilization rates and/or FFS data as a proxy for costs, which would have corroborated the self-reported summary data on which the actual rate development relied.

Without detailed paid experience, data utilized for the rate development was typically collected as summary paid experience by rating cell, with little or no additional information. Milliman did require supplemental claim reserve reports and ad hoc breakouts. Milliman received certification from the MCO's actuary that the data was appropriate and as requested. This data reliance is acceptable practice by the American Academy of Actuaries. Although acceptable for developing actuarial sound rates in any given year, at some point the data is not sufficient to meet the actuary's long-term needs.

Practically, for a program of this size, encounter data should have been collected and used for rebasing at a minimum at least every three years. That data should also have been utilized to support an extensive analysis of trend, especially with a program's trends that were running much higher than those of other state programs.

Segal briefly reviewed the MCO contract and we believe DHS had the authority and should have collected data over the period being reviewed. We were told that DHS did not push for this data and it was met with significant resistance from the MCOs. This left Milliman to rely on MCO self-reported information.

Findings

We believe a major factor contributing to the volatility in year to year gains/losses is the fact that capitation rates and other relevant actuarial analyses were based upon MCO's self-reported summary data. While this data is arguably appropriate for financial reporting, it is unlikely to have the consistency or the level of detail required in actuarial analyses and rate setting. The best data source for this purpose is the actual encounter data submitted by MCOs along with the associated cost data that have been appropriately scrubbed and audited.

Using encounter data would facilitate the desired building up of rates based on separate cost and utilization statistics by type of service for each program. In fact, this is the approach recommended by the American Academy of Actuaries in its guidelines regarding the use of appropriate data in rate setting for Medicaid managed care programs. It is our understanding that the MCOs submit encounter data to the State, but not the associated cost data.

On October 19, 2011, Mathematica Policy Research produced a report entitled, "Collecting, Using and Reporting Medicaid Encounter Data: A Primer for States". In that report, they listed the nine states with extensive experience in collecting and using encounter data (Arizona, Delaware, Michigan, Minnesota, New Jersey, Oregon, Pennsylvania, Texas and Washington) during their review period between November 2010 and April 2011. Table III.1 in their report (see *Appendix 4*) showed that Minnesota was the only state in the study group that did not require plans to report cost (paid amount) data.

Recommendation

Segal recommends that the State work with the MCOs to meet their contractual requirements and report the level of detailed encounter and cost data required for the build-up approach to developing capitation rates. We understand the DHS has started collecting this information and we recommend that it be made available to the actuary.

3. Adjustments to Base Data

CMS provides the following guidance for the adjustments to base data in the development of actuarially sound capitation rates for Medicaid managed care contracts in Section AA.3.0 of the Checklist:

Adjustments to the Base Year Data

The State made adjustments to the base period to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population.

Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment.

Sample Adjustments to the Base Year that may increase the Base Year:

- Administration
- Benefit, Programmatic and Policy change in FFS made after the claims data tape was cut
- Claims completion factors
- Medical service cost trend inflation
- Utilization due to changes in FFS utilization between the Base Year and the contract period. Changes in utilization of medical procedures over time is taken into account
- Certified Match provided by public providers in FFS
- Cost-sharing in FFS is not in the managed care program
- FFS benefit additions occurring after the extraction of the data from the MMIS are taken into account
- One-time only adjustment for historically low utilization in FFS program of a State Plan Approved benefit (i.e., dental)
- Patient liability for institutional care will be charged under this program
- Payments not processed through the MMIS
- Price increase in FFS made after the claims data tape was cut

Sample Adjustments to the Base Year that may adjust the Base Year downward:

- Benefit deletions in the FFS Program occurring after the extraction of the data from the MMIS are taken into account
- Cost-sharing in managed care in excess of FFS cost-sharing
- Disproportionate Share Hospital Payments
- Financial Experience Adjustment
- FQHC/RHC payments
- Graduate Medical Education
- Income Investment Factor
- Indirect Medical Education Payments
- Managed Care Adjustment
- PCCM Case Management Fee
- Pharmacy Rebates
- Post-pay recoveries (TPL) if the State will not collect and allow the MCE to keep TPL payments
- Recoupments not processed through the MMIS
- Retrospective Eligibility costs

All adjustments must be documented. Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment.

As previously stated, Milliman relied upon summary financial data supplied by the participating MCOs and made adjustments as appropriate for many of the items listed in the box above. Many of these adjustments are highlighted in our Chronology of Key Rate Development Events listed in the Introduction to the report. For example, in the analysis of base claims and experience-based trends, Milliman used restated incurred claim figures provided by the MCOs that were based upon additional claims runout and updated completion factors. We sampled many of the adjustments made and believe that Milliman recognized them as required. Segal has no way to verify whether those adjustments were correct or reasonable because the letters provided by Milliman do not include the development of the factor and supporting development, merely the results. Details of the adjustment calculations may have been communicated to DHS at some point, but Segal is unaware of that communication. We do not suggest that the adjustments made by the actuary were inappropriate, but we do note that with the lack of detailed information we are unable to validate those adjustments.

Recommendation

The actuary should build a detailed encounter database with paid claims experience. Recent legislated changes that are impacting rate development should be recast with this information. To the extent that the actuary makes adjustments to the base data, such adjustments should always be backed up with detailed methodology and disclosure of data used and adjusted.

4. Program Adjustments

CMS provides the following guidance for the recognition of benefit differences in the development of actuarially sound capitation rates for Medicaid managed care contracts in Section AA.3.1 of the Checklist:

Benefit Differences
Actuarially sound capitation rates are appropriate for the services to be furnished under the contract. The State must document that actuarially sound capitation rates payments are based only upon services covered under the State Plan. Differences in the service package for the Base Period data and the Medicaid managed care covered service package are adjusted in the rates. Documentation of assumptions and estimates is required for this adjustment.

Each year a number of benefit changes need to be factored into the rate development. Milliman provides an attachment to the certification that summarizes the financial impact of each component. Over our review period there were over a hundred such changes enacted.

There appears to be very limited data utilized to develop the cost impact of these changes. We were told that data for each change, if available, was requested from the MCOs. Milliman then utilized the self-reported summary data for their analysis. That means if there was a significant benefit reduction that would decrease the MCO rates, Milliman asked the MCO for the information to calculate the reduction they were to receive. This method intuitively presents issues of credibility of the data. We would expect that detailed paid claims data should have been utilized when doing this multitude of programmatic changes, but do not have any indication of such methodology being used. There are large amounts of premium impacted by these program changes.

If specific data were not available, a number of other sources were utilized appropriately by Milliman. These included information from, but not limited to, fiscal notes, CDC Morbidity and Mortality Weekly Reports and DHS fee-for-service records.

As stated above, Segal has no way to verify whether the factors were correct or reasonable since the letters provided by Milliman do not include the development of the factor and supporting development, just the results. These may have been communicated to DHS at some point but Segal is unaware of that communication. We are also not suggesting that the adjustments were inappropriate, just noting that with the lack of information we are unable to validate them .

There also appear to be years where there were "corrections" to the factors. For some, like the hospital rebase, it took three years to estimate the impact and DHS has indicated it is still not sure whether the impact was calculated correctly. That change is likely one of the reasons that profitability in 2007 dropped significantly for the MCOs.

Reliance on MCOs to estimate impact of benefit changes

Over the review period, Milliman was required to price the impact of many benefit changes. Because of the lack of detailed information, as identified above, they relied mostly upon data from the MCOs for their analyses. In some cases, they relied upon external sources, such as the Milliman Cost Guidelines. We do not believe it would be considered "best practice" to use self-reported data supplied by the MCOs for analyses that could directly affect their capitation revenue. Again, we believe that the best source for this analysis is the encounter data and recommend that the State work with the MCOs to report the level of detailed encounter and cost data that would facilitate these types of analyses.

Recommendation

Similar to our recommendation in (3), the actuary should build a detailed encounter database with paid claims experience. Recent legislated changes that are impacting rate development should be recast with this information. The actuary should also provide documentation to support the pricing changes for benefit changes.

5. Medical Cost/Trend Inflation and Utilization Adjustments

Section AA.3.10 of the CMS Rate-Setting Checklist provides guidance as to how medical cost/trend inflation is to be applied in the determination of actuarially sound capitation rates for Medicaid managed care contracts.

Medical Cost/Trend Inflation

Medical cost and utilization trend inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. All trend factors and assumptions are explained and documented.

NOTE: This also includes price increases not accounted for in inflation (i.e., price increases in the fee-for-service or managed care programs made after the claims data tape was cut). This adjustment is made if price increases are legislated by the Legislature. The RO must ensure that the State "inflates" the rate only once and does not double count inflation and legislative price increases. The State must document that program price increases since the rates were originally set are appropriately made.

Section AA.3.11 of the CMS Rate-Setting Checklist provides guidance relating to utilization adjustments and how they should be applied as well. Below is a component of that section:

> **Utilization Adjustments**
>
> Generally, there are two types of Utilization adjustments possible: utilization differences between base data and the Medicaid managed care population and changes in Medical utilization over time.

These two sections represent a significant element of the rate development work that Milliman did for Minnesota. That work included an extensive amount of analysis on trends and delivery of a lengthy report (approximately 30 pages) each year. Milliman's Trend and Surplus reports document the method utilized in developing the annual trend rate. The methodology was consistent each year, although the adjustments were somewhat different from 2009 on.

Below is a summary of the general steps Milliman used in their development of the annual trend:

1. Separately for each program, Milliman received restated incurred claim data from the MCOs on which to base their trend analyses. These restated claim figures, certified by the plan's actuary or chief financial officer, were determined with sufficient runout following the end of the plan year and should be an accurate representation of the ultimate incurred claims for the year. These figures are likely to be more accurate than using the claims in the financial statements filed with the State which have Incurred But Not Reported (IBNR) amounts that typically over/understate the claim liability and, ultimately, misstate the incurred claims.

2. Develop experience trend: From the MCO self-reported claims data, Milliman developed trends for each program for each of the last three years. The trends were then weighted (50% / 33% / 17%, with the highest percentage applied to the most recent year) to smooth out annual fluctuations.

3. Milliman also created an overall trend for all the programs over the 3-year period. This was averaged with the plan-specific experience-based trend.

4. The trends were adjusted for benefit and programmatic changes.

5. Milliman also had a target trend that was detailed by type of service, utilization and cost. This was their estimate of what they believed the trends should be during the rating period and was weighted (50% / 50%) with the trend developed in (3). Milliman states that the target, or benchmark, trends "are intended to reflect trend rates that are achievable by MCOs that successfully apply pro-active and effective medical management and contracting strategies and tactics." It appears that Milliman's target cost trends were estimated from provider charge data, not cost data. For example, in the development of 2010 capitation payment rates (shown below), Milliman targeted the hospital inpatient charge trend at 4.1% and the hospital outpatient charge trend at 4.0%. It is our understanding that FFS Medicaid hospital costs were flat during that time period. This implies that hospital charge trends were rising while hospital cost trends for Medicaid managed care were probably flat and that the target trends were probably overstated as a result. Similar conclusions can be drawn for other years as well.

BENCHMARK TREND RATE—PMAP

Benefit	Distribution	Utilization	Trend Rate Charge	Total Cost
Hospital Inpatient	33.19%	-0.50%	4.10%	3.58%
Hospital Outpatient	17.41%	4.00%	4.00%	8.16%
Drugs	10.93%			7.60%
Dental	4.02%	0.50%	4.50%	5.02%
Composite Trend Rate	**100.0%**			**5.56%**

Source: December 10, 2009 Milliman letter to Ms. Karen Peed, DHS
Re: Capitation Rate Adjustments for 2010 Payment Rates—PMAP and Minnesota Care

Tables 1, 2 and 3 below display the developed trend for the period 2003 – 2011 for PMAP, PGAMC and MNCare, respectively. Over the period 2003 – 2011, the trends ranged from 6%-11% annually. These are significantly higher trends for Medicaid managed care plans than we have observed in other states. For example, in Georgia and Tennessee, Medicaid Managed Care trends are in the 2% to 4% range. We believe much of the variation in Minnesota is due to cost trends similar to a commercial product. Most state Medicaid programs have a relationship between changes in the FFS (Fee-for-Service) Medicaid rates and rates for their Medicaid managed care programs. Milliman states in one of their certifications that the MCOs in Minnesota estimated a 75% correlation. The FFS increases over the review period were much lower than the assumed cost increases under the managed care plans. Milliman did not appear to take this into account and even the target trend, as stated above, has a significant cost trend component included.

Table 1

PMAP RATING TREND HISTORY

Calendar Year	Claims Experience Periods			3-Year Weighted Average[1]	3-Year Weighted Average All Plans[1]	50/50 Weighted Average[2]
2003	**1998-99**	**1999-00**	**2000-01**			
	6.90%	14.10%	3.50%	7.6%	8.3%	7.9%
2004	**1999-00**	**2000-01**	**2001-02**			
	7.70%	7.10%	13.50%	10.40%	10.60%	10.50%
2005	**2000-01**	**2001-02**	**2002-03**			
	7.10%	10.00%	12.70%	10.80%	11.00%	10.91%
2006	**2001-02**	**2002-03**	**2003-04**			
	10.90%	12.00%	5.20%	8.40%	9.10%	8.76%
2007	**2002-03**	**2003-04**	**2004-05**			
	11.80%	4.30%	10.00%	8.40%	7.60%	8.02%
2008	**2003-04**	**2004-05**	**2005-06**			
	4.74%	10.75%	5.28%	6.99%	6.33%	6.66%

Calendar Year	Claims Experience Periods			3-Year Weighted Average[1]	3-Year Weighted Average All Plans[1]	Experience Trend[2]	Benchmark Trend	Final Trend[2]
2009	**2005**	**2006**	**2007**					
	10.00%	5.80%	8.00%	7.60%	8.70%	8.13%	6.30%	7.21%
2010	**2006**	**2007**	**2008**					
	5.20%	7.90%	5.50%	6.30%	7.20%	6.74%	5.56%	6.15%
2011	**2007**	**2008**	**2009**					
	7.40%	5.80%	3.80%	5.10%	5.20%	5.13%	5.34%	5.24%

[1] Weights are 17%/33%/50%
[2] Weights are 50%/50%,

Table 2

PGAMC RATING TREND HISTORY

Calendar Year	Claims Experience Periods			3-Year Weighted Average[1]	3-Year Weighted Average All Plans[1]	50/50 Weighted Average[2]
2003	**1998-99**	**1999-00**	**2000-01**			
	14.70%	4.70%	18.10%	13.10%	8.30%	10.70%
2004	**1999-00**	**2000-01**	**2001-02**			
	6.00%	16.30%	9.20%	11.00%	10.60%	10.80%
2005	**2000-01**	**2001-02**	**2002-03**			
	16.10%	16.20%	8.10%	12.10%	11.00%	11.56%
2006	**2001-02**	**2002-03**	**2003-04**			
	14.60%	9.50%	8.30%	9.80%	9.10%	9.42%
2007	**2002-03**	**2003-04**	**2004-05**			
	9.40%	7.70%	4.00%	6.10%	7.60%	6.88%
2008	**2003-04**	**2004-05**	**2005-06**			
	7.45%	4.20%	8.22%	6.76%	6.33%	6.55%

Calendar Year	Claims Experience Periods			3-Year Weighted Average[1]	3-Year Weighted Average All Plans[1]	Experience Trend[2]	Benchmark Trend	Final Trend[2]
2009	**2005**	**2006**	**2007**					
	4.60%	8.70%	11.50%	9.40%	8.70%	9.04%	6.68%	7.86%
2010	**2006**	**2007**	**2008**					
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[1] Weights are 17%/33%/50%
[2] Weights are 50%/50%

MNCARE RATING TREND HISTORY

Calendar Year	Claims Experience Periods			3-Year Weighted Average[1]	3-Year Weighted Average All Plans[1]	50/50 Weighted Average[2]
2003	**1998-99**	**1999-00**	**2000-01**			
	8.10%	6.80%	9.30%	8.30%	8.30%	8.30%
2004	**1999-00**	**2000-01**	**2001-02**			
	6.60%	9.00%	13.50%	10.80%	10.60%	10.70%
2005	**2000-01**	**2001-02**	**2002-03**			
	8.80%	12.90%	10.10%	10.80%	11.00%	10.90%
2006	**2001-02**	**2002-03**	**2003-04**			
	11.80%	9.70%	6.80%	8.60%	9.10%	8.85%
2007	**2002-03**	**2003-04**	**2004-05**			
	9.60%	6.20%	3.90%	5.70%	7.60%	6.64%
2008	**2003-04**	**2004-05**	**2005-06**			
	5.03%	4.36%	5.01%	4.80%	6.33%	5.57%

Calendar Year	Claims Experience Periods			3-Year Weighted Average[1]	3-Year Weighted Average All Plans[1]	Experience Trend[2]	Benchmark Trend	Final Trend[2]
2009	**2005**	**2006**	**2007**					
	3.30%	7.10%	16.10%	11.00%	8.70%	9.83%	6.84%	8.34%
2010	**2006**	**2007**	**2008**					
	5.30%	13.30%	8.30%	9.50%	7.20%	8.36%	6.23%	7.29%
2011	**2007**	**2008**	**2009**					
	15.40%	0.40%	6.10%	5.80%	5.20%	5.48%	5.90%	5.69%

[1] Weights are 17%/33%/50%.
[2] Weights are 50%/50%

After putting together the target trend, Milliman then provided adjustment factors to take into account over/under statement of prior year's assumed trends as well as emerging profits reported on the Supplemental Report #1.

The following describes the adjustments made by Milliman for two different portions of the period reviewed. The actual adjustment factors applied to the demographic portion of the rates are shown in *Appendix 3*.

Calendar Year 2004-2008

The following adjustments were applied to the annual trend rates:

- Some years included a trend adjustment that was not clearly defined
- Rebased adjustment to reflect prior year trend variance—if the prior trend was overstated when compared to the updated analysis, this was adjusted downward since each year is a cumulative factor. Restated trends were almost always overstated.
- Adjustment for missed profit margin—if the profit margin for the calendar year prior was too high or low, the trend rate was rebased
- Adjustment for risk changes—a specific trend for risk was developed to reflect the unique aspect of the risk payment component

Calendar Year 2009-2011

Although a different methodology is used, the overall target is to adjust for variations similar to those made in earlier periods. In lieu of the steps above, the procedure is to project the expected costs, review what revenue is expected from the current rates and then use this relationship to produce the final rate increase.

Milliman starts with the self-reported claims cost from the MCOs, rolls that claims cost forward with the annual trend discussed above, adds administrative costs with trend and loads the assumed surplus to obtain a total expected cost. They then use an enrollment proxy (in some years they use the prior calendar year enrollment; in other years they use the most recent quarter) to estimate the expected revenue. They divide the revenue by the projection and get the expected trend. There is an attempt to incorporate investment income into the analysis, but by removing it from administration costs and loading it into margin, it has no impact on the rate increase.

Both methods present a number of concerns:

- Both rely on a three-year average of trend. Based on the size of the programs (number of enrollees), using three years may not be necessary. For example, trends developed for calculating 2009 rates were based in part on experience as far back as 2005. Based on the size of the programs (number of enrollees), using experience-based trends that far back probably contributes to inaccurate rate projections. In addition, the demographic make-up of the population over that 4-year period probably changed making it difficult, if not impossible, to estimate the underlying trend.

- Experience trends and average starting costs were all self-reported from MCOs. We have not seen any detailed trend build-up to explain the source of the large reported trends. We did find that restated costs and trends tended to be lower during the following year's rate development, when additional runout data was considered. This is an indication that the trend methodology is probably contributing to an overstating of the developed premium rates.

- Multiple smoothing levels mitigate current trends significantly and probably contribute to rating inaccuracies.

- Milliman's target trends appear to be built on charge-based data as compared to cost-based data. The charge-based cost trends are more than half of the Milliman target trends. Our understanding is that the providers have had marginal payment increases over time. Unless a specific rate change was implemented, we would expect the cost trends to be lower.

- For the most recent years we believe there may be a disconnect between how the average claims cost is developed compared to the average premium. The average premium used the most recent enrollment while the average claims cost used the historical enrollment. We do not believe there was an adjustment to reflect movement between cells in the final rate increase calculation.

- Resulting trends are higher than other Medicaid managed care programs.

- There was no utilization adjustment to reflect improvement in managed care expected from the MCOs and to hold them accountable.

Recommendation

We believe the methodology used by the actuary to analyze historical trends and, subsequently, to develop rating trends can be strengthened in a number of ways.

First, we believe the analysis of historical experience-based trend should be based upon a detailed review of cost and utilization data that would best come from using the encounter data. Currently, this analysis is being carried out using MCO self-reported summary data.

Secondly, we believe the encounter data is likely to produce more consistent (accurate) information and, therefore, the blending of experience-related trends could be shortened from the current three years to two years. This is likely to improve the accuracy of determining the experience-based trends and, ultimately, the rating trends.

Thirdly, we believe that Milliman's benchmark trend is charge-based (as opposed to cost-based). Since the final rating trend is a 50/50 blend of the experience and the benchmark trends, this is likely to overstate the needed premium capitation rates. The benchmark trend should be adjusted to more accurately reflect specific cost trends.

In general, we believe the Milliman trend methodology produced a systemic overstatement of the trend, causing the program to exceed targets over time. Segal recognizes that actuaries utilize a variety of acceptable and reasonable methods in developing trends. The issue is that over time an actuary should review and adjust the method as variances arise to remain close to actual market

costs. We believe Milliman attempted to adjust the methodology in 2009 and after, but given the financial outcome of those years, it is evident that some overstatement still existed.

6. Administrative Cost Allowance

Section AA.3.2 of the CMS Rate-Setting Checklist provides guidance for including administrative cost allowance calculations in actuarially sound capitation rates for Medicaid managed care contracts.

> **Administrative Cost Allowance Calculations**
>
> The State must document that an adjustment was made to the rate to account for MCO, PIHP or PAHP administration. Only administrative costs directly related to the provision of Medicaid State Plan approved services to Medicaid-eligible members are built into the rates. Documentation of assumptions and estimates are required>
>
> In order to receive Federal reimbursement, administrative costs at the entity level are subject to all applicable Medicaid administrative claiming regulations and policies. Medicaid pays for the administration of Medicaid Services to Medicaid beneficiaries covered under the contract. The following examples are not all inclusive.
>
> Public entities cannot build in administrative costs to pay for non-Medicaid administration or services such as education, prisons, or roads, bridges and stadiums using the administrative cost in capitated rates.
>
> Administrative costs for State Plan approved services can only be claimed for services to be delivered to Medicaid beneficiaries under the contract services. Administration costs in contracts must be allocated to the appropriate programs (e.g. public health must pay for the administration of public health services to non-Medicaid eligibles). CMS provides FFP only for the administration of Medicaid services to Medicaid beneficiaries covered under the contract.
>
> Regular Medicaid matching rules apply.

We have reviewed the development of the administrative costs that were included in the rate development. The administrative trend rate used is generally the average rate for the experience period, self-reported, trended at 2% to 4%, depending on the year. Both the actual and expected administrative loads varied from 6% to 11% over the period as shown below.

ADMINISTRATIVE EXPENSE RATIOS
% of Premium Revenue

Program	2003	2004	2005	2006	2007	2008	2009	2010	2011	Average
PMAP										
Actual[1]	6.54%	9.44%	8.80%	9.77%	9.68%	8.85%	8.89%	9.07%	10.94%	9.11%
Expected[2]	10.00%	7.60%	6.90%	9.20%	8.40%	8.89%	7.49%	7.78%	9.00%	8.36%
PGAMC										
Actual[1]	5.13%	7.43%	6.92%	7.04%	8.31%	6.31%	5.43%	6.69%	N/A	6.66%
Expected[2]	10.00%	7.60%	6.90%	9.20%	8.40%	8.89%	7.04%	N/A	N/A	8.29%
MinnesotaCare										
Actual[1]	6.17%	8.82%	8.67%	9.15%	8.54%	8.44%	7.73%	10.89%	8.29%	8.52%
Expected[2]	10.00%	7.60%	6.90%	9.20%	8.40%	8.89%	6.02%	7.24%	9.00%	8.14%

[1] Administrative expense percentage derived from financial statements filed with the Department of Commerce.
[2] Administrative expense percentage assumed in the development of capitation rates.

There did not seem to be any critical or diligent review of the administrative components going into the base rates. In our discussions with DHS, it appears that the reported administrative costs have elements included that should be pulled out from the development. We are aware that other audits have found similar issues in the administrative component, so we will not go into great detail in this review.

Recommendation

A targeted administrative load should be developed and stabilized. The rate should reflect what an efficient MCO needs to appropriately administer the programs and deliver the desired level of managed care. This could be expressed as a fixed price per contract or as an administrative percent load, but that assumption should not vary significantly over time.

7. Risk Adjustment

Section AA.5.3 of the CMS Rate-Setting Checklist provides guidance for how a risk-adjustment methodology is to function in actuarially sound capitation rates for Medicaid managed care contracts.

Risk Adjustment

The State may employ a risk adjustment methodology based upon enrollees' health status or diagnosis to set capitation rates. If the State uses a statistical methodology to calculate diagnosis-based risk adjusters they should use generally accepted diagnosis groupers. The RO should verify that:

- The State explains the risk assessment methodology chosen
- Documents how payments will be adjusted to reflect the expected costs of the disabled population
- Demonstrates how the particular methodology is cost-neutral
- Outlines periodic monitoring and/or rebasing to ensure that the overall payment rates do not artificially increase, due to providers finding more creative ways to classify individuals with more severe diagnoses (also called upcoding or diagnosis creep).

Risk-adjustment must be cost-neutral. Note: for example, risk-adjustment cannot add costs to the managed care program. Risk adjustment can only distribute costs differently amongst contracting entities.

Minnesota was one of the first states to implement a risk-adjusted reimbursement system. In general, a portion of the MCO reimbursement, approximately 50% for most years, is paid on a statewide risk basis only. By doing this, DHS has effectively eliminated 50% of the variation caused by geographic factors, as well as variations that are intrinsic in the demographic cells. The system prospectively pays MCOs based on a lagged population risk, updated quarterly. Some groups are excluded from the calculation.

In their rate development, Milliman appropriately attempts to adjust for the risk creep in the program. We cannot verify that the amount of adjustment produces the desired outcome, but it appears to be reasonable. We did not see where Milliman certified what the statewide base rate should be before the risk adjustment is applied, we only see where the rate is increased. Segal has also not been able to tie back to the base rate initially used.

Below are two concerns we have with the current risk-based reimbursement system:

1. **Prospective System:** In a stable population, a prospective system can adequately compensate different MCOs and better reflect their true risk and costs. Over time, these programs have had significant growth in membership, migration between programs and rate groupings. The risk system pays new members the average risk for the group. By doing this, as healthier members are enrolled who will eventually produce lower risk scores, DHS overstates the risk for those members for at least one year. With increasing enrollment, you are chasing the risk. We believe this factor was a component of the gains in 2009-2011. This seems logical since the lagged risk scores in 2010 and 2011 increased at a much slower pace than during prior periods. At the same time, enrollment was increasing significantly. The combination of the two (overstated risk and increasing enrollment) is a good mix for the MCOs to have. A retrospective system would better account for this variance.

2. **Risk Creep:** The change will vary by year but it looks to be around 1% per year in aggregate, with some years as much as a 5% different risk score, and less than 0.5% in the last two years. Higher risk should not result in overall higher payments to MCOs. The overall impact should be budget neutral and just redistribute the revenue. If all the risk went up 10%, for example, but it is proportional across all plans, the MCOs should not receive additional funding and no MCO should have any revenue change. This is the soundness requirement that the risk adjustment system be budget neutral in aggregate and is what Milliman has certified to. If risk creep is not accurately reflected in the rate development, DHS rates will be overstated. We understand that is marginally corrected in the quarterly risk update. There does not appear to be any assumed risk creep.

The risk adjustment mechanism was rebased in 2008 using a sampling of data from 2004-2006. The risk factors dropped significantly, requiring a corresponding increase in the statewide base rate to balance. *Appendix 6* shows the average risk scores and percentage change from the previous year of the MCOs by program and in total from 2002 – 2012. As noted above, the average risk score for 2008 declined by 16.1% from 2007 after rebasing. This resulted in average rates increasing by 10.4% (*Appendix 5*). Segal was unable to reconcile these values and determine whether they provide budget neutrality. This may have also contributed to the recent financial gains of the MCOs.

Note that if a risk adjustment system is not designed to be budget neutral, the rates will not be actuarially sound.

Recommendation

It is our belief that a retrospective risk adjustment system will more accurately reflect the required capitation rates for the reasons stated above. It is our understanding that DHS is already considering moving in this direction.

8. Rate Cells and Geographic Variances

As stated above, the rate cells were rebased in 2008. Given the limited data utilized, we believe the review was likely not adequate and did not focus on why there were emerging differences between the cells. We do believe the relativities balance to 1.0, as appropriate, but we are not

confident that the geographic differences were accurately developed. The same would hold true of the demographic changes implemented.

Using exactly the same methodology, the rates were again rebased in 2010. We believe these factors may be partially responsible for the profits in recent years.

Recommendation

A detailed analysis using complete encounter data with paid claims information should be performed. The results will need to be smoothed in over a few years.

9. Rate Worksheets from DHS

After Milliman provides their certification documentation, DHS inputs all the factors into their internal worksheet. The worksheet then calculates rates to be paid to each MCO for the applicable quarter. The worksheet develops both the demographic and risk adjusted rates. Milliman certifies that they have reviewed the rate worksheets.

For the most part, Segal was able to cross check the Milliman certified factors into the worksheet and validate that the formulas appear appropriate. For 2009 we linked the Milliman factors to the rate sheet and to the contract rates for a few MCOs. There are 30 to 40 tabs in each of these worksheets with thousands of formulas. A fully detailed review is beyond the scope of this review, but from our limited review of the spreadsheet, we believe there is a good faith effort to apply all the factors.

Given that all the years are “adjustments’ to prior years we went back to the first rate sheet for 2003. The starting point was an input that we were unable to verify. We discussed a few similar occurrences like this with DHS and they are researching. Given the extensive amount of inputs, it is highly likely that there are minor errors, but we believe most would be insignificant. Segal is uncomfortable with the volume of inputs and believes this needs to be redesigned in the future to reflect the source for each of the starting numbers.

Recommendation

Key elements of the worksheet should be audited and supporting documentation developed. The worksheet needs to be simplified and streamlined.

10. PGAMC Rate Adjustment Methodology

As indicated earlier, PGAMC had significant losses each year over the review period. Since the rates were not certified, at some point the rates overall were designed to generate losses for the plan. The distribution of the PGAMC enrollment in plans varied over time as the State began to reduce eligibility or attempt to have portions of the population enroll in other State programs that had either reduced benefits or some federal match.

Starting in 2006, Milliman began providing an annual letter describing the methodology to redistribute PGAMC revenue among MCOs. In general, Milliman is spreading the losses of PGAMC as evenly as possible over the MCOs, since they were disproportionately affected by the program. PMAP experience was used as a basis to proportionally adjust the GA rates. Only the GA rates and MCO-specific revenues were altered. Since these rates are not required to be actuarially sound, with no changes to PMAP or MNCare rates, there is not a "technical" issue with what Milliman was asked to do.

MCOs were required to participate in all the public programs, PMAP, MNCare and PGMAC (note that CMS approved these combined contracts). MCO executives will look at the contract that covers all three programs and recognize that the losses to be expected from PGAMC would be offset by gains in the other programs. Financially, this approach worked well for the State since the MCO had no choice but to evaluate the programs together, and it likely permitted the State to fund the PGAMC program at lower levels. Note that the federal government provides a match to the funds providing the gains, while the program generating the losses, PGAMC, was funded by the State only. The PGAMC program ended in 2010 and the MCOs no longer had the losses from this program.

With the certification likely sound and if profit targets were hit as projected, there would be no issue with this at all, since the MCOs would be having losses for that component of the business. The question is whether the rates for the other programs, matched by the federal government, were deliberately on the high end of the actuarial sound rate range in order to make up for anticipated losses from PGAMC.

Recommendation

Segal has no recommendation since this program is terminated. We believe as new State-only programs are developed they should stand on their own financially. MCOs should have the option of not participating if the program is not viable.

11. Actuarial Soundness

CMS requires that rates be actuarially sound for PMAP, MSHO and MNCare. In any given year, standing alone at the time of certification, the rates developed by Milliman, although overly conservative and at the high end of a reasonable rate range, were actuarially sound in our opinion. However, when taken in the context of prior year losses and profits, it seems unreasonable that no one (DHS, Actuary, or CMS) called into question the pattern over the extended period of review.

12. Plan Profitability

To gain a perspective on the history of Medicaid managed care rate setting in Minnesota, we summarized the financial information of the participating MCOs from State rate filings, which were found on Minnesota Supplement Report #1 of the NAIC Annual Statement. This report, known as the Statement of Revenues, Expenses and Net Income, detailed the financial results for each program offered by the MCO in a given year. We summed up the financial results of all MCOs for the 10-year period 2002 - 2011. Page 1 of *Appendix 2* displays a 10-year financial summary of the MCOs that participated in Medicaid managed care in the State from 2002 – 2011:

Over the 10-year period, for all programs, the MCOs received $27.0 billion in capitated premium revenues from the State and paid out $24.3 billion in medical and hospital expenses to providers. After consideration of $2.2 billion in administrative expenses, the MCOs recorded net income from operations of $528.6 million, which denoted an average profit margin of 2.0%. If you consider the $205.7 million of investment income, profits increase by another 0.7%. MCOs recorded total contribution to reserves of $734.3 million, or a 10-year average profit margin of 2.7% including the PGAMC losses.

PMAP profit margins ranged from -7.4% to +9.1% over the 10-year period, averaging 3.4%. The only loss year for PMAP occurred in 2006. By contrast, PGAMC experienced losses in every year ranging from -20.4% in 2007 to -2.2% in 2010, the year the program was terminated, averaging a -12.2% deficit margin over the 10-year period. MNCare was at a virtual break-even, averaging -0.2% over the period, although all the early gain years were wiped out by the losses from 2007 forward.

Two of the other larger programs should not be overlooked in the profitability analysis. MCOs were required (in the same contract that included MNCare and PMAP) to provide benefits to enrollees covered under PGAMC in any county the MCO covers PMAP and MNCare. This is problematic because the PGAMC program had losses of $191.7 million during the same period. This State-only funded program does not require certified rates. Given that fact, the losses of PGAMC could not influence rates for PMAP and MNCare. Since this program was always projected to lose money, there was a business decision to be made by MCO management to participate in the entire program, anticipating that gains from PMAP and MNCare would more than offset losses from PGAMC.

The other major State program was the Minnesota Senior Health Options (MSHO) program. The financial summary in Appendix 2 shows a gain of $290.4 million for this program over the period. MSHO experienced gains each year ranging from 1.4% to 8.8%, averaging 4.3% over the review period. This is an integrated program that contains revenues from both Medicare and Medicaid. It is difficult to isolate the source of the gain. Given the integration of funding, we suspect a component of the profits would be from Medicaid.

Plans Requiring Actuarial Certification

Reviewing the self-reported experience for PMAP and MNCare only for the period 2002 through 2011, the MCOs reported net operating income of $430 million. This is a 2.4% profit on $18.2 billion of premium over the period. It is difficult to isolate the investment income for each MCO

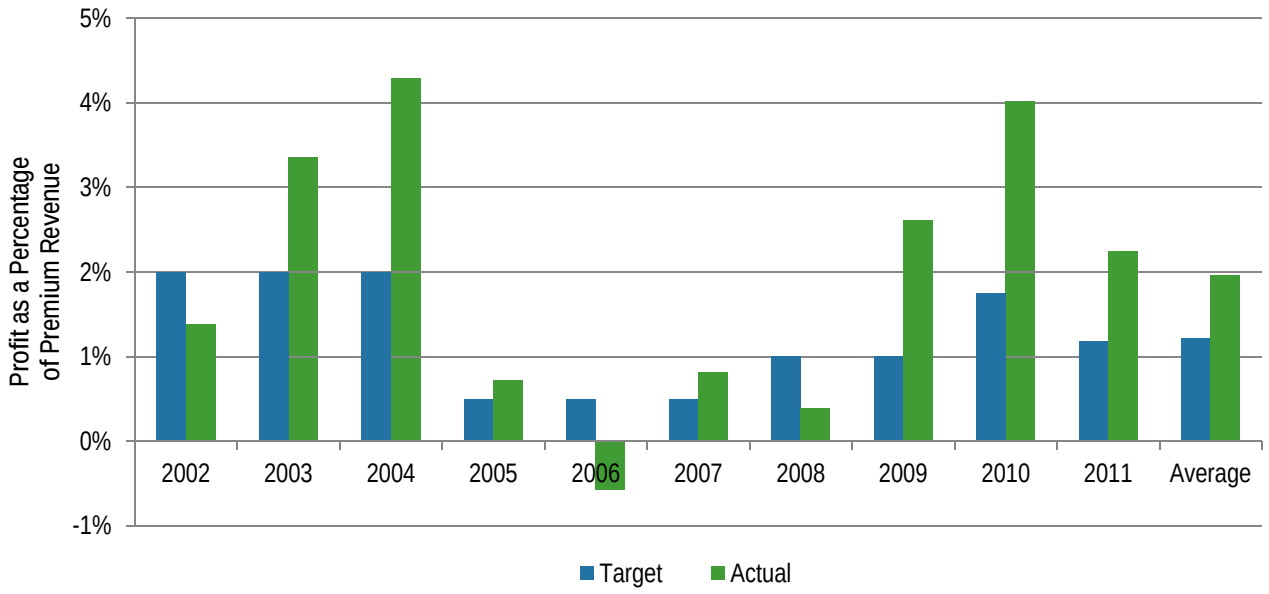
during the period. Self-reported amounts for these programs were approximately $127 million during the same period, contributing an additional 0.7% to profits.

Combining both components would yield a profit of approximately 3.1% for these programs over the full period reviewed. The target margin in the actuarial rate development ranges from 0% to 1.75% in 2010, with the most prevalent being 1%. This variation was reviewed by the actuary annually and taken into account during the rate development. Although Milliman had this line item in their report, the variation appears to continue each year and was actually greatest in the last four years 2008 to 2011.

Comparison to Target Profit

The profits received by the MCOs over the period are a good proxy for how the rates have missed over time. If we consider the experience of PMAP and MNCare from 2004 to 2011, the period over which the actuarial soundness requirement applied, our review indicates the MCOs achieved on average 1.0% above targeted levels for a total of $161 million. If investment income is taken into account, that grows by approximately $119 million.

TARGET VS. ACTUAL PROFIT MARGINS FOR PMAP AND MNCare



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Avg/Total 2002 – 2011	Avg/Total 2004 – 2011
PMAP & MNCare Revenue	$1,220,103	$1,378,732	$1,466,737	$1,606,823	$1,393,907	$1,626,532	$1,888,059	$2,290,822	$2,559,078	$2,762,275	$18,193,068	$15,594,233
Actual Net Income	$32,951	$64,687	$89,676	$28,572	-$67,657	-$19,674	$34,023	$112,195	$118,860	$36,868	$430,501	$332,863
Actual Profit Margin	2.70%	4.69%	6.11%	1.78%	-4.85%	-1.21%	1.80%	4.90%	4.64%	1.33%	2.37%	2.13%
Target Profit Margin	2.00%	2.00%	2.00%	0.50%	0.50%	0.50%	1.00%	1.00%	1.75%	1.18%	1.23%	1.10%
Expected Net Income	$24,402	$27,575	$29,335	$8,034	$6,970	$8,133	$18,881	$22,908	$44,784	$32,595	$223,615	$171,639

The continued overstatement of actual profits vs. targets is concerning. The results of 2.13% vs. 1.10%, actual vs. target profit margins demonstrate a miss of nearly 94%, with the last three years well over 100%.

Note that the 2011 contracts between DHS and BluePlus, HealthPartners, Medica, and UCare were amended between June and August of 2011 to limit those MCOs' operating margins for PMAP and MinnesotaCare to 1% of premium revenue. Margins in excess of 1% were calculated based on self-reported data from the plans and accepted by the State. The chart on the prior page does not reflect these repayments to the State and would impact the 2011 margins accordingly. The 1% limitation was for 2011 only, eliminated from the 2012 contracts.

Recommendations

The performance of the plans should tie to assumptions utilized in the actuarial rates developed and certified over an extended period. A methodology should be developed to accomplish this tie to assumptions and any necessary adjustments implemented.

13. Managed Care Model

In addition to FFS Medicaid, Minnesota provides Medicaid benefits on a risk-basis approach through contracts with participating MCOs. The idea behind this type of arrangement is to hold the MCOs accountable for holding down costs through quality improvements and other incentive arrangements. On the other hand, it has been well documented that one of the areas of weakness with this approach has been in the monitoring and oversight by CMS.

According to a February 2012 Kaiser Family Foundation policy brief on Medicaid and the uninsured, 31 states now operate Primary Care Case Management (PCCM) programs, sometimes in addition to their MCO contracts. Using this model, states contract directly with primary care providers (PCPs) who are responsible for direct and referral beneficiary care for a fee. States using the PCCM model have reported lower costs and higher beneficiary satisfaction compared to the MCO contracting approach. In addition, the PCCM model eliminates the potential for overpaying for care, as has been the case in Minnesota with higher than required capitation rates to MCOs.

There is also the possibility of using the PCCM model in the future, as a means to more effectively integrate primary care and community-based services through an enhanced PCCM (EPCCM) program or, patient-center medical home. This is an example of a model that has been used successfully in other states.

Recommendation

We also believe DHS could have achieved additional savings from more aggressive plan management, utilization of appropriate data, different managed care models and competition. These savings are not quantifiable and are beyond the scope of our review. We recommend that DHS review the Primary Care Case Management model as a possible means to integrate primary care and community-based services. In addition, we recommend that DHS review other emerging models as well.

APPENDIX 1: KEY DOCUMENTS REVIEWED

1. 2003-04 Rate Setting Checklist – PMAP – dated 9/25/2003
2. 2003-04 Rate Setting Checklist – MNCare – dated 9/25/2003
3. 2003-04 Rate Setting Checklist – MSHO – dated 9/25/2003
4. 2005 Rate Setting Checklist – PMAP – dated 12/28/2004
5. 2005 Rate Setting Checklist – MNCare – dated 12/28/2004
6. 2005 Rate Setting Checklist – MSHO – dated 12/28/2005
7. 2006 Rate Setting Checklist – PMAP – dated 12/15/2005
8. 2006 Rate Setting Checklist – MNCare – dated 12/15/2005
9. 2006 Rate Setting Checklist – MSHO – dated 12/15/2005
10. 2007 Rate Setting Checklist – PMAP – dated 12/15/2006
11. 2007 Rate Setting Checklist – MNCare – dated 12/15/2006
12. 2007 Rate Setting Checklist – MSHO – dated 12/15/2006
13. 2008 Rate Setting Checklist – PMAP – dated 12/20/2007
14. 2008 Rate Setting Checklist – MNCare – dated 12/20/2007
15. 2008 Rate Setting Checklist – MSHO – dated 12/20/2007
16. 2009 Rate Setting Checklist – PMAP – dated 12/24/2008
17. 2009 Rate Setting Checklist – MNCare – dated 12/24/2008
18. 2009 Rate Setting Checklist – MSHO – dated 12/24/2008
19. 2010 Rate Setting Checklist – PMAP – dated 12/29/2009
20. 2010 Rate Setting Checklist – MNCare – dated 12/29/2009
21. 2010 Rate Setting Checklist – MSHO – dated 12/29/2009
22. 2011 Rate Setting Checklist – PMAP – dated 12/29/2010
23. 2011 Rate Setting Checklist – MNCare – dated 12/29/2010
24. 2011 Rate Setting Checklist – MSHO – dated 12/29/2010
25. Milliman Actuarial Certification dated 9/19/2003 – PMAP/MNCare for the rating period 10/01/2003 – 12/31/2004
26. Milliman Actuarial Certification dated 9/17/2003 – MSHO for the rating period 10/01/2003 – 12/31/2004
27. Milliman Actuarial Certification dated 9/18/2003 – MnDHO for the rating period 10/01/2003 – 12/31/2004
28. Milliman Actuarial Certification dated 12/17/2004 – PMAP/MNCare for the 2005 rating period
29. Milliman Actuarial Certification dated 12/17/2004 – NF/EW for the 2005 rating period
30. Milliman Actuarial Certification dated 12/17/2004 – MSHO for the 2005 rating period

31. Milliman Actuarial Certification dated 12/17/2004 – MSC for the 2005 rating period
32. Milliman Actuarial Certification dated 12/17/2004 – MnDHO for the 2005 rating period
33. Milliman Actuarial Certification dated 12/09/2005 – PMAP/MNCare for the 2006 rating period
34. Milliman Actuarial Certification dated 12/14/2005 – MSHO for the 2006 rating period
35. Milliman Actuarial Certification dated 12/04/2006 – MSHO for the 2007 rating period
36. Milliman Actuarial Certification dated 11/30/2006 – PMAP/MNCare for the 2007 rating period
37. Milliman Actuarial Certification dated 12/04/2006 – MSHO for the 2007 rating period
38. PGAMC Revenue Adjustment Calculation letter dated 10/12/2006
39. Milliman Actuarial Certification dated 12/11/2007 – PMAP/MSC/MSHO and MNCare for the 2008 rating period
40. Milliman Actuarial Certification dated 12/05/2008 – PMAP/MSC/MSHO and MNCare for the 2009 rating period
41. Milliman Actuarial Certification dated 12/16/2009 – PMAP/MSC+/MSHO and MNCare for the 2010 rating period
42. Milliman Actuarial Certification dated 12/19/2008 – PMAP/MNCare for the 2011 rating period
43. Milliman Actuarial Certification dated 12/19/2008 – MSHO/MSC+ for the 2011 rating period
44. Milliman Trend and Surplus Analysis for 2003 for PMAP, PGAMC and MNCare dated 10/21/2002
45. Milliman Trend and Surplus Analysis for 2004 for PMAP, PGAMC and MNCare dated 8/19/2003
46. Milliman Trend and Surplus Analysis for 2005 for PMAP, PGAMC and MNCare dated 12/16/2004
47. Milliman Trend and Surplus Analysis for 2006 for PMAP, PGAMC and MNCare dated 10/12/2005
48. Milliman Trend and Surplus Analysis for 2007 for PMAP, PGAMC and MNCare dated 11/30/2006
49. Milliman Trend and Surplus Analysis for 2008 for PMAP, PGAMC and MNCare dated 11/19/2007
50. Milliman Trend and Surplus Analysis for 2008 for Seniors dated 11/19/2007
51. Milliman Trend and Surplus Analysis for 2009 PMAP, PGAMC and MNCare dated 10/07/2008
52. Milliman Trend and Surplus Analysis for 2009 for Seniors dated 10/21/2008
53. Milliman Trend and Surplus Analysis for 2010 for PMAP and MNCare dated 12/10/2009
54. Milliman Trend and Surplus Analysis for 2011 for PMAP and MNCare dated 12/17/2010
55. Milliman Area Factor Study dated 1/21/04

56. Milliman 2006 Benefit Changes dates 9/19/2005
57. Milliman Part D Analysis dated 10/11/2005
58. Milliman Proposed PGAMC Revenue Adjustment Methodology dated 9/19/2005
59. Milliman 2006 GAMC Enrollment Migration to MNCare Analysis dated 10/12/2005
60. Milliman 2007 PGAMC Revenue Adjustment Calculations dated 10/12/2006
61. Milliman Risk Adjustment Rate Rebasing dated 11/14/2007
62. Milliman PMAP Rate Cell Analysis dated 11/14/2007
63. Milliman MNCare Rate Cell Analysis dated 11/14/2007
64. Milliman PGAMC Rate Cell Analysis dated 11/14/2007
65. Milliman Seniors Rate Cell Analysis dated 11/14/2007
66. Milliman PGAMC Revenue Adjustment Calculations dated 9/11/2008
67. Milliman 2009 Benefit Changes dated 10/07/2008
68. Milliman Rate Adjustment for October Amendment dated 7/24/2009
69. Milliman 2010 MNCare Plan Specific Adjustment dated 12/1/2009
70. Milliman Rate Adjustment for September Amendment dated 8/6/2010
71. Milliman PMAP Rate Cell Analysis dated 6/30/2009
72. Milliman MNCare Rate Cell Analysis dated 6/30/2009
73. Milliman Seniors Rate Cell Analysis dated 6/30/2009
74. Milliman Seniors Rate Cell Analysis dated 12/16/2009
75. Milliman PMAP Rate Cell Analysis dated 6/01/2011
76. Milliman PMAP Rate Cell Analysis dated 6/24/2011
77. Milliman MNCare Rate Cell Analysis dated 6/01/2011
78. Milliman MA Expansion Rate Letter dated 3/19/2011
79. Milliman MNCare Plan Specific Adjustments dated 12/1/2010
80. Calendar Year Rate Files and Fiscal Year Rate Files – 2003-2011
81. Enrollment and Capitation Reports – PMAP – 2003-2011
82. Enrollment and Capitation Reports – MNCare – 2003-2011
83. MCO Financials – 2002-2011
84. Milliman's response to Segal's request for information

APPENDIX 2: MCO 10-YEAR SUMMARY FINANCIAL RESULTS

10-Year Summary by Program (in thousands $) Minnesota Public Programs Only

Program	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011**	10-Year Total
PMAP											
Premium Revenues	$ 800,709	$ 931,158	$ 1,018,024	$ 1,179,776	$ 995,263	$ 1,182,423	$ 1,419,709	$ 1,694,717	$ 1,851,819	$ 2,112,114	$ 13,185,712
Medical/Hospital Expenses	$ 725,029	$ 828,017	$ 879,862	$ 1,073,868	$ 971,792	$ 1,067,597	$ 1,213,322	$ 1,424,546	$ 1,515,876	$ 1,823,849	$ 11,523,758
Administrative Expenses	$ 71,210	$ 60,903	$ 96,136	$ 103,801	$ 97,257	$ 114,464	$ 125,631	$ 150,643	$ 167,884	$ 231,170	$ 1,219,099
Net Income (loss) from Operations	$ 4,470	$ 42,238	$ 42,026	$ 2,107	$ (73,786)	$ 362	$ 80,756	$ 119,528	$ 168,059	$ 57,095	$ 442,855
Ratios											
Medical Loss Ratio	90.5%	88.9%	86.4%	91.0%	97.6%	90.3%	85.5%	84.1%	81.9%	86.4%	87.4%
Administrative/Revenue	8.9%	6.5%	9.4%	8.8%	9.8%	9.7%	8.8%	8.9%	9.1%	10.9%	9.2%
Contribution to Reserves	0.6%	4.5%	4.1%	0.2%	-7.4%	0.0%	5.7%	7.1%	9.1%	2.7%	3.4%
PGAMC											
Premium Revenues	$ 122,235	$ 156,500	$ 172,993	$ 204,300	$ 232,717	$ 166,351	$ 196,782	$ 253,166	$ 70,396	$ -	$ 1,575,440
Medical/Hospital Expenses	$ 127,925	$ 164,507	$ 179,768	$ 210,477	$ 240,106	$ 186,641	$ 215,961	$ 269,918	$ 67,247	$ -	$ 1,662,550
Administrative Expenses	$ 8,653	$ 8,032	$ 12,862	$ 14,132	$ 16,392	$ 13,824	$ 12,409	$ 13,741	$ 4,713	$ -	$ 104,758
Net Income (loss) from Operations	$ (14,343)	$ (16,039)	$ (19,636)	$ (20,343)	$ (23,783)	$ (33,931)	$ (31,591)	$ (30,491)	$ (1,564)	$ -	$ (191,721)
Ratios											
Medical Loss Ratio	104.7%	105.1%	103.9%	103.0%	103.2%	112.2%	109.7%	106.6%	95.5%	0.0%	105.5%
Administrative/Revenue	7.1%	5.1%	7.4%	6.9%	7.0%	8.3%	6.3%	5.4%	6.7%	0.0%	6.6%
Contribution to Reserves	-11.7%	-10.2%	-11.4%	-10.0%	-10.2%	-20.4%	-16.1%	-12.0%	-2.2%	0.0%	-12.2%
MinnesotaCare											
Premium Revenues	$ 419,394	$ 447,574	$ 448,713	$ 427,047	$ 398,644	$ 444,109	$ 468,350	$ 596,105	$ 707,259	$ 650,161	$ 5,007,356
Medical/Hospital Expenses	$ 358,241	$ 397,493	$ 361,498	$ 363,661	$ 356,048	$ 426,199	$ 475,550	$ 557,330	$ 679,447	$ 616,521	$ 4,591,988
Administrative Expenses	$ 32,672	$ 27,632	$ 39,564	$ 37,020	$ 36,467	$ 37,948	$ 39,534	$ 46,107	$ 77,011	$ 53,867	$ 427,822
Net Income (loss) from Operations	$ 28,481	$ 22,449	$ 47,650	$ 26,465	$ 6,129	$ (20,036)	$ (46,733)	$ (7,333)	$ (49,199)	$ (20,227)	$ (12,354)
Ratios											
Medical Loss Ratio	85.4%	88.8%	80.6%	85.2%	89.3%	96.0%	101.5%	93.5%	96.1%	94.8%	91.7%
Administrative/Revenue	7.8%	6.2%	8.8%	8.7%	9.1%	8.5%	8.4%	7.7%	10.9%	8.3%	8.5%
Contribution to Reserves	6.8%	5.0%	10.6%	6.2%	1.5%	-4.5%	-10.0%	-1.2%	-7.0%	-3.1%	-0.2%
MSHO											
Premium Revenues	$ -	$ 107,555	$ 127,727	$ 180,104	$ 860,080	$ 965,500	$ 1,020,171	$ 1,120,229	$ 1,158,685	$ 1,187,081	$ 6,727,132
Medical/Hospital Expenses	$ -	$ 94,975	$ 114,270	$ 154,946	$ 734,904	$ 824,913	$ 939,229	$ 1,036,172	$ 1,067,163	$ 1,073,137	$ 6,039,709
Administrative Expenses	$ -	$ 5,721	$ 8,732	$ 15,580	$ 49,420	$ 64,807	$ 66,730	$ 65,061	$ 58,749	$ 62,288	$ 397,088
Net Income (loss) from Operations	$ -	$ 6,859	$ 4,726	$ 9,584	$ 75,756	$ 75,779	$ 14,301	$ 18,996	$ 32,773	$ 51,656	$ 290,430
Ratios											
Medical Loss Ratio	0.0%	88.3%	89.5%	86.0%	85.4%	85.4%	92.1%	92.5%	92.1%	90.4%	89.8%
Administrative/Revenue	0.0%	5.3%	6.8%	8.7%	5.7%	6.7%	6.5%	5.8%	5.1%	5.2%	5.9%
Contribution to Reserves	0.0%	6.4%	3.7%	5.3%	8.8%	7.8%	1.4%	1.7%	2.8%	4.4%	4.3%
MnDHO											
Premium Revenues	$ -	$ 13,225	$ 26,608	$ 40,704	$ 62,023	$ 76,527	$ 91,711	$ 106,997	$ 80,343	$ -	$ 498,138
Medical/Hospital Expenses	$ -	$ 12,552	$ 22,892	$ 41,184	$ 57,277	$ 70,776	$ 91,087	$ 102,711	$ 70,057	$ -	$ 468,536
Administrative Expenses	$ -	$ 676	$ 1,601	$ 2,531	$ 3,719	$ 4,853	$ 4,968	$ 6,538	$ 5,052	$ -	$ 29,938
Net Income (loss) from Operations	$ -	$ (3)	$ 2,116	$ (3,010)	$ 1,027	$ 898	$ (4,344)	$ (2,253)	$ 5,234	$ -	$ (335)
Ratios											
Medical Loss Ratio	0.0%	94.9%	86.0%	101.2%	92.3%	92.5%	99.3%	96.0%	87.2%	0.0%	94.1%
Administrative/Revenue	0.0%	5.1%	6.0%	6.2%	6.0%	6.3%	5.4%	6.1%	6.3%	0.0%	6.0%
Contribution to Reserves	0.0%	0.0%	8.0%	-7.4%	1.7%	1.2%	-4.7%	-2.1%	6.5%	0.0%	-0.1%
All Public Products											
Premium Revenues	$ 1,342,338	$ 1,656,012	$ 1,794,065	$ 2,031,931	$ 2,548,727	$ 2,834,910	$ 3,196,723	$ 3,771,214	$ 3,868,502	$ 3,949,356	$ 26,993,778
Medical/Hospital Expenses	$ 1,211,195	$ 1,497,544	$ 1,558,290	$ 1,844,136	$ 2,360,127	$ 2,576,126	$ 2,935,149	$ 3,390,677	$ 3,399,790	$ 3,513,507	$ 24,286,541
Administrative Expenses	$ 112,535	$ 102,964	$ 158,895	$ 173,064	$ 203,255	$ 235,896	$ 249,272	$ 282,090	$ 313,409	$ 347,325	$ 2,178,705
Net Income (loss) from Operations	$ 18,608	$ 55,504	$ 76,880	$ 14,731	$ (14,655)	$ 22,888	$ 12,302	$ 98,447	$ 155,303	$ 88,524	$ 528,532
Ratios											
Medical Loss Ratio	90.2%	90.4%	86.9%	90.8%	92.6%	90.9%	91.8%	89.9%	87.9%	89.0%	90.0%
Administrative/Revenue	8.4%	6.2%	8.9%	8.5%	8.0%	8.3%	7.8%	7.5%	8.1%	8.8%	8.1%
Contribution to Reserves	1.4%	3.4%	4.3%	0.7%	-0.6%	0.8%	0.4%	2.6%	4.0%	2.2%	2.0%
All Public Products excluding PGAMC											
Premium Revenues	$ 1,220,103	$ 1,499,512	$1,621,072	$1,827,631	$2,316,010	$2,668,559	$2,999,941	$3,518,048	$3,798,106	$3,949,356	$ 25,418,338
Medical/Hospital Expenses	$ 1,083,270	$ 1,333,037	$1,378,522	$1,633,659	$2,120,021	$2,389,485	$2,719,188	$3,120,759	$3,332,543	$3,513,507	$ 22,623,991
Administrative Expenses	$ 103,882	$ 94,932	$146,033	$158,932	$186,863	$222,072	$236,863	$268,349	$308,696	$347,325	$ 2,073,947
Net Income (loss) from Operations	$ 32,951	$ 71,543	$96,516	$35,074	$9,128	$56,819	$43,893	$128,938	$156,867	$88,524	$ 720,253
Ratios											
Medical Loss Ratio	88.8%	88.9%	85.0%	89.4%	91.5%	89.5%	90.6%	88.7%	87.7%	89.0%	89.0%
Administrative/Revenue	8.5%	6.3%	9.0%	8.7%	8.1%	8.3%	7.9%	7.6%	8.1%	8.8%	8.2%
Contribution to Reserves	2.7%	4.8%	6.0%	1.9%	0.4%	2.1%	1.5%	3.7%	4.1%	2.2%	2.8%

Investment Income	$ 7,252	$ 7,295	$ 12,954	$ 20,572	$ 30,190	$ 30,998	$ 8,850	$ 34,563	$ 26,691	$ 26,329	$ 205,694
Total contribution to Reserves	$ 25,860	$ 62,799	$ 89,834	$ 35,303	$ 15,535	$ 53,886	$ 21,152	$ 133,010	$ 181,994	$ 114,853	$ 734,226
Percent	1.9%	3.8%	5.0%	1.7%	0.6%	1.9%	0.7%	3.5%	4.7%	2.9%	2.7%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

** BluePlus, HealthPartners, Medica and UCare agreed to a 1% cap on profits for 2011 only. Contributions to Reserves shown above do not reflect any repayments to the State.

2011 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus***	First Plan	Health Partners***	Itasca Medical	Medica***	Metro Health	PrimeWest	South Country	Ucare Minnesota***	All Plans
PMAP										
Premium Revenues	$ 431,682	$ -	$ 221,150	$ 26,665	$ 637,484	$ 116,546	$ 100,505	$ 106,400	$ 471,682	$ 2,112,114
Medical/Hospital Expenses	$ 375,035	$ -	$ 199,699	$ 22,288	$ 580,754	$ 89,660	$ 74,037	$ 86,845	$ 395,531	$ 1,823,849
Administrative Expenses	$ 54,005	$ -	$ 16,620	$ 2,137	$ 51,358	$ 13,825	$ 10,808	$ 11,891	$ 70,526	$ 231,170
Net Income (loss) from Operations	$ 2,642	$ -	$ 4,831	$ 2,240	$ 5,372	$ 13,061	$ 15,660	$ 7,664	$ 5,625	$ 57,095
Ratios										
Medical Loss Ratio	86.9%	0.0%	90.3%	83.6%	91.1%	76.9%	73.7%	81.6%	83.9%	86.4%
Administrative/Revenue	12.5%	0.0%	7.5%	8.0%	8.1%	11.9%	10.8%	11.2%	15.0%	10.9%
Contribution to Reserves	0.6%	0.0%	2.2%	8.4%	0.8%	11.2%	15.6%	7.2%	1.2%	2.7%
MinnesotaCare										
Premium Revenues	$ 246,862	$ -	$ 81,233	$ 6,935	$ 174,529	$ 8,959	$ 9,325	$ 7,300	$ 115,018	$ 650,161
Medical/Hospital Expenses	$ 229,982	$ -	$ 75,662	$ 7,548	$ 170,624	$ 8,222	$ 9,250	$ 8,725	$ 106,508	$ 616,521
Administrative Expenses	$ 24,761	$ -	$ 6,198	$ 555	$ 12,256	$ 2,073	$ 1,129	$ (1,276)	$ 8,171	$ 53,867
Net Income (loss) from Operations	$ (7,881)	$ -	$ (627)	$ (1,168)	$ (8,351)	$ (1,336)	$ (1,054)	$ (149)	$ 339	$ (20,227)
Ratios										
Medical Loss Ratio	93.2%	0.0%	93.1%	108.8%	97.8%	91.8%	99.2%	119.5%	92.6%	94.8%
Administrative/Revenue	10.0%	0.0%	7.6%	8.0%	7.0%	23.1%	12.1%	-17.5%	7.1%	8.3%
Contribution to Reserves	-3.2%	0.0%	-0.8%	-16.8%	-4.8%	-14.9%	-11.3%	-2.0%	0.3%	-3.1%
MSHO										
Premium Revenues	$ 352,830	$ -	$ 102,564	$ 13,643	$ 314,658	$ 23,543	$ 57,824	$ 47,267	$ 274,752	$ 1,187,081
Medical/Hospital Expenses	$ 301,806	$ -	$ 86,849	$ 13,623	$ 293,873	$ 21,264	$ 55,923	$ 48,132	$ 251,667	$ 1,073,137
Administrative Expenses	$ 16,625	$ -	$ 6,571	$ 1,091	$ 12,420	$ 2,642	$ 4,057	$ 4,092	$ 14,790	$ 62,288
Net Income (loss) from Operations	$ 34,399	$ -	$ 9,144	$ (1,071)	$ 8,365	$ (363)	$ (2,156)	$ (4,957)	$ 8,295	$ 51,656
Ratios										
Medical Loss Ratio	85.5%	0.0%	84.7%	99.9%	93.4%	90.3%	96.7%	101.8%	91.6%	90.4%
Administrative/Revenue	4.7%	0.0%	6.4%	8.0%	3.9%	11.2%	7.0%	8.7%	5.4%	5.2%
Contribution to Reserves	9.7%	0.0%	8.9%	-7.9%	2.7%	-1.5%	-3.7%	-10.5%	3.0%	4.4%
All Public Products **										
Premium Revenues	$ 1,031,374	$ -	$ 404,947	$ 47,243	$ 1,126,671	$ 149,048	$ 167,654	$ 160,967	$ 861,452	$ 3,949,356
Medical/Hospital Expenses	$ 906,823	$ -	$ 362,210	$ 43,459	$ 1,045,251	$ 119,146	$ 139,210	$ 143,702	$ 753,706	$ 3,513,507
Administrative Expenses	$ 95,391	$ -	$ 29,389	$ 3,783	$ 76,034	$ 18,540	$ 15,994	$ 14,707	$ 93,487	$ 347,325
Net Income (loss) from Operations	$ 29,160	$ -	$ 13,348	$ 1	$ 5,386	$ 11,362	$ 12,450	$ 2,558	$ 14,259	$ 88,524
Ratios										
Medical Loss Ratio	87.9%	0.0%	89.4%	92.0%	92.8%	79.9%	83.0%	89.3%	87.5%	89.0%
Administrative/Revenue	9.2%	0.0%	7.3%	8.0%	6.7%	12.4%	9.5%	9.1%	10.9%	8.8%
Contribution to Reserves	2.8%	0.0%	3.3%	0.0%	0.5%	7.6%	7.4%	1.6%	1.7%	2.2%

Investment Income	$ 14,607	$ -	$ (131)	$ -	$ 6,729	$ 555	$ 21	$ 9	$4,539	$ 26,329
Total contribution to Reserves	$ 43,767	$ -	$ 13,217	$ 1	$ 12,115	$ 11,917	$ 12,471	$ 2,567	$ 18,798	$ 114,853
Percent	4.2%	0.0%	3.3%	0.0%	1.1%	8.0%	7.4%	1.6%	2.2%	2.9%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

** PGAMC phased out.

*** These plans agreed to a 1% cap on profits for PMAP and MinnesotaCare for 2011 only. Contributions to Reserves shown above do not reflect any repayments to the State.

2010 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus	First Plan	Health Partners	Itasca Medical	Medica	Metro Health	PrimeWest	South Country	Ucare Minnesota	All Plans
PMAP										
Premium Revenues	$ 367,274	$ -	$ 183,312	$ 21,531	$ 565,131	$ 90,060	$ 85,650	$ 130,186	$ 408,675	$ 1,851,819
Medical/Hospital Expenses	$ 299,117	$ -	$ 155,362	$ 18,835	$ 465,246	$ 69,417	$ 63,948	$ 105,221	$ 338,730	$ 1,515,876
Administrative Expenses	$ 31,925	$ -	$ 12,004	$ 1,799	$ 39,174	$ 19,959	$ 9,581	$ 13,625	$ 39,817	$ 167,884
Net Income (loss) from Operations	$ 36,232	$ -	$ 15,946	$ 897	$ 60,711	$ 684	$ 12,121	$ 11,340	$ 30,128	$ 168,059
Ratios										
Medical Loss Ratio	81.4%	0.0%	84.8%	87.5%	82.3%	77.1%	74.7%	80.8%	82.9%	81.9%
Administrative/Revenue	8.7%	0.0%	6.5%	8.4%	6.9%	22.2%	11.2%	10.5%	9.7%	9.1%
Contribution to Reserves	9.9%	0.0%	8.7%	4.2%	10.7%	0.8%	14.2%	8.7%	7.4%	9.1%
PGAMC										
Premium Revenues	$ 8,381	$ -	$ 12,728	$ 402	$ 22,446	$ 5,521	$ 1,433	$ 2,608	$ 16,877	$ 70,396
Medical/Hospital Expenses	$ 8,416	$ -	$ 11,585	$ 816	$ 24,706	$ 4,298	$ 1,224	$ 3,176	$ 13,026	$ 67,247
Administrative Expenses	$ 580	$ -	$ 642	$ 77	$ 933	$ 616	$ 115	$ 111	$ 1,639	$ 4,713
Net Income (loss) from Operations	$ (615)	$ -	$ 501	$ (491)	$ (3,193)	$ 607	$ 94	$ (679)	$ 2,212	$ (1,564)
Ratios										
Medical Loss Ratio	100.4%	0.0%	91.0%	203.0%	110.1%	77.8%	85.4%	121.8%	77.2%	95.5%
Administrative/Revenue	6.9%	0.0%	5.0%	19.2%	4.2%	11.2%	8.0%	4.3%	9.7%	6.7%
Contribution to Reserves	-7.3%	0.0%	3.9%	-122.1%	-14.2%	11.0%	6.6%	-26.0%	13.1%	-2.2%
MinnesotaCare										
Premium Revenues	$ 256,015	$ -	$ 87,828	$ 8,143	$ 188,610	$ 12,498	$ 8,984	$ 15,360	$ 129,821	$ 707,259
Medical/Hospital Expenses	$ 232,458	$ -	$ 82,284	$ 7,930	$ 203,804	$ 10,942	$ 11,923	$ 16,907	$ 113,199	$ 679,447
Administrative Expenses	$ 26,918	$ -	$ 5,759	$ 651	$ 25,686	$ 2,599	$ 1,173	$ 3,931	$ 10,294	$ 77,011
Net Income (loss) from Operations	$ (3,361)	$ -	$ (215)	$ (438)	$ (40,880)	$ (1,043)	$ (4,112)	$ (5,478)	$ 6,328	$ (49,199)
Ratios										
Medical Loss Ratio	90.8%	0.0%	93.7%	97.4%	108.1%	87.6%	132.7%	110.1%	87.2%	96.1%
Administrative/Revenue	10.5%	0.0%	6.6%	8.0%	13.6%	20.8%	13.1%	25.6%	7.9%	10.9%
Contribution to Reserves	-1.3%	0.0%	-0.2%	-5.4%	-21.7%	-8.3%	-45.8%	-35.7%	4.9%	-7.0%
MSHO										
Premium Revenues	$ 331,360	$ -	$ 93,962	$ 13,641	$ 320,694	$ 23,760	$ 67,579	$ 46,445	$ 261,244	$ 1,158,685
Medical/Hospital Expenses	$ 304,142	$ -	$ 81,514	$ 12,929	$ 300,909	$ 19,723	$ 58,716	$ 44,258	$ 244,972	$ 1,067,163
Administrative Expenses	$ 16,093	$ -	$ 7,588	$ 1,301	$ 12,772	$ 1,817	$ 4,416	$ (709)	$ 15,471	$ 58,749
Net Income (loss) from Operations	$ 11,125	$ -	$ 4,860	$ (589)	$ 7,013	$ 2,220	$ 4,447	$ 2,896	$ 801	$ 32,773
Ratios										
Medical Loss Ratio	91.8%	0.0%	86.8%	94.8%	93.8%	83.0%	86.9%	95.3%	93.8%	92.1%
Administrative/Revenue	4.9%	0.0%	8.1%	9.5%	4.0%	7.6%	6.5%	-1.5%	5.9%	5.1%
Contribution to Reserves	3.4%	0.0%	5.2%	-4.3%	2.2%	9.3%	6.6%	6.2%	0.3%	2.8%
MnDHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 80,343	$ 80,343
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 70,057	$ 70,057
Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,052	$ 5,052
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,234	$ 5,234
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	87.2%	87.2%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.3%	6.3%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.5%	6.5%
All Public Products										
Premium Revenues	$ 707,015	$ -	$ 290,002	$ 35,574	$ 908,271	$ 119,341	$ 154,662	$ 179,239	$ 767,139	$ 3,161,243
Medical/Hospital Expenses	$ 611,675	$ -	$ 248,461	$ 32,580	$ 790,861	$ 93,438	$ 123,888	$ 152,655	$ 666,785	$ 2,720,343
Administrative Expenses	$ 48,598	$ -	$ 20,234	$ 3,177	$ 52,879	$ 22,392	$ 14,112	$ 13,027	$ 61,979	$ 236,398
Net Income (loss) from Operations	$ 46,742	$ -	$ 21,307	$ (183)	$ 64,531	$ 3,511	$ 16,662	$ 13,557	$ 38,375	$ 204,502
Ratios										
Medical Loss Ratio	86.5%	0.0%	85.7%	91.6%	87.1%	78.3%	80.1%	85.2%	86.9%	86.1%
Administrative/Revenue	6.9%	0.0%	7.0%	8.9%	5.8%	18.8%	9.1%	7.3%	8.1%	7.5%
Contribution to Reserves	6.6%	0.0%	7.3%	-0.5%	7.1%	2.9%	10.8%	7.6%	5.0%	6.5%
All Public Products excluding PGAMC										
Premium Revenues	$ 698,634	$ -	$ 277,274	$ 35,172	$ 885,825	$ 113,820	$ 153,229	$ 176,631	$ 750,262	$ 3,090,847
Medical/Hospital Expenses	$ 603,259	$ -	$ 236,876	$ 31,764	$ 766,155	$ 89,140	$ 122,664	$ 149,479	$ 653,759	$ 2,653,096
Administrative Expenses	$ 48,018	$ -	$ 19,592	$ 3,100	$ 51,946	$ 21,776	$ 13,997	$ 12,916	$ 60,340	$ 231,685
Net Income (loss) from Operations	$ 47,357	$ -	$ 20,806	$ 308	$ 67,724	$ 2,904	$ 16,568	$ 14,236	$ 36,163	$ 206,066
Ratios										
Medical Loss Ratio	120.8%	0.0%	119.3%	115.2%	112.3%	91.7%	88.6%	96.0%	104.0%	110.0%
Administrative/Revenue	10.9%	0.0%	9.6%	11.3%	9.5%	22.0%	10.3%	9.9%	9.5%	10.3%
Contribution to Reserves	6.9%	0.0%	7.4%	-3.6%	-2.3%	0.8%	8.0%	-2.2%	6.7%	5.1%

Investment Income	$ 13,363	$ -	$ 147	$ 47	$ 8,033	$ 193	$ 27	$ 20	$5,155	$ 26,691
Total contribution to Reserves	$ 60,105	$ -	$ 21,454	$ (136)	$ 72,564	$ 3,704	$ 16,689	$ 13,577	$ 43,530	$ 231,193
Percent	8.5%	0.0%	7.4%	-0.4%	8.0%	3.1%	10.8%	7.6%	5.7%	7.3%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

2009 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus	First Plan	Health Partners	Itasca Medical	Medica	Metro Health	PrimeWest	South Country	Ucare Minnesota	All Plans
PMAP										
Premium Revenues	$ 318,339	$ 31,631	$ 180,175	$ 25,058	$ 526,813	$ 79,965	$ 81,037	$ 117,210	$ 334,489	$ 1,694,717
Medical/Hospital Expenses	$ 270,996	$ 28,341	$ 155,425	$ 24,349	$ 439,649	$ 61,196	$ 65,623	$ 100,811	$ 278,156	$ 1,424,546
Administrative Expenses	$ 27,757	$ 1,914	$ 11,632	$ 2,244	$ 38,202	$ 16,503	$ 8,341	$ 13,936	$ 30,114	$ 150,643
Net Income (loss) from Operations	$ 19,586	$ 1,377	$ 13,118	$ (1,535)	$ 48,963	$ 2,266	$ 7,073	$ 2,464	$ 26,218	$ 119,530
Ratios										
Medical Loss Ratio	85.1%	89.6%	86.3%	97.2%	83.5%	76.5%	81.0%	86.0%	83.2%	84.1%
Administrative/Revenue	8.7%	6.1%	6.5%	9.0%	7.3%	20.6%	10.3%	11.9%	9.0%	8.9%
Contribution to Reserves	6.2%	4.4%	7.3%	-6.1%	9.3%	2.8%	8.7%	2.1%	7.8%	7.1%
PGAMC										
Premium Revenues	$ 28,587	$ 6,263	$ 45,350	$ 2,231	$ 77,215	$ 20,274	$ 5,509	$ 10,252	$ 57,485	$ 253,166
Medical/Hospital Expenses	$ 34,492	$ 6,510	$ 49,147	$ 1,159	$ 84,580	$ 17,684	$ 5,861	$ 13,331	$ 57,154	$ 269,918
Administrative Expenses	$ 1,012	$ 348	$ 1,665	$ 107	$ 3,341	$ 2,882	$ 563	$ 492	$ 3,331	$ 13,741
Net Income (loss) from Operations	$ (6,917)	$ (595)	$ (5,462)	$ 965	$ (10,706)	$ (291)	$ (915)	$ (3,570)	$ (3,000)	$ (30,491)
Ratios										
Medical Loss Ratio	120.7%	103.9%	108.4%	51.9%	109.5%	87.2%	106.4%	130.0%	99.4%	106.6%
Administrative/Revenue	3.5%	5.6%	3.7%	4.8%	4.3%	14.2%	10.2%	4.8%	5.8%	5.4%
Contribution to Reserves	-24.2%	-9.5%	-12.0%	43.3%	-13.9%	-1.4%	-16.6%	-34.8%	-5.2%	-12.0%
MinnesotaCare										
Premium Revenues	$ 216,262	$ 17,370	$ 67,253	$ 7,117	$ 155,508	$ 10,162	$ 8,899	$ 12,348	$ 101,186	$ 596,105
Medical/Hospital Expenses	$ 195,527	$ 16,039	$ 65,786	$ 10,049	$ 144,989	$ 9,288	$ 9,813	$ 14,978	$ 90,861	$ 557,330
Administrative Expenses	$ 16,820	$ 1,205	$ 4,448	$ 926	$ 10,804	$ 2,514	$ 908	$ 1,335	$ 7,147	$ 46,107
Net Income (loss) from Operations	$ 3,914	$ 127	$ (2,981)	$ (3,858)	$ (284)	$ (1,641)	$ (1,822)	$ (3,965)	$ 3,177	$ (7,333)
Ratios										
Medical Loss Ratio	90.4%	92.3%	97.8%	141.2%	93.2%	91.4%	110.3%	121.3%	89.8%	93.5%
Administrative/Revenue	7.8%	6.9%	6.6%	13.0%	6.9%	24.7%	10.2%	10.8%	7.1%	7.7%
Contribution to Reserves	1.8%	0.7%	-4.4%	-54.2%	-0.2%	-16.1%	-20.5%	-32.1%	3.1%	-1.2%
MSHO										
Premium Revenues	$ 306,403	$ 33,357	$ 92,771	$ 7,805	$ 276,214	$ 27,532	$ 57,968	$ 49,720	$ 268,459	$ 1,120,229
Medical/Hospital Expenses	$ 288,245	$ 31,160	$ 76,377	$ 3,092	$ 261,463	$ 23,236	$ 57,279	$ 44,215	$ 251,105	$ 1,036,172
Administrative Expenses	$ 18,420	$ 1,325	$ 7,211	$ 285	$ 12,685	$ 2,676	$ 5,899	$ 2,036	$ 14,524	$ 65,061
Net Income (loss) from Operations	$ (262)	$ 871	$ 9,183	$ 4,429	$ 2,066	$ 1,620	$ (5,209)	$ 3,468	$ 2,830	$ 18,996
Ratios										
Medical Loss Ratio	94.1%	93.4%	82.3%	39.6%	94.7%	84.4%	98.8%	88.9%	93.5%	92.5%
Administrative/Revenue	6.0%	4.0%	7.8%	3.7%	4.6%	9.7%	10.2%	4.1%	5.4%	5.8%
Contribution to Reserves	-0.1%	2.6%	9.9%	56.7%	0.7%	5.9%	-9.0%	7.0%	1.1%	1.7%
MnDHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 106,997	$ 106,997
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 102,711	$ 102,711
Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,538	$ 6,538
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,253)	$ (2,253)
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	96.0%	96.0%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.1%	6.1%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-2.1%	-2.1%
All Public Products										
Premium Revenues	$ 869,591	$ 88,621	$ 385,549	$ 42,211	$ 1,035,750	$ 137,933	$ 153,413	$ 189,530	$ 868,616	$ 3,771,214
Medical/Hospital Expenses	$ 789,260	$ 82,050	$ 346,735	$ 38,649	$ 930,681	$ 111,404	$ 138,576	$ 173,335	$ 779,987	$ 3,390,677
Administrative Expenses	$ 64,009	$ 4,792	$ 24,956	$ 3,562	$ 65,032	$ 24,575	$ 15,711	$ 17,799	$ 61,654	$ 282,090
Net Income (loss) from Operations	$ 16,321	$ 1,780	$ 13,858	$ 1	$ 40,039	$ 1,954	$ (873)	$ (1,603)	$ 26,972	$ 98,449
Ratios										
Medical Loss Ratio	90.8%	92.6%	89.9%	91.6%	89.9%	80.8%	90.3%	91.5%	89.8%	89.9%
Administrative/Revenue	7.4%	5.4%	6.5%	8.4%	6.3%	17.8%	10.2%	9.4%	7.1%	7.5%
Contribution to Reserves	1.9%	2.0%	3.6%	0.0%	3.9%	1.4%	-0.6%	-0.8%	3.1%	2.6%
All Public Products excluding PGAMC										
Premium Revenues	$ 841,004	$ 82,358	$ 340,199	$ 39,980	$ 958,535	$ 117,659	$ 147,904	$ 179,278	$ 811,131	$ 3,518,048
Medical/Hospital Expenses	$ 754,768	$ 75,540	$ 297,588	$ 37,490	$ 846,101	$ 93,720	$ 132,715	$ 160,004	$ 722,833	$ 3,120,759
Administrative Expenses	$ 62,997	$ 4,444	$ 23,291	$ 3,455	$ 61,691	$ 21,693	$ 15,148	$ 17,307	$ 58,323	$ 268,349
Net Income (loss) from Operations	$ 23,238	$ 2,375	$ 19,320	$ (964)	$ 50,745	$ 2,245	$ 42	$ 1,967	$ 29,972	$ 128,940
Ratios										
Medical Loss Ratio	93.8%	99.6%	101.9%	96.7%	97.1%	94.7%	93.7%	96.7%	96.2%	96.4%
Administrative/Revenue	7.6%	5.9%	7.4%	9.8%	6.8%	21.0%	10.7%	10.0%	7.6%	8.0%
Contribution to Reserves	2.8%	2.1%	5.0%	-12.5%	5.1%	0.8%	-0.5%	-1.0%	4.2%	3.5%

Investment Income	$ 12,811	$ 246	$ (253)	$ 41	$ 13,856	$ 349	$ 674	$ 88	$ 6,751	$ 34,563
Total contribution to Reserves	$ 29,132	$ 2,026	$ 13,605	$ 42	$ 53,895	$ 2,303	$ (199)	$ (1,515)	$ 33,723	$ 133,012
Percent	3.4%	2.3%	3.5%	0.1%	5.2%	1.7%	-0.1%	-0.8%	3.9%	3.5%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

2008 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus	First Plan	Health Partners	Itasca Medical	Medica	Metro Health	PrimeWest	South Country	Ucare Minnesota	All Plans
PMAP										
Premium Revenues	$ 260,660	$ 26,821	$ 156,591	$ 23,930	$ 454,915	$ 71,508	$ 57,540	$ 96,033	$ 271,711	$ 1,419,709
Medical/Hospital Expenses	$ 222,743	$ 25,669	$ 130,065	$ 21,217	$ 384,121	$ 52,878	$ 44,661	$ 92,817	$ 239,151	$ 1,213,322
Administrative Expenses	$ 24,222	$ 2,013	$ 8,721	$ 2,038	$ 37,151	$ 14,928	$ 9,203	$ 8,180	$ 19,175	$ 125,631
Net Income (loss) from Operations	$ 13,695	$ (860)	$ 17,805	$ 676	$ 33,643	$ 3,703	$ 3,675	$ (4,964)	$ 13,385	$ 80,758
Ratios										
Medical Loss Ratio	85.5%	95.7%	83.1%	88.7%	84.4%	73.9%	77.6%	96.7%	88.0%	85.5%
Administrative/Revenue	9.3%	7.5%	5.6%	8.5%	8.2%	20.9%	16.0%	8.5%	7.1%	8.8%
Contribution to Reserves	5.3%	-3.2%	11.4%	2.8%	7.4%	5.2%	6.4%	-5.2%	4.9%	5.7%
PGAMC										
Premium Revenues	$ 23,036	$ 4,749	$ 33,390	$ 1,800	$ 61,445	$ 18,006	$ 3,627	$ 8,360	$ 42,369	$ 196,782
Medical/Hospital Expenses	$ 30,563	$ 6,022	$ 36,973	$ 1,027	$ 65,534	$ 15,997	$ 3,570	$ 11,192	$ 45,083	$ 215,961
Administrative Expenses	$ 862	$ 353	$ 1,905	$ 98	$ 2,996	$ 2,827	$ 575	$ 297	$ 2,496	$ 12,409
Net Income (loss) from Operations	$ (8,390)	$ (1,627)	$ (5,488)	$ 675	$ (7,084)	$ (819)	$ (519)	$ (3,129)	$ (5,210)	$ (31,591)
Ratios										
Medical Loss Ratio	132.7%	126.8%	110.7%	57.1%	106.7%	88.8%	98.4%	133.9%	106.4%	109.7%
Administrative/Revenue	3.7%	7.4%	5.7%	5.4%	4.9%	15.7%	15.9%	3.6%	5.9%	6.3%
Contribution to Reserves	-36.4%	-34.3%	-16.4%	37.5%	-11.5%	-4.5%	-14.3%	-37.4%	-12.3%	-16.1%
MinnesotaCare										
Premium Revenues	$ 176,179	$ 13,181	$ 53,140	$ 6,486	$ 119,190	$ 8,823	$ 5,375	$ 7,495	$ 78,481	$ 468,350
Medical/Hospital Expenses	$ 176,415	$ 14,183	$ 56,198	$ 9,240	$ 114,420	$ 8,807	$ 5,423	$ 10,259	$ 80,605	$ 475,550
Administrative Expenses	$ 14,962	$ 1,016	$ 3,137	$ 887	$ 9,945	$ 2,516	$ 849	$ 725	$ 5,497	$ 39,534
Net Income (loss) from Operations	$ (15,197)	$ (2,018)	$ (6,195)	$ (3,641)	$ (5,175)	$ (2,501)	$ (898)	$ (3,489)	$ (7,619)	$ (46,733)
Ratios										
Medical Loss Ratio	100.1%	107.6%	105.8%	142.5%	96.0%	99.8%	100.9%	136.9%	102.7%	101.5%
Administrative/Revenue	8.5%	7.7%	5.9%	13.7%	8.3%	28.5%	15.8%	9.7%	7.0%	8.4%
Contribution to Reserves	-8.6%	-15.3%	-11.7%	-56.1%	-4.3%	-28.3%	-16.7%	-46.6%	-9.7%	-10.0%
MSHO										
Premium Revenues	$ 288,985	$ 29,892	$ 83,649	$ 5,291	$ 249,602	$ 25,909	$ 56,040	$ 49,398	$ 231,405	$ 1,020,171
Medical/Hospital Expenses	$ 270,232	$ 27,167	$ 72,654	$ 2,738	$ 229,460	$ 22,949	$ 56,527	$ 42,755	$ 214,747	$ 939,229
Administrative Expenses	$ 18,294	$ 2,231	$ 7,541	$ 262	$ 12,762	$ 2,720	$ 8,829	$ 953	$ 13,138	$ 66,730
Net Income (loss) from Operations	$ 459	$ 494	$ 3,544	$ 2,291	$ 7,380	$ 240	$ (9,316)	$ 5,690	$ 3,519	$ 14,301
Ratios										
Medical Loss Ratio	93.5%	90.9%	86.9%	51.7%	91.9%	88.6%	100.9%	86.6%	92.8%	92.1%
Administrative/Revenue	6.3%	7.5%	9.0%	5.0%	5.1%	10.5%	15.8%	1.9%	5.7%	6.5%
Contribution to Reserves	0.2%	1.7%	4.2%	43.3%	3.0%	0.9%	-16.6%	11.5%	1.5%	1.4%
MnDHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 91,711	$ 91,711
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 91,087	$ 91,087
Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,968	$ 4,968
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (4,344)	$ (4,344)
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.3%	99.3%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.4%	5.4%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-4.7%	-4.7%
All Public Products										
Premium Revenues	$ 748,860	$ 74,643	$ 326,770	$ 37,507	$ 885,152	$ 124,246	$ 122,582	$ 161,286	$ 715,677	$ 3,196,723
Medical/Hospital Expenses	$ 699,953	$ 73,041	$ 295,890	$ 34,222	$ 793,535	$ 100,631	$ 110,181	$ 157,023	$ 670,673	$ 2,935,149
Administrative Expenses	$ 58,340	$ 5,613	$ 21,304	$ 3,285	$ 62,854	$ 22,991	$ 19,456	$ 10,155	$ 45,274	$ 249,272
Net Income (loss) from Operations	$ (9,433)	$ (4,011)	$ 9,666	$ 1	$ 28,764	$ 623	$ (7,058)	$ (5,892)	$ (269)	$ 12,391
Ratios										
Medical Loss Ratio	93.5%	97.9%	90.5%	91.2%	89.6%	81.0%	89.9%	97.4%	93.7%	91.8%
Administrative/Revenue	7.8%	7.5%	6.5%	8.8%	7.1%	18.5%	15.9%	6.3%	6.3%	7.8%
Contribution to Reserves	-1.3%	-5.4%	3.0%	0.0%	3.2%	0.5%	-5.8%	-3.7%	0.0%	0.4%
All Public Products excluding PGAMC										
Premium Revenues	$ 725,824	$ 69,894	$ 293,380	$ 35,707	$ 823,707	$ 106,240	$ 118,955	$ 152,926	$ 673,308	$ 2,999,941
Medical/Hospital Expenses	$ 669,390	$ 67,019	$ 258,917	$ 33,195	$ 728,001	$ 84,634	$ 106,611	$ 145,831	$ 625,590	$ 2,719,188
Administrative Expenses	$ 57,478	$ 5,260	$ 19,399	$ 3,187	$ 59,858	$ 20,164	$ 18,881	$ 9,858	$ 42,778	$ 236,863
Net Income (loss) from Operations	$ (1,043)	$ (2,384)	$ 15,154	$ (674)	$ 35,848	$ 1,442	$ (6,539)	$ (2,763)	$ 4,941	$ 43,982
Ratios										
Medical Loss Ratio	96.4%	104.5%	100.9%	95.8%	96.3%	94.7%	92.6%	102.7%	99.6%	97.8%
Administrative/Revenue	8.1%	8.2%	7.4%	9.8%	7.7%	21.8%	16.4%	6.9%	6.8%	8.4%
Contribution to Reserves	-0.5%	-5.8%	3.3%	-9.1%	3.9%	-0.2%	-5.8%	-7.7%	0.2%	0.8%

Investment Income	$ 12,854	$ 22	$ (314)	$ 163	$ (7,733)	$ 797	$ 674	$ 806	$ 1,581	$ 8,850
Total contribution to Reserves	$ 3,421	$ (3,989)	$ 9,352	$ 164	$ 21,031	$ 1,420	$ (6,384)	$ (5,086)	$ 1,312	$ 21,241
Percent	0.5%	-5.3%	2.9%	0.4%	2.4%	1.1%	-5.2%	-3.2%	0.2%	0.7%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

2007 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus	First Plan	Health Partners	Itasca Medical	Medica	Metro Health	PrimeWest	South Country	Ucare Minnesota	All Plans
PMAP										
Premium Revenues	$ 213,712	$ 19,757	$ 135,056	$ 21,120	$ 393,611	$ 62,586	$ 28,709	$ 83,995	$ 223,877	$ 1,182,423
Medical/Hospital Expenses	$ 207,912	$ 18,418	$ 125,667	$ 17,362	$ 339,773	$ 49,700	$ 23,975	$ 84,567	$ 200,223	$ 1,067,597
Administrative Expenses	$ 19,742	$ 1,516	$ 8,463	$ 2,719	$ 32,022	$ 13,649	$ 4,535	$ 11,510	$ 20,308	$ 114,464
Net Income (loss) from Operations	$ (13,942)	$ (177)	$ 926	$ 1,039	$ 21,818	$ (764)	$ 199	$ (12,083)	$ 3,346	$ 362
Ratios										
Medical Loss Ratio	97.3%	93.2%	93.0%	82.2%	86.3%	79.4%	83.5%	100.7%	89.4%	90.3%
Administrative/Revenue	9.2%	7.7%	6.3%	12.9%	8.1%	21.8%	15.8%	13.7%	9.1%	9.7%
Contribution to Reserves	-6.5%	-0.9%	0.7%	4.9%	5.5%	-1.2%	0.7%	-14.4%	1.5%	0.0%
PGAMC										
Premium Revenues	$ 16,795	$ 3,707	$ 26,506	$ 1,992	$ 53,208	$ 26,337	$ 1,490	$ 5,691	$ 30,625	$ 166,351
Medical/Hospital Expenses	$ 24,759	$ 5,221	$ 29,483	$ 1,703	$ 60,386	$ 22,586	$ 1,851	$ 6,723	$ 33,929	$ 186,641
Administrative Expenses	$ 732	$ 301	$ 1,462	$ 178	$ 2,505	$ 6,076	$ 235	$ 372	$ 1,963	$ 13,824
Net Income (loss) from Operations	$ (8,516)	$ (1,814)	$ (4,436)	$ 110	$ (9,682)	$ (2,326)	$ (597)	$ (1,403)	$ (5,267)	$ (33,931)
Ratios										
Medical Loss Ratio	147.4%	140.8%	111.2%	85.5%	113.5%	85.8%	124.2%	118.1%	110.8%	112.2%
Administrative/Revenue	4.4%	8.1%	5.5%	8.9%	4.7%	23.1%	15.8%	6.5%	6.4%	8.3%
Contribution to Reserves	-50.7%	-48.9%	-16.7%	5.5%	-18.2%	-8.8%	-40.1%	-24.7%	-17.2%	-20.4%
MinnesotaCare										
Premium Revenues	$ 168,572	$ 12,460	$ 50,275	$ 5,952	$ 111,661	$ 9,065	$ 3,056	$ 6,859	$ 76,209	$ 444,109
Medical/Hospital Expenses	$ 165,789	$ 12,628	$ 48,154	$ 8,151	$ 107,854	$ 8,042	$ 2,940	$ 6,268	$ 66,373	$ 426,199
Administrative Expenses	$ 13,019	$ 1,272	$ 3,252	$ 1,160	$ 8,929	$ 2,095	$ 483	$ 724	$ 7,014	$ 37,948
Net Income (loss) from Operations	$ (10,236)	$ (1,439)	$ (1,131)	$ (3,358)	$ (5,122)	$ (1,073)	$ (366)	$ (133)	$ 2,822	$ (20,036)
Ratios										
Medical Loss Ratio	98.3%	101.3%	95.8%	136.9%	96.6%	88.7%	96.2%	91.4%	87.1%	96.0%
Administrative/Revenue	7.7%	10.2%	6.5%	19.5%	8.0%	23.1%	15.8%	10.6%	9.2%	8.5%
Contribution to Reserves	-6.1%	-11.5%	-2.2%	-56.4%	-4.6%	-11.8%	-12.0%	-1.9%	3.7%	-4.5%
MSHO										
Premium Revenues	$ 272,202	$ 25,446	$ 75,813	$ 7,110	$ 232,871	$ 26,337	$ 56,458	$ 51,197	$ 218,066	$ 965,500
Medical/Hospital Expenses	$ 218,613	$ 23,864	$ 64,787	$ 3,120	$ 209,035	$ 22,586	$ 46,665	$ 41,981	$ 194,262	$ 824,913
Administrative Expenses	$ 14,017	$ 2,205	$ 6,205	$ 401	$ 9,004	$ 6,076	$ 8,918	$ 1,611	$ 16,370	$ 64,807
Net Income (loss) from Operations	$ 39,573	$ (622)	$ 4,821	$ 3,588	$ 14,831	$ (2,326)	$ 874	$ 7,606	$ 7,434	$ 75,779
Ratios										
Medical Loss Ratio	80.3%	93.8%	85.5%	43.9%	89.8%	85.8%	82.7%	82.0%	89.1%	85.4%
Administrative/Revenue	5.1%	8.7%	8.2%	5.6%	3.9%	23.1%	15.8%	3.1%	7.5%	6.7%
Contribution to Reserves	14.5%	-2.4%	6.4%	50.5%	6.4%	-8.8%	1.5%	14.9%	3.4%	7.8%
MnDHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 76,527	$ 76,527
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 70,776	$ 70,776
Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,853	$ 4,853
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 898	$ 898
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	92.5%	92.5%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.3%	6.3%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	1.2%
All Public Products										
Premium Revenues	$ 671,281	$ 61,370	$ 287,650	$ 36,174	$ 791,351	$ 124,325	$ 89,713	$ 147,742	$ 625,304	$ 2,834,910
Medical/Hospital Expenses	$ 617,073	$ 60,131	$ 268,091	$ 30,336	$ 717,048	$ 102,914	$ 75,431	$ 139,539	$ 565,563	$ 2,576,126
Administrative Expenses	$ 47,510	$ 5,294	$ 19,382	$ 4,458	$ 52,460	$ 27,896	$ 14,171	$ 14,217	$ 50,508	$ 235,896
Net Income (loss) from Operations	$ 6,879	$ (4,052)	$ 180	$ 1,379	$ 21,845	$ (6,489)	$ 110	$ (6,013)	$ 9,233	$ 23,072
Ratios										
Medical Loss Ratio	91.9%	98.0%	93.2%	83.9%	90.6%	82.8%	84.1%	94.4%	90.4%	90.9%
Administrative/Revenue	7.1%	8.6%	6.7%	12.3%	6.6%	22.4%	15.8%	9.6%	8.1%	8.3%
Contribution to Reserves	1.0%	-6.6%	0.1%	3.8%	2.8%	-5.2%	0.1%	-4.1%	1.5%	0.8%
All Public Products excluding PGAMC										
Premium Revenues	$ 654,486	$ 57,663	$ 261,144	$ 34,182	$ 738,143	$ 97,988	$ 88,223	$ 142,051	$ 594,679	$ 2,668,559
Medical/Hospital Expenses	$ 592,314	$ 54,910	$ 238,608	$ 28,633	$ 656,662	$ 80,328	$ 73,580	$ 132,816	$ 531,634	$ 2,389,485
Administrative Expenses	$ 46,778	$ 4,993	$ 17,920	$ 4,280	$ 49,955	$ 21,820	$ 13,936	$ 13,845	$ 48,545	$ 222,072
Net Income (loss) from Operations	$ 15,395	$ (2,238)	$ 4,616	$ 1,269	$ 31,527	$ (4,163)	$ 707	$ (4,610)	$ 14,500	$ 57,003
Ratios										
Medical Loss Ratio	94.3%	104.3%	102.7%	88.7%	97.1%	105.0%	85.5%	98.2%	95.1%	96.5%
Administrative/Revenue	7.5%	9.5%	7.5%	14.5%	7.2%	28.8%	16.2%	10.5%	8.6%	9.0%
Contribution to Reserves	-0.9%	-7.2%	0.8%	-7.2%	3.0%	-6.8%	0.1%	-11.0%	1.7%	0.3%

Investment Income	$ 14,869	$ 459	$ (742)	$ 343	$ (869)	$ 898	$ 1,765	$ 2,218	$ 12,057	$ 30,998
Total contribution to Reserves	$ 21,748	$ (3,593)	$ (562)	$ 1,722	$ 20,976	$ (5,591)	$ 1,875	$ (3,795)	$ 21,290	$ 54,070
Percent	3.2%	-5.9%	-0.2%	4.8%	2.7%	-4.5%	2.1%	-2.6%	3.4%	1.9%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

2006 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus	First Plan	Health Partners	Itasca Medical	Medica	Metro Health	PrimeWest	South Country	Ucare Minnesota	All Plans
PMAP										
Premium Revenues	$ 184,062	$ 14,127	$ 122,307	$ 16,858	$ 346,171	$ 52,257	$ 25,014	$ 38,830	$ 195,637	$ 995,263
Medical/Hospital Expenses	$ 189,677	$ 13,771	$ 123,710	$ 15,810	$ 346,540	$ 45,409	$ 21,582	$ 35,885	$ 179,408	$ 971,792
Administrative Expenses	$ 18,495	$ 1,215	$ 8,551	$ 1,379	$ 31,173	$ 11,309	$ 2,190	$ 6,379	$ 16,566	$ 97,257
Net Income (loss) from Operations	$ (24,110)	$ (859)	$ (9,954)	$ (331)	$ (31,542)	$ (4,460)	$ 1,242	$ (3,433)	$ (338)	$ (73,785)
Ratios										
Medical Loss Ratio	103.1%	97.5%	101.1%	93.8%	100.1%	86.9%	86.3%	92.4%	91.7%	97.6%
Administrative/Revenue	10.0%	8.6%	7.0%	8.2%	9.0%	21.6%	8.8%	16.4%	8.5%	9.8%
Contribution to Reserves	-13.1%	-6.1%	-8.1%	-2.0%	-9.1%	-8.5%	5.0%	-8.8%	-0.2%	-7.4%
PGAMC										
Premium Revenues	$ 33,154	$ 5,861	$ 35,218	$ 3,175	$ 78,105	$ 23,155	$ 3,714	$ 5,963	$ 44,372	$ 232,717
Medical/Hospital Expenses	$ 40,075	$ 6,744	$ 36,500	$ 2,728	$ 84,153	$ 16,718	$ 3,590	$ 6,559	$ 43,039	$ 240,106
Administrative Expenses	$ 1,608	$ 491	$ 2,018	$ 197	$ 4,165	$ 4,081	$ 325	$ 521	$ 2,986	$ 16,392
Net Income (loss) from Operations	$ (8,529)	$ (1,374)	$ (3,300)	$ 250	$ (10,213)	$ 2,356	$ (202)	$ (1,117)	$ (1,654)	$ (23,783)
Ratios										
Medical Loss Ratio	120.9%	115.1%	103.6%	85.9%	107.7%	72.2%	96.7%	110.0%	97.0%	103.2%
Administrative/Revenue	4.9%	8.4%	5.7%	6.2%	5.3%	17.6%	8.8%	8.7%	6.7%	7.0%
Contribution to Reserves	-25.7%	-23.4%	-9.4%	7.9%	-13.1%	10.2%	-5.4%	-18.7%	-3.7%	-10.2%
MinnesotaCare										
Premium Revenues	$ 164,741	$ 11,912	$ 43,317	$ 5,303	$ 98,827	$ 6,274	$ 586	$ 447	$ 67,237	$ 398,644
Medical/Hospital Expenses	$ 145,421	$ 10,716	$ 38,222	$ 8,444	$ 91,319	$ 4,858	$ 679	$ 460	$ 55,929	$ 356,048
Administrative Expenses	$ 14,619	$ 1,019	$ 3,189	$ 689	$ 8,655	$ 1,190	$ 51	$ 71	$ 6,984	$ 36,467
Net Income (loss) from Operations	$ 4,702	$ 177	$ 1,906	$ (3,832)	$ (1,148)	$ 227	$ (144)	$ (84)	$ 4,325	$ 6,129
Ratios										
Medical Loss Ratio	88.3%	90.0%	88.2%	159.2%	92.4%	77.4%	115.9%	102.9%	83.2%	89.3%
Administrative/Revenue	8.9%	8.6%	7.4%	13.0%	8.8%	19.0%	8.7%	15.9%	10.4%	9.1%
Contribution to Reserves	2.9%	1.5%	4.4%	-72.3%	-1.2%	3.6%	-24.6%	-18.8%	6.4%	1.5%
MSHO										
Premium Revenues	$ 231,923	$ 22,322	$ 54,613	$ 6,687	$ 228,610	$ 29,645	$ 53,216	$ 44,991	$ 188,073	$ 860,080
Medical/Hospital Expenses	$ 184,561	$ 18,566	$ 50,300	$ 2,577	$ 207,526	$ 23,842	$ 46,006	$ 34,724	$ 166,802	$ 734,904
Administrative Expenses	$ 8,365	$ 1,865	$ 4,718	$ 197	$ 8,531	$ 6,289	$ 4,660	$ 1,472	$ 13,323	$ 49,420
Net Income (loss) from Operations	$ 38,997	$ 1,893	$ (405)	$ 3,912	$ 12,552	$ (486)	$ 2,550	$ 8,795	$ 7,948	$ 75,756
Ratios										
Medical Loss Ratio	79.6%	83.2%	92.1%	38.5%	90.8%	80.4%	86.5%	77.2%	88.7%	85.4%
Administrative/Revenue	3.6%	8.4%	8.6%	2.9%	3.7%	21.2%	8.8%	3.3%	7.1%	5.7%
Contribution to Reserves	16.8%	8.5%	-0.7%	58.5%	5.5%	-1.6%	4.8%	19.5%	4.2%	8.8%
MnDHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 62,023	$ 62,023
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 57,277	$ 57,277
Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,719	$ 3,719
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,027	$ 1,027
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	92.3%	92.3%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.0%	6.0%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.7%	1.7%
All Public Products										
Premium Revenues	$ 613,880	$ 54,222	$ 255,455	$ 32,023	$ 751,713	$ 111,331	$ 82,530	$ 90,231	$ 557,342	$ 2,548,727
Medical/Hospital Expenses	$ 559,734	$ 49,797	$ 248,732	$ 29,559	$ 729,538	$ 90,827	$ 71,857	$ 77,628	$ 502,455	$ 2,360,127
Administrative Expenses	$ 43,087	$ 4,590	$ 18,476	$ 2,462	$ 52,524	$ 22,869	$ 7,226	$ 8,443	$ 43,578	$ 203,255
Net Income (loss) from Operations	$ 11,060	$ (163)	$ (11,753)	$ (1)	$ (30,351)	$ (2,363)	$ 3,446	$ 4,161	$ 11,308	$ (14,656)
Ratios										
Medical Loss Ratio	91.2%	91.8%	97.4%	92.3%	97.1%	81.6%	87.1%	86.0%	90.2%	92.6%
Administrative/Revenue	7.0%	8.5%	7.2%	7.7%	7.0%	20.5%	8.8%	9.4%	7.8%	8.0%
Contribution to Reserves	1.8%	-0.3%	-4.6%	0.0%	-4.0%	-2.1%	4.2%	4.6%	2.0%	-0.6%
All Public Products excluding PGAMC										
Premium Revenues	$ 580,726	$ 48,361	$ 220,237	$ 28,848	$ 673,608	$ 88,176	$ 78,816	$ 84,268	$ 512,970	$ 2,316,010
Medical/Hospital Expenses	$ 519,659	$ 43,053	$ 212,232	$ 26,831	$ 645,385	$ 74,109	$ 68,267	$ 71,069	$ 459,416	$ 2,120,021
Administrative Expenses	$ 41,479	$ 4,099	$ 16,458	$ 2,265	$ 48,359	$ 18,788	$ 6,901	$ 7,922	$ 40,592	$ 186,863
Net Income (loss) from Operations	$ 19,589	$ 1,211	$ (8,453)	$ (251)	$ (20,138)	$ (4,719)	$ 3,648	$ 5,278	$ 12,962	$ 9,127
Ratios										
Medical Loss Ratio	96.4%	103.0%	112.9%	102.5%	108.3%	103.0%	91.2%	92.1%	98.0%	101.9%
Administrative/Revenue	7.8%	9.8%	8.4%	9.8%	8.0%	25.3%	9.2%	10.8%	8.5%	9.0%
Contribution to Reserves	-2.4%	-0.4%	-4.7%	-17.4%	-6.2%	-3.2%	4.4%	-4.9%	2.3%	-2.1%
Investment Income	$ 2,217	$ 860	$ (748)	$ 325	$ 16,905	$ 898	$ 1,399	$ 1,564	$ 6,770	$ 30,190
Total contribution to Reserves	$ 13,277	$ 697	$ (12,501)	$ 324	$ (13,446)	$ (1,465)	$ 4,845	$ 5,725	$ 18,078	$ 15,534
Percent	2.2%	1.3%	-4.9%	1.0%	-1.8%	-1.3%	5.9%	6.3%	3.2%	0.6%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

2005 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus	First Plan	Health Partners	Itasca Medical	Medica	Metro Health	PrimeWest	South Country	Ucare Minnesota	All Plans
PMAP										
Premium Revenues	$ 243,313	$ 12,689	$ 137,360	$ 14,981	$ 397,663	$ 63,169	$ 38,704	$ 54,551	$ 217,346	$ 1,179,776
Medical/Hospital Expenses	$ 214,696	$ 11,054	$ 137,502	$ 15,131	$ 364,852	$ 52,372	$ 31,917	$ 47,816	$ 198,528	$ 1,073,868
Administrative Expenses	$ 20,114	$ 1,238	$ 10,483	$ 1,420	$ 32,051	$ 11,316	$ 3,975	$ 5,324	$ 17,880	$ 103,801
Net Income (loss) from Operations	$ 8,503	$ 396	$ (10,625)	$ (1,571)	$ 761	$ (518)	$ 2,813	$ 1,410	$ 938	$ 2,107
Ratios										
Medical Loss Ratio	88.2%	87.1%	100.1%	101.0%	91.7%	82.9%	82.5%	87.7%	91.3%	91.0%
Administrative/Revenue	8.3%	9.8%	7.6%	9.5%	8.1%	17.9%	10.3%	9.8%	8.2%	8.8%
Contribution to Reserves	3.5%	3.1%	-7.7%	-10.5%	0.2%	-0.8%	7.3%	2.6%	0.4%	0.2%
PGAMC										
Premium Revenues	$ 29,798	$ 4,950	$ 29,967	$ 2,587	$ 69,898	$ 21,158	$ 3,610	$ 5,291	$ 37,041	$ 204,300
Medical/Hospital Expenses	$ 34,286	$ 4,937	$ 32,583	$ 1,617	$ 73,929	$ 17,180	$ 3,931	$ 5,789	$ 36,225	$ 210,477
Administrative Expenses	$ 1,483	$ 478	$ 1,575	$ 152	$ 3,393	$ 3,662	$ 371	$ 522	$ 2,496	$ 14,132
Net Income (loss) from Operations	$ (5,972)	$ (497)	$ (4,191)	$ 818	$ (7,425)	$ 316	$ (692)	$ (1,020)	$ (1,680)	$ (20,343)
Ratios										
Medical Loss Ratio	115.1%	99.7%	108.7%	62.5%	105.8%	81.2%	108.9%	109.4%	97.8%	103.0%
Administrative/Revenue	5.0%	9.7%	5.3%	5.9%	4.9%	17.3%	10.3%	9.9%	6.7%	6.9%
Contribution to Reserves	-20.0%	-10.0%	-14.0%	31.6%	-10.6%	1.5%	-19.2%	-19.3%	-4.5%	-10.0%
MinnesotaCare										
Premium Revenues	$ 185,364	$ 12,686	$ 45,724	$ 5,724	$ 103,177	$ 6,353	$ 22	$ -	$ 67,997	$ 427,047
Medical/Hospital Expenses	$ 158,714	$ 11,498	$ 39,563	$ 4,509	$ 87,911	$ 5,683	$ 53	$ -	$ 55,730	$ 363,661
Administrative Expenses	$ 15,314	$ 1,231	$ 4,345	$ 463	$ 8,676	$ 1,228	$ 2	$ -	$ 5,761	$ 37,020
Net Income (loss) from Operations	$ 11,337	$ 53	$ 1,816	$ 752	$ 6,591	$ (557)	$ (33)	$ -	$ 6,506	$ 26,465
Ratios										
Medical Loss Ratio	85.6%	90.6%	86.5%	78.8%	85.2%	89.5%	240.9%	0.0%	82.0%	85.2%
Administrative/Revenue	8.3%	9.7%	9.5%	8.1%	8.4%	19.3%	9.1%	0.0%	8.5%	8.7%
Contribution to Reserves	6.1%	0.4%	4.0%	13.1%	6.4%	-8.8%	-150.0%	0.0%	9.6%	6.2%
MSHO										
Premium Revenues	$ 4,868	$ 1,065	$ 1,903	$ -	$ 70,504	$ 12,089	$ 12,148	$ 98	$ 77,429	$ 180,104
Medical/Hospital Expenses	$ 4,090	$ 797	$ 1,175	$ -	$ 64,364	$ 10,860	$ 8,677	$ 23	$ 64,960	$ 154,946
Administrative Expenses	$ 1,808	$ 103	$ 54	$ -	$ 3,900	$ 3,787	$ 614	$ 11	$ 5,303	$ 15,580
Net Income (loss) from Operations	$ (1,030)	$ 169	$ 674	$ -	$ 2,241	$ (2,558)	$ 2,858	$ 64	$ 7,166	$ 9,584
Ratios										
Medical Loss Ratio	84.0%	74.8%	61.7%	0.0%	91.3%	89.8%	71.4%	23.5%	83.9%	86.0%
Administrative/Revenue	37.1%	9.7%	2.8%	0.0%	5.5%	31.3%	5.1%	11.2%	6.8%	8.7%
Contribution to Reserves	-21.2%	15.9%	35.4%	0.0%	3.2%	-21.2%	23.5%	65.3%	9.3%	5.3%
MnDHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 40,704	$ 40,704
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 41,184	$ 41,184
Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,531	$ 2,531
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (3,010)	$ (3,010)
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	101.2%	101.2%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.2%	6.2%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-7.4%	-7.4%
All Public Products										
Premium Revenues	$ 463,343	$ 31,390	$ 214,954	$ 23,292	$ 641,242	$ 102,769	$ 54,484	$ 59,940	$ 440,517	$ 2,031,931
Medical/Hospital Expenses	$ 411,786	$ 28,286	$ 210,823	$ 21,257	$ 591,056	$ 86,095	$ 44,578	$ 53,628	$ 396,627	$ 1,844,136
Administrative Expenses	$ 38,719	$ 3,050	$ 16,457	$ 2,035	$ 48,020	$ 19,993	$ 4,962	$ 5,857	$ 33,971	$ 173,064
Net Income (loss) from Operations	$ 12,838	$ 121	$ (12,326)	$ (1)	$ 2,168	$ (3,317)	$ 4,946	$ 454	$ 9,920	$ 14,803
Ratios										
Medical Loss Ratio	88.9%	90.1%	98.1%	91.3%	92.2%	83.8%	81.8%	89.5%	90.0%	90.8%
Administrative/Revenue	8.4%	9.7%	7.7%	8.7%	7.5%	19.5%	9.1%	9.8%	7.7%	8.5%
Contribution to Reserves	2.8%	0.4%	-5.7%	0.0%	0.3%	-3.2%	9.1%	0.8%	2.3%	0.7%
All Public Products excluding PGAMC										
Premium Revenues	$ 433,545	$ 26,440	$ 184,987	$ 20,705	$ 571,344	$ 81,611	$ 50,874	$ 54,649	$ 403,476	$ 1,827,631
Medical/Hospital Expenses	$ 377,500	$ 23,349	$ 178,240	$ 19,640	$ 517,127	$ 68,915	$ 40,647	$ 47,839	$ 360,402	$ 1,633,659
Administrative Expenses	$ 37,236	$ 2,572	$ 14,882	$ 1,883	$ 44,627	$ 16,331	$ 4,591	$ 5,335	$ 31,475	$ 158,932
Net Income (loss) from Operations	$ 18,810	$ 618	$ (8,135)	$ (819)	$ 9,593	$ (3,633)	$ 5,638	$ 1,474	$ 11,600	$ 35,146
Ratios										
Medical Loss Ratio	95.0%	107.0%	114.0%	102.7%	103.5%	105.5%	87.6%	98.1%	98.3%	100.9%
Administrative/Revenue	9.0%	11.8%	9.0%	9.6%	8.5%	24.5%	10.1%	11.0%	8.5%	9.6%
Contribution to Reserves	2.6%	0.5%	-5.6%	-2.1%	0.8%	-5.8%	7.8%	0.8%	2.6%	1.1%

Investment Income	$ 440	$ 366	$ (454)	$ 202	$ 14,707	$ 483	$ 495	$ 661	$ 3,672	$ 20,572
Total contribution to Reserves	$ 13,278	$ 487	$ (12,780)	$ 201	$ 16,875	$ (2,834)	$ 5,441	$ 1,115	$ 13,592	$ 35,375
Percent	2.9%	1.6%	-5.9%	0.9%	2.6%	-2.8%	10.0%	1.9%	3.1%	1.7%

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2004 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus	First Plan	Health Partners	Itasca Medical	Medica	Metro Health	PrimeWest	South Country	Ucare Minnesota	All Plans
PMAP										
Premium Revenues	$ 205,743	$ 10,450	$ 111,611	$ 12,373	$ 352,974	$ 57,012	$ 34,342	$ 46,048	$ 187,471	$ 1,018,024
Medical/Hospital Expenses	$ 173,657	$ 9,487	$ 110,968	$ 11,256	$ 306,696	$ 47,147	$ 27,456	$ 34,885	$ 158,310	$ 879,862
Administrative Expenses	$ 17,141	$ 942	$ 8,986	$ 1,025	$ 36,933	$ 8,925	$ 3,139	$ 4,255	$ 14,790	$ 96,136
Net Income (loss) from Operations	$ 14,943	$ 21	$ (8,343)	$ 93	$ 9,346	$ 940	$ 3,747	$ 6,909	$ 14,371	$ 42,027
Ratios										
Medical Loss Ratio	84.4%	90.8%	99.4%	91.0%	86.9%	82.7%	79.9%	75.8%	84.4%	86.4%
Administrative/Revenue	8.3%	9.0%	8.1%	8.3%	10.5%	15.7%	9.1%	9.2%	7.9%	9.4%
Contribution to Reserves	7.3%	0.2%	-7.5%	0.8%	2.6%	1.6%	10.9%	15.0%	7.7%	4.1%
PGAMC										
Premium Revenues	$ 23,856	$ 3,987	$ 26,613	$ 2,068	$ 59,739	$ 20,174	$ 2,602	$ 4,149	$ 29,805	$ 172,993
Medical/Hospital Expenses	$ 28,393	$ 3,796	$ 28,255	$ 1,148	$ 62,897	$ 18,947	$ 2,701	$ 4,220	$ 29,411	$ 179,768
Administrative Expenses	$ 1,312	$ 355	$ 1,418	$ 105	$ 3,593	$ 3,456	$ 171	$ 383	$ 2,069	$ 12,862
Net Income (loss) from Operations	$ (5,849)	$ (163)	$ (3,060)	$ 815	$ (6,750)	$ (2,229)	$ (269)	$ (455)	$ (1,676)	$ (19,636)
Ratios										
Medical Loss Ratio	119.0%	95.2%	106.2%	55.5%	105.3%	93.9%	103.8%	101.7%	98.7%	103.9%
Administrative/Revenue	5.5%	8.9%	5.3%	5.1%	6.0%	17.1%	6.6%	9.2%	6.9%	7.4%
Contribution to Reserves	-24.5%	-4.1%	-11.5%	39.4%	-11.3%	-11.0%	-10.3%	-11.0%	-5.6%	-11.4%
MinnesotaCare										
Premium Revenues	$ 195,554	$ 13,713	$ 49,088	$ 6,141	$ 104,953	$ 6,412	$ -	$ -	$ 72,852	$ 448,713
Medical/Hospital Expenses	$ 152,109	$ 10,096	$ 42,949	$ 6,462	$ 87,211	$ 6,561	$ -	$ -	$ 56,110	$ 361,498
Administrative Expenses	$ 15,793	$ 1,226	$ 4,107	$ 588	$ 10,909	$ 1,228	$ -	$ -	$ 5,713	$ 39,564
Net Income (loss) from Operations	$ 27,652	$ 2,392	$ 2,032	$ (908)	$ 6,832	$ (1,378)	$ -	$ -	$ 11,028	$ 47,650
Ratios										
Medical Loss Ratio	77.8%	73.6%	87.5%	105.2%	83.1%	102.3%	0.0%	0.0%	77.0%	80.6%
Administrative/Revenue	8.1%	8.9%	8.4%	9.6%	10.4%	19.2%	0.0%	0.0%	7.8%	8.8%
Contribution to Reserves	14.1%	17.4%	4.1%	-14.8%	6.5%	-21.5%	0.0%	0.0%	15.1%	10.6%
MSHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ 56,865	$ 10,905	$ -	$ -	$ 59,957	$ 127,727
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ 50,845	$ 9,741	$ -	$ -	$ 53,684	$ 114,270
Administrative Expenses	$ -	$ -	$ -	$ -	$ 3,386	$ 1,882	$ -	$ -	$ 3,464	$ 8,732
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ 2,635	$ (718)	$ -	$ -	$ 2,809	$ 4,726
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	89.4%	89.3%	0.0%	0.0%	89.5%	89.5%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	6.0%	17.3%	0.0%	0.0%	5.8%	6.8%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	4.6%	-6.6%	0.0%	0.0%	4.7%	3.7%
MnDHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,608	$ 26,608
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 22,892	$ 22,892
Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,601	$ 1,601
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,116	$ 2,116
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	86.0%	86.0%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.0%	6.0%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.0%	8.0%
All Public Products										
Premium Revenues	$ 425,153	$ 28,150	$ 187,312	$ 20,582	$ 574,531	$ 94,503	$ 36,944	$ 50,197	$ 376,693	$ 1,794,065
Medical/Hospital Expenses	$ 354,159	$ 23,379	$ 182,172	$ 18,866	$ 507,649	$ 82,396	$ 30,157	$ 39,105	$ 320,407	$ 1,558,290
Administrative Expenses	$ 34,246	$ 2,523	$ 14,511	$ 1,718	$ 54,821	$ 15,491	$ 3,310	$ 4,638	$ 27,637	$ 158,895
Net Income (loss) from Operations	$ 36,746	$ 2,250	$ (9,371)	$ -	$ 12,063	$ (3,385)	$ 3,478	$ 6,454	$ 28,648	$ 76,883
Ratios										
Medical Loss Ratio	83.3%	83.1%	97.3%	91.7%	88.4%	87.2%	81.6%	77.9%	85.1%	86.9%
Administrative/Revenue	8.1%	9.0%	7.7%	8.3%	9.5%	16.4%	9.0%	9.2%	7.3%	8.9%
Contribution to Reserves	8.6%	8.0%	-5.0%	0.0%	2.1%	-3.6%	9.4%	12.9%	7.6%	4.3%
All Public Products excluding PGAMC										
Premium Revenues	$ 401,297	$ 24,163	$ 160,699	$ 18,514	$ 514,792	$ 74,329	$ 34,342	$ 46,048	$ 346,888	$ 1,621,072
Medical/Hospital Expenses	$ 325,766	$ 19,583	$ 153,917	$ 17,718	$ 444,752	$ 63,449	$ 27,456	$ 34,885	$ 290,996	$ 1,378,522
Administrative Expenses	$ 32,934	$ 2,168	$ 13,093	$ 1,613	$ 51,228	$ 12,035	$ 3,139	$ 4,255	$ 25,568	$ 146,033
Net Income (loss) from Operations	$ 42,595	$ 2,413	$ (6,311)	$ (815)	$ 18,813	$ (1,156)	$ 3,747	$ 6,909	$ 30,324	$ 96,519
Ratios										
Medical Loss Ratio	88.3%	96.8%	113.4%	101.9%	98.6%	110.9%	87.8%	84.9%	92.4%	96.1%
Administrative/Revenue	8.7%	10.7%	9.1%	9.1%	10.8%	21.4%	9.8%	10.4%	8.0%	10.0%
Contribution to Reserves	9.6%	9.3%	-5.1%	-2.3%	2.8%	-5.2%	10.3%	14.0%	8.5%	4.9%

Investment Income	$ 386	$ 185	$ (125)	$ 94	$ 8,922	$ 611	$ 142	$ 232	$ 2,507	$ 12,954
Total contribution to Reserves	$ 37,132	$ 2,435	$ (9,496)	$ 94	$ 20,985	$ (2,774)	$ 3,620	$ 6,686	$ 31,155	$ 89,837
Percent	8.7%	8.7%	-5.1%	0.5%	3.7%	-2.9%	9.8%	13.3%	8.3%	5.0%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

2003 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus	First Plan	Health Partners	Itasca Medical	Medica	Metro Health	PrimeWest	South Country	Ucare Minnesota	All Plans
PMAP										
Premium Revenues	$ 224,668	$ 9,821	$ 106,247	$ 11,276	$ 300,240	$ 59,418	$ 10,378	$ 42,837	$ 166,273	$ 931,158
Medical/Hospital Expenses	$ 201,010	$ 9,495	$ 105,612	$ 10,360	$ 270,217	$ 46,243	$ 8,170	$ 32,503	$ 144,407	$ 828,017
Administrative Expenses	$ 12,408	$ 619	$ 7,121	$ 774	$ 15,159	$ 7,385	$ 1,799	$ 3,802	$ 11,836	$ 60,903
Net Income (loss) from Operations	$ 11,250	$ (293)	$ (6,486)	$ 142	$ 14,864	$ 5,790	$ 409	$ 6,532	$ 10,030	$ 42,238
Ratios										
Medical Loss Ratio	89.5%	96.7%	99.4%	91.9%	90.0%	77.8%	78.7%	75.9%	86.8%	88.9%
Administrative/Revenue	5.5%	6.3%	6.7%	6.9%	5.0%	12.4%	17.3%	8.9%	7.1%	6.5%
Contribution to Reserves	5.0%	-3.0%	-6.1%	1.3%	5.0%	9.7%	3.9%	15.2%	6.0%	4.5%
PGAMC										
Premium Revenues	$ 25,681	$ 3,819	$ 25,714	$ 2,060	$ 50,510	$ 21,233	$ 471	$ -	$ 27,012	$ 156,500
Medical/Hospital Expenses	$ 32,835	$ 3,559	$ 27,252	$ 1,151	$ 54,165	$ 18,403	$ 371	$ -	$ 26,771	$ 164,507
Administrative Expenses	$ 867	$ 238	$ 1,047	$ 86	$ 915	$ 2,970	$ 82	$ -	$ 1,827	$ 8,032
Net Income (loss) from Operations	$ (8,021)	$ 22	$ (2,585)	$ 823	$ (4,570)	$ (140)	$ 18	$ -	$ (1,586)	$ (16,039)
Ratios										
Medical Loss Ratio	127.9%	93.2%	106.0%	55.9%	107.2%	86.7%	78.8%	0.0%	99.1%	105.1%
Administrative/Revenue	3.4%	6.2%	4.1%	4.2%	1.8%	14.0%	17.4%	0.0%	6.8%	5.1%
Contribution to Reserves	-31.2%	0.6%	-10.1%	40.0%	-9.0%	-0.7%	3.8%	0.0%	-5.9%	-10.2%
MinnesotaCare										
Premium Revenues	$ 203,265	$ 14,837	$ 51,029	$ 6,427	$ 91,747	$ 7,235	$ -	$ -	$ 73,034	$ 447,574
Medical/Hospital Expenses	$ 183,941	$ 13,410	$ 48,783	$ 6,878	$ 79,119	$ 6,235	$ -	$ -	$ 59,127	$ 397,493
Administrative Expenses	$ 11,744	$ 927	$ 3,469	$ 514	$ 4,570	$ 1,014	$ -	$ -	$ 5,394	$ 27,632
Net Income (loss) from Operations	$ 7,580	$ 500	$ (1,223)	$ (965)	$ 8,058	$ (14)	$ -	$ -	$ 8,513	$ 22,449
Ratios										
Medical Loss Ratio	90.5%	90.4%	95.6%	107.0%	86.2%	86.2%	0.0%	0.0%	81.0%	88.8%
Administrative/Revenue	5.8%	6.2%	6.8%	8.0%	5.0%	14.0%	0.0%	0.0%	7.4%	6.2%
Contribution to Reserves	3.7%	3.4%	-2.4%	-15.0%	8.8%	-0.2%	0.0%	0.0%	11.7%	5.0%
MSHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ 47,461	$ 9,989	$ -	$ -	$ 50,105	$ 107,555
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ 42,376	$ 10,833	$ -	$ -	$ 41,766	$ 94,975
Administrative Expenses	$ -	$ -	$ -	$ -	$ 1,579	$ 1,776	$ -	$ -	$ 2,366	$ 5,721
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ 3,506	$ (2,620)	$ -	$ -	$ 5,973	$ 6,859
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	89.3%	108.4%	0.0%	0.0%	83.4%	88.3%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	3.3%	17.8%	0.0%	0.0%	4.7%	5.3%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	7.4%	-26.2%	0.0%	0.0%	11.9%	6.4%
MnDHO										
Premium Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,225	$ 13,225
Medical/Hospital Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,552	$ 12,552
Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 676	$ 676
Net Income (loss) from Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (3)	$ (3)
Ratios										
Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	94.9%	94.9%
Administrative/Revenue	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.1%	5.1%
Contribution to Reserves	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
All Public Products										
Premium Revenues	$ 453,614	$ 28,477	$ 182,990	$ 19,763	$ 489,958	$ 97,875	$ 10,849	$ 42,837	$ 329,649	$ 1,656,012
Medical/Hospital Expenses	$ 417,786	$ 26,464	$ 181,647	$ 18,389	$ 445,877	$ 81,714	$ 8,541	$ 32,503	$ 284,623	$ 1,497,544
Administrative Expenses	$ 25,019	$ 1,784	$ 11,637	$ 1,374	$ 22,223	$ 13,145	$ 1,881	$ 3,802	$ 22,099	$ 102,964
Net Income (loss) from Operations	$ 10,809	$ 229	$ (10,294)	$ -	$ 21,858	$ 3,016	$ 427	$ 6,532	$ 22,927	$ 55,504
Ratios										
Medical Loss Ratio	92.1%	92.9%	99.3%	93.0%	91.0%	83.5%	78.7%	75.9%	86.3%	90.4%
Administrative/Revenue	5.5%	6.3%	6.4%	7.0%	4.5%	13.4%	17.3%	8.9%	6.7%	6.2%
Contribution to Reserves	2.4%	0.8%	-5.6%	0.0%	4.5%	3.1%	3.9%	15.2%	7.0%	3.4%
All Public Products excluding PGAMC										
Premium Revenues	$ 427,933	$ 24,658	$ 157,276	$ 17,703	$ 439,448	$ 76,642	$ 10,378	$ 42,837	$ 302,637	$ 1,499,512
Medical/Hospital Expenses	$ 384,951	$ 22,905	$ 154,395	$ 17,238	$ 391,712	$ 63,311	$ 8,170	$ 32,503	$ 257,852	$ 1,333,037
Administrative Expenses	$ 24,152	$ 1,546	$ 10,590	$ 1,288	$ 21,308	$ 10,175	$ 1,799	$ 3,802	$ 20,272	$ 94,932
Net Income (loss) from Operations	$ 18,830	$ 207	$ (7,709)	$ (823)	$ 26,428	$ 3,156	$ 409	$ 6,532	$ 24,513	$ 71,543
Ratios										
Medical Loss Ratio	90.0%	92.9%	98.2%	97.4%	89.1%	82.6%	78.7%	75.9%	85.2%	88.9%
Administrative/Revenue	5.6%	6.3%	6.7%	7.3%	4.8%	13.3%	17.3%	8.9%	6.7%	6.3%
Contribution to Reserves	4.4%	0.8%	-4.9%	-4.6%	6.0%	4.1%	3.9%	15.2%	8.1%	4.8%

Investment Income (includes PGAMC	$ 134	$ 15	$ 79	$ -	$ 4,107	$ 792	$ 19	$ 121	$ 2,216	$ 7,295
Total contribution to Reserves	$ 10,943	$ 244	$ (10,215)	$ -	$ 25,965	$ 3,808	$ 446	$ 6,653	$ 25,143	$ 62,799
Percent	2.4%	0.9%	-5.6%	0.0%	5.3%	3.9%	4.1%	15.5%	7.6%	3.8%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

2002 Health Plan Financial Summary by Program (in thousands $) Minnesota Public Programs Only

Program	Blue Plus	First Plan	Health Partners	Itasca Medical	Medica	Metro Health	PrimeWest	South Country	Ucare Minnesota	All Plans
PMAP										
Premium Revenues	$ 172,604	$ 9,000	$ 94,249	$ 9,196	$ 273,418	$ 65,689	$ -	$ 35,029	$ 141,524	$ 800,709
Medical/Hospital Expenses	$ 168,735	$ 8,985	$ 92,995	$ 7,913	$ 237,727	$ 51,120	$ -	$ 31,839	$ 125,714	$ 725,029
Administrative Expenses	$ 13,566	$ 502	$ 6,646	$ 670	$ 29,596	$ 6,231	$ -	$ 2,992	$ 11,008	$ 71,210
Net Income (loss) from Operations	$ (9,697)	$ (487)	$ (5,392)	$ 613	$ 6,095	$ 8,338	$ -	$ 198	$ 4,802	$ 4,470
Ratios										
Medical Loss Ratio	97.8%	99.8%	98.7%	86.0%	86.9%	77.8%	0.0%	90.9%	88.8%	90.5%
Administrative/Revenue	7.9%	5.6%	7.1%	7.3%	10.8%	9.5%	0.0%	8.5%	7.8%	8.9%
Contribution to Reserves	-5.6%	-5.4%	-5.7%	6.7%	2.2%	12.7%	0.0%	0.6%	3.4%	0.6%
PGAMC										
Premium Revenues	$ 18,209	$ 2,589	$ 17,860	$ 1,306	$ 37,814	$ 17,773	$ -	$ 3,696	$ 22,988	$ 122,235
Medical/Hospital Expenses	$ 21,073	$ 2,732	$ 20,101	$ 829	$ 43,124	$ 17,814	$ -	$ 2,032	$ 20,220	$ 127,925
Administrative Expenses	$ 940	$ 156	$ 793	$ 70	$ 2,759	$ 2,185	$ -	$ 191	$ 1,559	$ 8,653
Net Income (loss) from Operations	$ (3,804)	$ (299)	$ (3,034)	$ 407	$ (8,069)	$ (2,226)	$ -	$ 1,473	$ 1,209	$ (14,343)
Ratios										
Medical Loss Ratio	115.7%	105.5%	112.5%	63.5%	114.0%	100.2%	0.0%	55.0%	88.0%	104.7%
Administrative/Revenue	5.2%	6.0%	4.4%	5.4%	7.3%	12.3%	0.0%	5.2%	6.8%	7.1%
Contribution to Reserves	-20.9%	-11.5%	-17.0%	31.2%	-21.3%	-12.5%	0.0%	39.9%	5.3%	-11.7%
MinnesotaCare										
Premium Revenues	$ 192,164	$ 15,405	$ 48,965	$ 5,847	$ 79,154	$ 6,824	$ -	$ -	$ 71,035	$ 419,394
Medical/Hospital Expenses	$ 162,959	$ 13,668	$ 43,576	$ 6,331	$ 66,697	$ 6,375	$ -	$ -	$ 58,635	$ 358,241
Administrative Expenses	$ 12,999	$ 781	$ 3,691	$ 536	$ 8,538	$ 815	$ -	$ -	$ 5,312	$ 32,672
Net Income (loss) from Operations	$ 16,206	$ 956	$ 1,698	$ (1,020)	$ 3,919	$ (366)	$ -	$ -	$ 7,088	$ 28,481
Ratios										
Medical Loss Ratio	84.8%	88.7%	89.0%	108.3%	84.3%	93.4%	0.0%	0.0%	82.5%	85.4%
Administrative/Revenue	6.8%	5.1%	7.5%	9.2%	10.8%	11.9%	0.0%	0.0%	7.5%	7.8%
Contribution to Reserves	8.4%	6.2%	3.5%	-17.4%	5.0%	-5.4%	0.0%	0.0%	10.0%	6.8%
All Public Products										
Premium Revenues	$ 382,978	$ 26,994	$ 161,074	$ 16,349	$ 390,387	$ 90,286	$ -	$ 38,725	$ 235,546	$ 1,342,339
Medical/Hospital Expenses	$ 352,767	$ 25,385	$ 156,672	$ 15,073	$ 347,548	$ 75,309	$ -	$ 33,871	$ 204,570	$ 1,211,195
Administrative Expenses	$ 27,505	$ 1,439	$ 11,130	$ 1,276	$ 40,894	$ 9,231	$ -	$ 3,183	$ 17,878	$ 112,536
Net Income (loss) from Operations	$ 2,705	$ 170	$ (6,728)	$ -	$ 1,945	$ 5,746	$ -	$ 1,671	$ 13,099	$ 18,608
Ratios										
Medical Loss Ratio	92.1%	94.0%	97.3%	92.2%	89.0%	83.4%	0.0%	87.5%	86.8%	90.2%
Administrative/Revenue	7.2%	5.3%	6.9%	7.8%	10.5%	10.2%	0.0%	8.2%	7.6%	8.4%
Contribution to Reserves	0.7%	0.6%	-4.2%	0.0%	0.5%	6.4%	0.0%	4.3%	5.6%	1.4%
All Public Products excluding PGAMC										
Premium Revenues	$ 364,769	$ 24,405	$ 143,214	$ 15,043	$ 352,573	$ 72,513	$ -	$ 35,029	$ 212,558	$ 1,220,104
Medical/Hospital Expenses	$ 331,694	$ 22,653	$ 136,571	$ 14,244	$ 304,424	$ 57,495	$ -	$ 31,839	$ 184,350	$ 1,083,270
Administrative Expenses	$ 26,565	$ 1,283	$ 10,337	$ 1,206	$ 38,135	$ 7,046	$ -	$ 2,992	$ 16,319	$ 103,883
Net Income (loss) from Operations	$ 6,509	$ 469	$ (3,694)	$ (407)	$ 10,014	$ 7,972	$ -	$ 198	$ 11,890	$ 32,951
Ratios										
Medical Loss Ratio	90.9%	92.8%	95.4%	94.7%	86.3%	79.3%	0.0%	90.9%	86.7%	88.8%
Administrative/Revenue	7.3%	5.3%	7.2%	8.0%	10.8%	9.7%	0.0%	8.5%	7.7%	8.5%
Contribution to Reserves	1.8%	1.9%	-2.6%	-2.7%	2.8%	11.0%	0.0%	0.6%	5.6%	2.7%

Investment Income (includes PGAMC	$ 279	$ 115	$ 21	$ -	$ 1,952	$ 1,853	$ -	$ 140	$ 2,893	$ 7,252
Total contribution to Reserves	$ 2,984	$ 285	$ (6,707)	$ -	$ 3,897	$ 7,599	$ -	$ 1,811	$ 15,992	$ 25,860
Percent	0.8%	1.1%	-4.2%	0.0%	1.0%	8.4%	0.0%	4.7%	6.8%	1.9%

* An empty cell signifies that the corresponding Health Plan did not participate in the program for the given calendar year

APPENDIX 3: RATING TREND HISTORY BY PROGRAM

PMAP Rating Trend History

Calendar Year	Claims Experience Periods			3-Yr Wtd Avg[1]	3-Yr Wtd Avg - All Plans[1]	50/50 Wtd Avg[2]	Admin Trend Adj	Plan Trend Adj	Adj Plan Trend for Demo Rates	Demo Target	Final Demo Trend	Trend Factor	Trend Rebase Adj	Contribution to Reserves	FFS Hospital Rebase Adj	Other Adj	Final Rate Adj
2003	1998-99	1999-00	2000-01														
	6.90%	14.10%	3.50%	7.60%	8.30%	7.90%	-0.50%	1.30%	8.80%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2004	1999-00	2000-01	2001-02														
	7.70%	7.10%	13.50%	10.40%	10.60%	10.50%	-0.50%	0.00%	10.00%	10.06%	10.05%	1.1005	1.0115	0.9775	1.0000	0.9349	1.0172
2005	2000-01	2001-02	2002-03														
	7.10%	10.00%	12.70%	10.80%	11.00%	10.91%	0.73%	-0.43%	9.75%	7.85%	8.51%	1.0851	1.0031	0.9903	1.0000	0.9980	1.0757
2006	2001-02	2002-03	2003-04														
	10.90%	12.00%	5.20%	8.40%	9.10%	8.76%	-0.65%	0.00%	8.11%	6.40%	7.25%	1.0725	0.9811	0.9759	1.0000	1.0020	1.0289
2007	2002-03	2003-04	2004-05														
	11.80%	4.30%	10.00%	8.40%	7.60%	8.02%	-0.39%	1.00%	8.64%	6.25%	7.44%	1.0744	0.9964	1.0312	1.0000	1.0000	1.1039
2008	2003-04	2004-05	2005-06														
	4.74%	10.75%	5.28%	6.99%	6.33%	6.66%	-0.30%	1.00%	7.36%	6.65%	7.01%	1.0701	0.9945	1.0399	1.0300	1.0000	1.1399

[1] Weights are 17%/33%/50%
[2] Weights are 50%/50%

PMAP Rating Trend History

Calendar Year	Claims Experience Periods			3-Yr Wtd Avg[1]	3-Yr Wtd Avg - All Plans[1]	Experience Trend[2]	Benchmark Trend	Final Trend[2]	Indicated Rate Increase	Actual Rate Increase	Trend Factor	Trend Rebase Adj	Contribution to Reserves	FFS Hospital Rebase Adj	Other Adj	Final Rate Adj
2009	2005	2006	2007													
	10.00%	5.80%	8.00%	7.60%	8.70%	8.13%	6.30%	7.21%	6.28%	6.28%	1.0628	1.0000	1.0000	0.9917	0.9812	1.0342
2010	2006	2007	2008													
	5.20%	7.90%	5.50%	6.30%	7.20%	6.74%	5.56%	6.15%	3.59%	0.00%	1.0000	1.0084	1.0000	0.9943	1.0000	1.0027
2011	2007	2008	2009													
	7.40%	5.80%	3.80%	5.10%	5.20%	5.13%	5.34%	5.24%	0.00%	0.00%	1.0000	0.9890	1.0000	0.9944	1.0106	0.9939

[1] Weights are 17%/33%/50%
[2] Weights are 50%/50%

PGAMC Rating Trend History

Calendar Year	Claims Experience Periods			3-Yr Wtd Avg[1]	3-Yr Wtd Avg - All Plans[1]	50/50 Wtd Avg[2]	Admin Trend Adj	Plan Trend Adj	Adj Plan Trend for Demo Rates	Demo Target	Final Demo Trend	Trend Factor	Trend Rebase Adj	Contribution to Reserves	FFS Hospital Rebase Adj	Other Adj	Final Rate Adj
2003	1998-99	1999-00	2000-01														
	14.70%	4.70%	18.10%	13.10%	8.30%	10.70%	-0.50%	1.30%	11.50%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2004	1999-00	2000-01	2001-02														
	6.00%	16.30%	9.20%	11.00%	10.60%	10.80%	-0.50%	0.00%	10.30%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2005	2000-01	2001-02	2002-03														
	16.10%	16.20%	8.10%	12.10%	11.00%	11.56%	-1.00%	-0.43%	10.13%	0.00%	8.39%	1.0839	0.9982	1.0000	1.0000	1.0000	1.0819
2006	2001-02	2002-03	2003-04														
	14.60%	9.50%	8.30%	9.80%	9.10%	9.42%	-0.65%	0.00%	8.77%	8.52%	8.65%	1.0865	0.9889	1.0000	1.0000	1.0004	1.0749
2007	2002-03	2003-04	2004-05														
	9.40%	7.70%	4.00%	6.10%	7.60%	6.88%	-0.39%	1.00%	7.49%	8.54%	8.02%	1.0802	0.9854	1.0000	1.0010	1.0000	1.0655
2008	2003-04	2004-05	2005-06														
	7.45%	4.20%	8.22%	6.76%	6.33%	6.55%	-0.30%	1.00%	7.25%	8.45%	7.85%	1.0785	1.0012	1.0000	1.0150	1.2386	1.3575

[1] Weights are 17%/33%/50%
[2] Weights are 50%/50%

PGAMC Rating Trend History

Calendar Year	Claims Experience Periods			3-Yr Wtd Avg[1]	3-Yr Wtd Avg - All Plans[1]	Experience Trend[2]	Benchmark Trend	Final Trend[2]	Indicated Rate Increase	Actual Rate Increase	Trend Factor	Trend Rebase Adj	Contribution to Reserves	FFS Hospital Rebase Adj	Other Adj	Final Rate Adj
2009	2005	2006	2007													
	4.60%	8.70%	11.50%	9.40%	8.70%	9.04%	6.68%	7.86%	8.69%	8.78%	1.0878	0.9354	1.0000	0.9945	0.9957	1.0076
2010																
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.00%	1.0000	1.0055	1.0000	0.9962	1.0072	1.0089

[1] Weights are 17%/33%/50%
[2] Weights are 50%/50%

MNCare Rating Trend History

Calendar Year	Claims Experience Periods			3-Yr Wtd Avg[1]	3-Yr Wtd Avg - All Plans[1]	50/50 Wtd Avg[2]	Admin Trend Adj	Plan Trend Adj	Adj Plan Trend for Demo Rates	Demo Target	Final Demo Trend	Trend Factor	Trend Rebase Adj	Contribution to Reserves	FFS Hospital Rebase Adj	Other Adj	Final Rate Adj
2003	1998-99	1999-00	2000-01														
	8.10%	6.80%	9.30%	8.30%	8.30%	8.30%	-0.50%	1.20%	9.00%	N/A	9.00%	1.0900	0.9980	0.9780	1.0000	1.0003	1.0642
2004	1999-00	2000-01	2001-02														
	6.60%	9.00%	13.50%	10.80%	10.60%	10.70%	-0.50%	0.00%	10.20%	N/A	10.39%	1.1039	1.0127	0.9701	1.0000	0.9663	1.0479
2005	2000-01	2001-02	2002-03														
	8.80%	12.90%	10.10%	10.80%	11.00%	10.90%	-1.00%	-0.43%	9.47%	N/A	7.65%	1.0765	1.0000	1.0000	1.0000	1.0000	1.0765
2006	2001-02	2002-03	2003-04														
	11.80%	9.70%	6.80%	8.60%	9.10%	8.85%	-0.65%	0.00%	8.20%	5.27%	6.73%	1.0673	1.0000	1.0000	1.0000	1.0000	1.0673
2007	2002-03	2003-04	2004-05														
	9.60%	6.20%	3.90%	5.70%	7.60%	6.64%	-0.39%	1.00%	7.25%	5.81%	6.53%	1.0653	1.0000	1.0000	1.0000	1.0000	1.0653
2008	2003-04	2004-05	2005-06														
	5.03%	4.36%	5.01%	4.80%	6.33%	5.57%	-0.30%	1.00%	6.27%	6.23%	6.25%	1.0625	1.0000	1.0000	1.0000	1.0000	1.0625

[1] Weights are 17%/33%/50%
[2] Weights are 50%/50%

																	I
2009	2005	2006	2007														Adj
	3.30%	7.10%	16.10%	11.00%	8.70%	9.83%	6.84%	8.34%	13.74%	13.74%	1.1374	0.9920	1.0000	1.0000	0.9847	1.1111
2010	2006	2007	2008														
	5.30%	13.30%	8.30%	9.50%	7.20%	8.36%	6.23%	7.29%	18.35%	0.00%	1.0000	0.8450	1.0000	1.0000	1.0026	0.8472
2011	2007	2008	2009														
	15.40%	0.40%	6.10%	5.80%	5.20%	5.48%	5.90%	5.69%	1.14%	1.14%	1.0114	0.9921	1.0000	1.0000	1.0029	1.0063

[1] Weights are 17%/33%/50%
[2] Weights are 50%/50%

APPENDIX 4: *MATHEMATICA*
ENCOUNTER DATA USAGE BY SELECTED STATES

Table III.1. Selected States' Experience Collecting, Using, and Reporting Medicaid Encounter Data

	When managed care and encounter data collection began	State uses of encounter data	Encounter data validation	State requires health plans to report amounts paid to providers	Submission of encounter data to MSIS	Percentage of Medicaid enrollees in any Managed Care	Number of Managed Care Entities[a]
Arizona	AHCCCS (1982) ALTCS (1989) Encounter data required from the outset	Rate setting, performance and quality measurement and reporting	State staff including actuary	Yes	Yes	90.5	30
Delaware	Mandatory managed care since 1996; data collected since 2004/2005	Rate setting, performance and quality measurement and reporting	EQRO (Mercer) and actuary (Mercer)	Yes	Yes	77.4	3
Michigan	Managed care since 1982; data collected since 1997 dates of service	Rate setting, performance and quality measurement and reporting	State staff	Yes	Yes	86.2	36
Minnesota	Managed care since 1985; data collected since mid-to late 1990s	Rate setting, performance and quality measurement and reporting	State staff	No	Yes	63.8	8
New Jersey	Managed care since 1995; data collected since 1995	Performance and quality measurement and reporting	State staff	Yes	Yes	76.8	7
Oregon	Managed care since 1994/1995; data collected since 1995/1996	Rate setting, performance and quality measurement and reporting	Actuary on staff	Yes	Yes	86.7	32
Pennsylvania	Mandatory managed care since 1986; encounter data collected since 1997	Rate setting, performance and quality measurement and reporting	EQRO (IPRO) and actuary (Mercer)	Yes	No	81.7	67
Texas	Mandatory managed care began in 1993; data collected since late 1990s	Rate setting, performance and quality measurement and reporting	EQRO (Florida Institute for Child Health Policy)	Yes	Yes	66.9	25
Washington	Managed care began in 1994; mandatory data reporting began in the late 1990s	Rate setting, beginning to use for reporting	State staff including actuary	Yes	Yes	86.7	13

[a] CMS. "2010 Medicaid Managed Care Enrollment Report: Medicaid Managed Care Enrollment as of July 1, 2010 and Number of Managed Care Entities By State as of July 1, 2010."

Source: Collecting, Using and Reporting Encounter Data Final Report, October 19, 2011, Mathematica.

APPENDIX 5: SUMMARY OF ENROLLMENT AND CAPITATION PAID REPORT INFORMATION

Summary - Enrollment and Capitation Paid Report Information

Program	PMAP							MNCare			Combined
Year	Families with Children	Pregnant Women	Aged - Institutional	Aged - Non-Institutional	General Assistance	GMAC	Total	MinnesotaCare/ MA	MinnesotaCare	Total	Grand Total
CY 2002											
Member Months	2,329,632	73,412	191,848	243,920	58,436	175,018	3,072,266	860,291	935,274	1,795,565	4,867,831
Premium	$ 605,193,573	$ 48,822,945	$ 90,063,762	$ 149,654,376	$ 34,200,057	$ 89,089,659	$1,017,024,372	$ 132,358,357	$ 286,720,417	$ 419,078,774	$ 1,436,103,146
Average Rate	$ 260	$ 665	$ 469	$ 614	$ 585	$ 509	$ 331	$ 154	$ 307	$ 233	$ 295
CY 2003											
Member Months	2,652,837	82,908	189,189	267,826	64,247	217,535	3,474,542	844,937	966,701	1,811,638	5,286,180
Premium	$ 664,471,348	$ 59,520,645	$ 100,067,815	$ 181,104,035	$ 45,593,907	$ 116,791,297	$1,167,549,047	$ 133,211,969	$ 315,051,331	$ 448,263,300	$ 1,615,812,347
Average Rate	$ 250	$ 718	$ 529	$ 676	$ 710	$ 537	$ 336	$ 158	$ 326	$ 247	$ 306
Average Rate Change %	-3.6%	7.9%	12.7%	10.2%	21.3%	5.5%	1.5%	2.5%	6.3%	6.0%	3.6%
CY 2004											
Member Months	2,748,482	115,421	191,241	288,335	66,663	228,332	3,638,474	789,283	907,557	1,696,840	5,335,314
Premium	$ 689,413,553	$ 88,948,969	$ 111,276,538	$ 209,594,393	$ 48,412,802	$ 126,434,880	$1,274,081,135	$ 129,471,863	$ 295,529,046	$ 425,000,909	$ 1,699,082,044
Rate	$ 251	$ 771	$ 582	$ 727	$ 726	$ 554	$ 350	$ 164	$ 326	$ 250	$ 318
Average Rate Change %	0.1%	7.3%	10.0%	7.5%	2.3%	3.1%	4.2%	4.0%	-0.1%	1.2%	4.2%
CY 2005											
Member Months	2,932,659	120,462	184,710	306,521	78,585	245,821	3,868,758	746,137	868,983	1,615,120	5,483,878
Premium	$ 808,331,744	$ 97,157,163	$ 111,407,225	$ 223,150,270	$ 58,452,079	$ 140,614,234	$1,439,112,715	$ 126,550,668	$ 282,983,066	$ 409,533,734	$ 1,848,646,449
Average Rate	$ 276	$ 807	$ 603	$ 728	$ 744	$ 572	$ 372	$ 170	$ 326	$ 254	$ 337
Average Rate Change %	9.9%	4.7%	3.7%	0.2%	2.4%	3.3%	6.2%	3.4%	0.0%	1.2%	5.9%
CY 2006											
Member Months	2,965,792	127,586	186,790	337,735	91,183	242,366	3,951,452	643,984	768,981	1,412,965	5,364,417
Premium	$ 840,962,804	$ 102,460,318	$ 51,751,261	$ 197,608,153	$ 73,697,706	$ 152,210,262	$1,418,690,504	$ 114,269,892	$ 273,337,362	$ 387,607,254	$ 1,806,297,758
Average Rate	$ 284	$ 803	$ 277	$ 585	$ 808	$ 628	$ 359	$ 177	$ 355	$ 274	$ 337
Average Rate Change %	2.9%	-0.4%	-54.1%	-19.6%	8.7%	9.8%	-3.5%	4.6%	9.2%	8.2%	-0.1%
CY 2007											
Member Months	3,014,385	129,853	183,090	374,443	105,919	87,487	3,895,177	539,764	813,217	1,352,981	5,248,158
Premium	$ 983,956,890	$ 116,992,808	$ 51,320,430	$ 222,845,270	$ 92,548,176	$ 60,272,788	$1,527,936,362	$ 100,758,259	$ 325,194,164	$ 425,952,423	$ 1,953,888,785
Average Rate	$ 326	$ 901	$ 280	$ 595	$ 874	$ 689	$ 392	$ 187	$ 400	$ 315	$ 372
Average Rate Change %	15.1%	12.2%	1.2%	1.7%	8.1%	9.7%	9.3%	5.2%	12.5%	14.8%	10.6%
CY 2008											
Member Months	3,213,820	134,285	177,016	391,455	124,534	74,833	4,115,943	499,626	854,243	1,353,869	5,469,812
Premium	$1,160,600,493	$ 127,004,339	$ 49,838,296	$ 270,650,135	$ 130,826,044	$ 59,680,760	$1,798,600,067	$ 123,291,939	$ 326,360,711	$ 449,652,650	$ 2,248,252,717
Average Rate	$ 361	$ 946	$ 282	$ 691	$ 1,051	$ 798	$ 437	$ 247	$ 382	$ 332	$ 411
Average Rate Change %	10.6%	5.0%	0.4%	16.2%	20.2%	15.8%	11.4%	32.2%	-4.5%	5.5%	10.4%
CY 2009											
Member Months	3,577,196	138,074	173,983	405,477	139,496	95,653	4,529,879	475,373	961,880	1,437,253	5,967,132
Premium	$1,338,616,259	$ 137,264,122	$ 51,900,388	$ 293,121,160	$ 157,393,202	$ 77,553,334	$2,055,848,465	$ 134,580,445	$ 432,727,998	$ 567,308,443	$ 2,623,156,908
Average Rate	$ 374	$ 994	$ 298	$ 723	$ 1,128	$ 811	$ 454	$ 283	$ 450	$ 395	$ 440
Average Rate Change %	3.6%	5.1%	6.0%	4.6%	7.4%	1.7%	3.9%	14.7%	17.8%	18.8%	7.0%
CY 2010											
Member Months	3,946,685	137,980	167,834	416,545	34,884	26,890	4,730,818	514,116	1,186,727	1,700,843	6,431,661
Premium	$1,408,553,555	$ 128,466,027	$ 52,213,601	$ 298,046,404	$ 40,840,955	$ 22,561,680	$1,950,682,222	$ 125,173,039	$ 556,040,156	$ 681,213,195	$ 2,631,895,417
Average Rate	$ 357	$ 931	$ 311	$ 716	$ 1,171	$ 839	$ 412	$ 243	$ 469	$ 401	$ 409
Average Rate Change %	-4.6%	-6.3%	4.3%	-1.0%	3.8%	3.5%	-9.1%	-14.0%	4.2%	1.5%	-6.9%
8-Year Summary											
Total Rate Change %	37.4%	40.0%	-33.7%	16.6%	100.0%	64.8%	24.6%	58.2%	52.8%	71.6%	38.7%
Average Annual Rate Change %	4.0%	4.3%	-5.0%	1.9%	9.1%	6.4%	2.8%	5.9%	5.4%	7.0%	4.2%

APPENDIX 6: RISK ADJUSTMENT SUMMARY BY HEALTH PLANS AND ELIGIBILITY GROUP

State of Minnesota
Risk Adjustment Summary by Health Plan and Eligibility Group

		Calendar Year 2012 Persons	% Inc	Average Risk Factor	% Inc	Calendar Year 2011 Persons	% Inc	Average Risk Factor	% Inc	Calendar Year 2010 Persons	% Inc	Average Risk Factor	% Inc
Eligibility Group	**Health Plan**												
MA													
	Blue Plus	436,143	10.8%	1.2585	0.4%	393,568	12.4%	1.2530	0.4%	350,239	7.4%	1.2484	2.9%
	First Plan					20,557	-33.8%	0.7895	-43.3%	31,049	9.1%	1.3916	14.7%
	HealthPartners	242,379	5.4%	1.1837	-1.3%	230,062	9.4%	1.1995	-11.4%	210,266	4.9%	1.3540	16.5%
	Itasca Medical care	23,223	4.0%	1.3409	1.1%	22,331	6.0%	1.3264	7.7%	21,065	3.9%	1.2314	13.0%
	Medica	588,073	3.4%	1.2599	-0.9%	568,949	7.8%	1.2712	0.7%	527,659	4.3%	1.2619	1.8%
	Metropolitan Health Plan	81,270	-0.1%	1.1593	-5.1%	81,339	3.9%	1.2218	0.9%	78,262	-0.1%	1.2108	-1.6%
	PrimeWest	97,479	2.9%	1.2722	0.2%	94,748	8.4%	1.2692	2.0%	87,440	27.1%	1.2441	7.2%
	South Country	142,362	-7.8%	1.1247	-6.9%	154,389	7.9%	1.2084	-4.1%	143,057	7.9%	1.2603	17.6%
	Ucare Minnesota	486,693	10.0%	1.1618	0.6%	442,424	13.8%	1.1548	7.5%	388,915	9.7%	1.0744	-3.9%
MA		**2,097,622**	**4.4%**	**1.2171**	**-0.6%**	**2,008,367**	**9.3%**	**1.2248**	**2.0%**	**1,837,952**	**7.1%**	**1.2010**	**1.6%**
GAMC													
	Blue Plus	4,530	-89.0%	0.4521	-53.0%	41,361	-3.8%	0.9618	-21.8%	42,979	7.3%	1.2306	4.8%
	First Plan					3,788	-46.2%	0.9608	-27.4%	7,044	7.2%	1.3241	6.9%
	HealthPartners	3,995	-90.9%	0.4082	-58.4%	43,964	-5.3%	0.9814	-24.5%	46,424	8.8%	1.3002	3.0%
	Itasca Medical care	299	-90.0%	0.4538	-57.2%	2,983	-13.6%	1.0596	-13.3%	3,451	2.3%	1.2220	23.8%
	Medica	6,363	-91.3%	0.4908	-57.5%	72,910	-5.4%	1.1553	-22.5%	77,058	7.8%	1.4903	3.0%
	Metropolitan Health Plan	1,301	-91.9%	0.4595	-59.2%	16,014	-10.8%	1.1257	-23.0%	17,951	-0.2%	1.4623	-1.2%
	PrimeWest	1,192	-88.2%	0.4085	-53.5%	10,140	-8.2%	0.8776	-17.6%	11,051	36.5%	1.0649	12.5%
	South Country	1,842	-88.8%	0.4128	-56.3%	16,476	-7.8%	0.9440	-22.0%	17,870	10.8%	1.2096	12.0%
	Ucare Minnesota	5,708	-90.4%	0.4442	-56.0%	59,601	-0.5%	1.0095	-20.9%	59,872	13.7%	1.2765	-1.1%
GAMC		**25,230**	**-90.6%**	**0.4491**	**-56.8%**	**267,237**	**-5.8%**	**1.0400**	**-22.4%**	**283,700**	**9.5%**	**1.3402**	**2.5%**
MNCare ULH													
	Blue Plus	177,655	10.8%	1.4888	1.1%	160,281	8.1%	1.4729	5.5%	148,256	-3.9%	1.3967	4.8%
	First Plan					6,042	-35.6%	0.8700	-38.6%	9,386	-2.1%	1.4175	10.9%
	HealthPartners	57,141	23.8%	1.4776	0.2%	46,144	13.9%	1.4750	2.9%	40,524	-1.7%	1.4342	4.5%
	Itasca Medical care	4,393	1.2%	1.5942	-2.4%	4,341	-2.0%	1.6340	20.4%	4,431	-4.6%	1.3577	19.8%
	Medica	127,118	18.9%	1.5710	1.8%	106,899	14.3%	1.5437	6.3%	93,553	-0.2%	1.4524	3.2%
	Metropolitan Health Plan	6,317	22.8%	1.2556	0.4%	5,145	12.4%	1.2502	2.1%	4,579	-9.9%	1.2250	10.5%
	PrimeWest	7,071	33.7%	1.5450	-13.3%	5,287	50.1%	1.7825	-3.6%	3,523	75.1%	1.8482	18.9%
	South Country	7,489	24.9%	1.4910	-3.2%	5,997	65.0%	1.5398	16.1%	3,635	53.3%	1.3264	12.3%
	Ucare Minnesota	79,345	17.8%	1.5006	6.3%	67,350	15.3%	1.4117	5.3%	58,417	-2.8%	1.3410	3.6%
MNCare ULH		**466,529**	**14.5%**	**1.5110**	**2.0%**	**407,486**	**11.2%**	**1.4808**	**5.2%**	**366,304**	**-1.8%**	**1.4073**	**4.8%**
MNCare LH													
	Blue Plus	149,564	27.1%	1.2080	-1.3%	117,702	22.7%	1.2241	5.5%	95,929	10.6%	1.1603	7.3%
	First Plan					5,641	-39.8%	0.7207	-30.6%	9,372	7.7%	1.0378	2.6%
	HealthPartners	66,380	36.1%	1.0558	-10.4%	48,758	36.3%	1.1788	2.5%	35,767	21.0%	1.1499	11.2%
	Itasca Medical care	4,649	16.8%	1.2617	-7.3%	3,979	10.8%	1.3617	13.9%	3,591	11.6%	1.1954	26.5%
	Medica	114,594	29.4%	1.2588	-2.1%	88,562	33.5%	1.2862	4.8%	66,356	17.2%	1.2271	8.3%
	Metropolitan Health Plan	12,291	44.0%	1.1022	-4.9%	8,535	53.5%	1.1589	2.1%	5,561	28.5%	1.1351	-6.4%
	PrimeWest	8,649	27.9%	1.2110	0.4%	6,763	60.8%	1.2060	4.6%	4,206	74.5%	1.1532	-7.6%
	South Country	9,800	7.4%	1.2279	-3.9%	9,128	52.8%	1.2783	11.1%	5,975	51.2%	1.1510	3.9%
	Ucare Minnesota	94,776	34.6%	1.2093	-2.4%	70,437	38.8%	1.2390	9.7%	50,762	16.9%	1.1294	1.8%
MNCare LH		**460,703**	**28.1%**	**1.1991**	**-2.8%**	**359,505**	**29.5%**	**1.2331**	**5.9%**	**277,519**	**16.1%**	**1.1648**	**6.7%**
Total Population		**3,050,084**	**0.2%**	**1.2530**	**0.7%**	**3,042,595**	**10.0%**	**1.2439**	**0.4%**	**2,765,475**	**6.9%**	**1.2390**	**2.4%**

State of Minnesota
Risk Adjustment Summary by Health Plan and Eligibility Group

		Calendar Year 2009 Persons	% Inc	Average Risk Factor	% Inc	Calendar Year 2008 Persons	% Inc	Average Risk Factor	% Inc	Calendar Year 2007 Persons	% Inc	Average Risk Factor	% Inc
Eligibility Group	**Health Plan**												
MA													
	Blue Plus	326,068	1.4%	1.2135	4.1%	321,708	0.1%	1.1660	-16.0%	321,421	4.6%	1.3884	3.6%
	First Plan	28,460	7.7%	1.2134	-1.0%	26,415	19.1%	1.2253	-14.0%	22,182	-0.4%	1.4249	3.7%
	HealthPartners	200,536	1.8%	1.1627	4.3%	197,017	-0.2%	1.1151	-17.4%	197,418	3.6%	1.3500	5.5%
	Itasca Medical care	20,270	4.8%	1.0894	-1.3%	19,334	4.5%	1.1032	-14.8%	18,497	1.2%	1.2942	0.7%
	Medica	505,929	-2.3%	1.2399	2.4%	517,668	-1.4%	1.2110	-17.8%	525,112	1.8%	1.4737	3.9%
	Metropolitan Health Plan	78,310	-1.1%	1.2311	12.3%	79,188	-3.9%	1.0963	-17.9%	82,388	-1.6%	1.3360	4.6%
	PrimeWest	68,776	42.1%	1.1610	-4.7%	48,395	-0.1%	1.2187	-16.4%	48,463	0.9%	1.4584	9.7%
	South Country	132,608	12.2%	1.0720	11.5%	118,148	65.4%	0.9618	-28.7%	71,422	2.3%	1.3494	3.1%
	Ucare Minnesota	354,436	3.8%	1.1177	7.1%	341,594	1.2%	1.0433	-19.9%	337,406	4.7%	1.3022	4.4%
MA		**1,715,393**	**2.8%**	**1.1822**	**4.2%**	**1,669,467**	**2.8%**	**1.1348**	**-18.4%**	**1,624,309**	**2.9%**	**1.3909**	**4.2%**
GAMC													
	Blue Plus	40,050	-1.9%	1.1745	10.3%	40,809	2.8%	1.0647	-36.4%	39,702	6.6%	1.6729	3.4%
	First Plan	6,569	-1.8%	1.2388	1.6%	6,688	9.8%	1.2198	-31.0%	6,091	11.9%	1.7679	7.5%
	HealthPartners	42,662	4.5%	1.2623	9.3%	40,830	6.4%	1.1553	-33.4%	38,372	4.1%	1.7357	6.3%
	Itasca Medical care	3,372	6.3%	0.9872	1.9%	3,171	0.3%	0.9687	-39.4%	3,161	9.7%	1.5975	1.1%
	Medica	71,502	-2.3%	1.4466	8.2%	73,183	1.2%	1.3365	-32.4%	72,288	3.7%	1.9763	2.5%
	Metropolitan Health Plan	17,979	-4.7%	1.4804	4.4%	18,863	-1.9%	1.4176	-29.9%	19,222	-2.7%	2.0231	1.4%
	PrimeWest	8,094	38.2%	0.9469	-6.0%	5,855	6.1%	1.0074	-40.7%	5,517	8.4%	1.6987	8.6%
	South Country	16,129	14.8%	1.0798	18.9%	14,049	78.4%	0.9079	-45.1%	7,873	7.7%	1.6523	9.0%
	Ucare Minnesota	52,646	3.0%	1.2911	10.8%	51,116	6.5%	1.1652	-32.7%	47,977	11.1%	1.7309	4.1%
GAMC		**259,003**	**1.7%**	**1.3076**	**8.5%**	**254,564**	**6.0%**	**1.2057**	**-33.7%**	**240,203**	**5.6%**	**1.8198**	**3.5%**
MNCare ULH													
	Blue Plus	154,203	-12.7%	1.3325	3.4%	176,600	30.2%	1.2891	38.9%	135,673	-9.0%	0.9281	1.1%
	First Plan	9,587	-13.2%	1.2776	3.1%	11,051	36.2%	1.2394	45.0%	8,115	-7.6%	0.8549	-0.5%
	HealthPartners	41,244	-12.3%	1.3730	6.5%	47,051	28.3%	1.2889	45.7%	36,660	-8.2%	0.8847	0.0%
	Itasca Medical care	4,647	-6.5%	1.1332	-9.3%	4,971	38.3%	1.2493	48.3%	3,594	-8.5%	0.8424	-3.3%
	Medica	93,734	-11.3%	1.4078	5.1%	105,685	34.6%	1.3393	38.8%	78,523	-5.2%	0.9651	1.2%
	Metropolitan Health Plan	5,083	-14.2%	1.1083	-5.4%	5,925	13.7%	1.1722	46.1%	5,212	-11.7%	0.8025	-9.8%
	PrimeWest	2,012	47.9%	1.5545	10.2%	1,360		1.4108		354		0.7055	
	South Country	2,371	87.9%	1.1812	55.5%	1,262		0.7595		198		0.7844	
	Ucare Minnesota	60,076	-11.8%	1.2939	4.9%	68,112	27.7%	1.2330	38.3%	53,351	-8.1%	0.8913	-4.5%
MNCare ULH		**372,957**	**-11.6%**	**1.3432**	**4.2%**	**422,017**	**31.2%**	**1.2887**	**39.9%**	**321,680**	**-7.7%**	**0.9214**	**-0.1%**
MNCare LH													
	Blue Plus	86,722	0.0%	1.0810	13.6%	86,733	-45.0%	0.9515	-32.5%	157,836	-7.9%	1.4087	-0.6%
	First Plan	8,698	8.0%	1.0113	6.6%	8,050	-37.8%	0.9485	-26.2%	12,939	-5.1%	1.2846	-2.0%
	HealthPartners	29,568	7.9%	1.0338	13.0%	27,410	-41.6%	0.9148	-30.1%	46,941	-6.1%	1.3084	-0.6%
	Itasca Medical care	3,218	11.1%	0.9452	5.0%	2,897	-43.6%	0.9004	-36.5%	5,139	-8.6%	1.4181	3.9%
	Medica	56,639	4.7%	1.1328	14.3%	54,072	-44.0%	0.9907	-29.5%	96,626	-4.1%	1.4046	-0.6%
	Metropolitan Health Plan	4,328	5.2%	1.2123	10.1%	4,115	-40.0%	1.1008	-22.9%	6,863	-7.9%	1.4276	-10.7%
	PrimeWest	2,411	84.0%	1.2474	-1.7%	1,310		1.2695		655		1.2064	
	South Country	3,953	107.9%	1.1074	53.1%	1,901		0.7232		420		0.9293	
	Ucare Minnesota	43,439	9.0%	1.1092	16.2%	39,835	-39.2%	0.9549	-31.7%	65,486	-5.5%	1.3990	-0.8%
MNCare LH		**238,976**	**5.6%**	**1.0918**	**13.9%**	**226,323**	**-42.4%**	**0.9589**	**-31.0%**	**392,905**	**-6.0%**	**1.3907**	**-0.8%**
Total Population		**2,586,329**	**0.5%**	**1.2097**	**5.0%**	**2,572,371**	**-0.3%**	**1.1516**	**-16.1%**	**2,579,097**	**0.3%**	**1.3723**	**3.4%**

State of Minnesota
Risk Adjustment Summary by Health Plan and Eligibility Group

		Calendar Year 2006 Persons	% Inc	Average Risk Factor	% Inc	Calendar Year 2005 Persons	% Inc	Average Risk Factor	% Inc	Calendar Year 2004 Persons	% Inc	Average Risk Factor	% Inc	Calendar Year 2003 Persons	Average Risk Factor
Eligibility Group	**Health Plan**														
MA															
	Blue Plus	307,283	1.1%	1.3403	4.2%	303,865	3.7%	1.2868	-6.3%	293,007	26.5%	1.3727	-0.1%	231,676	1.3738
	First Plan	22,269	5.5%	1.3746	5.3%	21,107	6.7%	1.3050	-2.7%	19,785	24.2%	1.3412	4.0%	15,929	1.2898
	HealthPartners	190,477	6.0%	1.2796	4.6%	179,618	4.0%	1.2238	-4.9%	172,680	13.9%	1.2869	2.2%	151,663	1.2587
	Itasca Medical care	18,280	7.8%	1.2847	7.4%	16,960	6.5%	1.1963	2.9%	15,928	14.2%	1.1626	-4.2%	13,950	1.2135
	Medica	515,873	5.6%	1.4180	4.7%	488,398	10.1%	1.3547	13.9%	443,570	13.5%	1.1896	-13.6%	390,931	1.3765
	Metropolitan Health Plan	83,716	-0.5%	1.2774	5.7%	84,166	-4.9%	1.2079	-6.4%	88,526	0.3%	1.2900	-4.0%	88,237	1.3444
	PrimeWest	48,021	11.8%	1.3298	15.5%	42,961	282.5%	1.1512	73.1%	11,231		0.6650		-	-
	South Country	69,798	6.6%	1.3094	6.5%	65,479	6.4%	1.2297	-4.5%	61,526	33.6%	1.2873	20.7%	46,049	1.0664
	Ucare Minnesota	322,381	8.8%	1.2477	7.2%	296,377	13.4%	1.1641	-4.8%	261,414	12.8%	1.2225	-1.3%	231,827	1.2390
MA		**1,578,098**	**5.3%**	**1.3349**	**5.4%**	**1,498,931**	**9.6%**	**1.2670**	**-5.3%**	**1,367,667**	**16.9%**	**1.3377**	**1.4%**	**1,170,262**	**1.3196**
GAMC															
	Blue Plus	37,250	2.9%	1.6187	-0.3%	36,209	1.2%	1.6242	-1.5%	35,789	33.2%	1.6497	4.6%	26,861	1.5773
	First Plan	5,444	9.2%	1.6451	7.4%	4,985	6.7%	1.5319	1.5%	4,670	28.7%	1.5098	5.6%	3,628	1.4298
	HealthPartners	36,875	8.2%	1.6336	1.4%	34,072	6.7%	1.6107	-0.1%	31,930	32.2%	1.6129	1.1%	24,161	1.5959
	Itasca Medical care	2,881	3.1%	1.5797	10.4%	2,794	7.4%	1.4311	3.3%	2,602	27.4%	1.3850	-8.0%	2,043	1.5057
	Medica	69,691	6.1%	1.9273	1.9%	65,707	8.9%	1.8918	2.1%	60,359	26.0%	1.8523	6.8%	47,908	1.7352
	Metropolitan Health Plan	19,748	-5.6%	1.9953	1.7%	20,922	-7.1%	1.9615	8.5%	22,533	18.2%	1.8080	-0.1%	19,060	1.8104
	PrimeWest	5,089	34.7%	1.5648	14.0%	3,778	648.1%	1.3725	120.3%	505		0.6229		-	-
	South Country	7,308	9.6%	1.5153	8.8%	6,666	2.5%	1.3927	0.7%	6,502	46.3%	1.3834	9.6%	4,443	1.2626
	Ucare Minnesota	43,178	10.5%	1.6634	5.6%	39,083	14.2%	1.5746	3.0%	34,227	30.7%	1.5292	-1.2%	26,186	1.5477
GAMC		**227,464**	**6.2%**	**1.7582**	**2.4%**	**214,216**	**7.6%**	**1.7174**	**1.7%**	**199,117**	**29.1%**	**1.6889**	**2.7%**	**154,290**	**1.6439**
MNCare ULH															
	Blue Plus	149,154	-9.4%	0.9184	1.0%	164,708	-7.4%	0.9093	0.1%	177,899	-0.1%	0.9079	3.8%	178,070	0.8749
	First Plan	8,781	-8.4%	0.8587	8.5%	9,584	-9.6%	0.7915	-5.6%	10,599	-3.8%	0.8382	8.5%	11,015	0.7727
	HealthPartners	39,941	-8.5%	0.8849	5.1%	43,674	-9.8%	0.8421	-0.4%	48,423	3.5%	0.8452	-0.4%	46,783	0.8486
	Itasca Medical care	3,930	-8.4%	0.8707	-1.6%	4,291	-8.3%	0.8849	9.0%	4,678	-6.8%	0.8115	0.0%	5,017	0.8112
	Medica	82,793	-3.7%	0.9532	5.1%	86,012	-0.3%	0.9073	0.6%	86,237	13.8%	0.9020	4.1%	75,785	0.8663
	Metropolitan Health Plan	5,904	-10.9%	0.8895	8.4%	6,623	-12.3%	0.8202	6.8%	7,555	-1.2%	0.7683	4.2%	7,646	0.7370
	PrimeWest	11		0.2562										-	-
	South Country													-	-
	Ucare Minnesota	58,061	-9.1%	0.9332	11.9%	63,895	-8.8%	0.8337	-5.6%	70,034	-4.9%	0.8834	8.1%	73,616	0.8173
MNCare ULH		**348,575**	**-8.0%**	**0.9226**	**4.4%**	**378,787**	**-6.6%**	**0.8836**	**-0.8%**	**405,425**	**1.9%**	**0.8903**	**4.2%**	**397,932**	**0.8542**
MNCare LH															
	Blue Plus	171,294	-9.8%	1.4178	0.0%	189,968	-4.6%	1.4179	-1.4%	199,173	6.6%	1.4380	30.3%	186,795	1.1035
	First Plan	13,638	-10.4%	1.3103	-0.3%	15,223	-8.4%	1.3147	-2.9%	16,625	2.8%	1.3541	2.1%	16,169	1.3264
	HealthPartners	49,978	-7.5%	1.3161	0.2%	54,007	-5.4%	1.3139	-1.4%	57,073	12.3%	1.3327	-2.5%	50,822	1.3665
	Itasca Medical care	5,620	-11.0%	1.3655	4.0%	6,312	-5.7%	1.3125	2.1%	6,690	-0.1%	1.2856	-0.1%	6,698	1.2865
	Medica	100,809	-3.8%	1.4132	0.3%	104,843	5.4%	1.4086	-2.1%	99,510	22.2%	1.4381	5.3%	81,413	1.3653
	Metropolitan Health Plan	7,454	-12.0%	1.5980	8.2%	8,472	-4.7%	1.4770	3.0%	8,889	12.1%	1.4337	-2.4%	7,929	1.4695
	PrimeWest	48		0.3928										-	-
	South Country													-	-
	Ucare Minnesota	69,318	-7.9%	1.4109	4.3%	75,288	-4.6%	1.3521	-3.1%	78,955	3.9%	1.3957	5.0%	76,023	1.3292
MNCare LH		**418,159**	**-7.9%**	**1.4024**	**0.9%**	**454,113**	**-2.7%**	**1.3893**	**-1.7%**	**466,915**	**9.6%**	**1.4135**	**4.3%**	**425,849**	**1.3559**
Total Population		**2,572,296**	**1.0%**	**1.3274**	**4.6%**	**2,546,047**	**4.4%**	**1.2696**	**-2.8%**	**2,439,124**	**13.5%**	**1.3065**	**3.4%**	**2,148,333**	**1.2639**

APPENDIX 7: CMS CHECKLIST

Appendix A. PAHP, PIHP and MCO Contracts
Financial Review Documentation for At-risk Capitated Contracts Ratesetting
Edit Date: 7/22/03

State: _____
Contract Period: _____
Contractor:_____
(Put "model" if same for all)

Type of Program:
___ 1915(a)(1)(A) voluntary
___ State Plan Amendment
___ 1915(b) waiver
___ 1115 waiver
___ Other ___

Type of Entity:
___ MCO
___ HIO
___ PIHP
___ PAHP

Type of Review:
____ Initial
____ Renewal
____ Amendment
____ Rates Only

Reviewer: _____ Date: _____

Rate Checklist Instructions: This checklist is a tool for Regional Offices for use in approving rates under 42 CFR 438.6(c) for all capitated Medicaid managed care programs [1915(a)(1)(A), 1915(b), 1932(a), and 1115] excluding PACE capitated programs. See Attachment 1 to this Appendix for a listing of requirements for capitated rates. PACE capitated programs are still subject to Upper Payment Limit requirements under 42 CFR 460. 182. The PACE specific checklist should be used to approve PACE program rates. This checklist does not replace cost-effectiveness tests for 1915(b) waivers and budget neutrality for 1115 demonstrations. Some items only apply if the State has included a particular population, adjustment, program or policy for the managed care program. For example, if the State includes dual eligibles in its managed care program, the State must follow the regulations and statues outlined in item AA.2.2.

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
Subsection AA.1 – General					
AA.1.0	42 CFR 438. 6(c)(2)(i) and (ii) 42 CFR 438.806 SMM 2089.2, SMM 2092.8 SMM 2089.1	Overview of ratesetting methodology - The Contract must specify the payment rates and any risk-sharing mechanisms and the actuarial basis for computation of those rates and mechanisms: Specifically, the contract includes: __ The rates and the time period for the rates, __ The risk-sharing mechanisms, __ The actuarial basis for the computation of those rates and risk-sharing mechanisms (*a lay person's description of the general steps the State followed to set rates is sufficient).* *Rate Development or Update* *__ The State is developing a new rate (RO completes steps AA.1 - AA.7).* *__ The State is adjusting rates approved under 42 CFR 438.6(c)-(RO completes all of step AA.1)*	Contract		
AA.1.1	42 CFR 438.6(c)(1)(i)(A) and (C) 42 CFR 438.6(2)(i) and (ii) 42 CFR 438.6(c)(3)	Actuarial certification -The State must provide the actuarial certification of the capitation rates and payments under the contract. All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. Actuarially sound capitation rates means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices, are appropriate for the populations to be covered, and the services to be furnished under the contract; and the Actuary must submit a certification, as meeting the requirements of the regulation, by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board. *Note: An Actuary who is a member of the American Academy of Actuaries will sign his name followed by the designation M.A.A.A., meaning a Member of the American Academy of Actuaries. For further information see* www.actuary.org/faqs.htm	Required Documentation		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
	42 CFR 438.6(c)(4)(i) SMM 2089.2	*Note: Actuaries can create either rates or rate ranges so long as the methodology (including all assumptions) to get to the actual rates in the contract are specified and meet CMS requirements. If there are instances where actuaries believe that information their State is required to submit would represent trade secrets or proprietary information, as described in the Freedom of Information Act (FOIA) (5 U.S.C. 552(a)), the information should be identified as such and may be withheld from public disclosure under the provisions of the FOIA.*			
AA.1.2	42 CFR 438.6(c)(4)(iii)	Projection of expenditures -The State must provide a projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.	Contract or Documentation		
AA.1.3	45 CFR 74.43 and Appendix A 42 CFR 438.6(a) 42 CFR 438.806(a) and (b)	Procurement, Prior Approval and Ratesetting - All contracts must meet the procurement requirements in 45 CFR Part 74. Regardless of the procurement method, the final rates must be in the contract and include documentation and a description of how the resulting contract rates are determined in sufficient detail to address this set of regulatory criteria for each contract. In general, there are two options: ___ Option 1: State set rates -- The rates are developed using a set of assumptions meeting federal regulations that results in a set of rates. Open cooperative contracting occurs when the State signs a contract with any entity meeting the technical programmatic requirements of the State and willing to be reimbursed the actuarially-sound, State-determined rate. Sole source contracting occurs where the state contracts with a single entity to provide a set of services must be documented as meeting the requirements of 42 CFR 438.6(c) under this option. ___ Option 2: Competitive Procurement -- The rates are developed using a set of assumptions meeting federal regulations that results in a range of acceptable bids to determine a bid range for rates. Competitive procurement occurs when entities submit bids and the State negotiates rates within the range of acceptable bids. *A State could also disclose a maximum or minimum acceptable payment and encourage bids below or above that amount.*	Contract or Documentation		
AA.1.5	42 CFR 447.15 42 CFR 438.2 42 CFR 438.812(a)	Risk contracts – The entity assumes risk for the cost of services covered under the contract and incurs loss if the cost of furnishing the services exceed the payments under the contract. The entity must accept as payment in full, the amount paid by the State plus any cost sharing from the members. Payments for carrying out contract provisions including incentive payments are medical assistance costs.	State Regulation or Contract		
AA.1.6	42 CFR 438.60	Limit on payment to other providers - The State agency must ensure that no payment is made to a provider other than the entity for services available under the contract between the State and the entity, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract to make payments for graduate medical education. *Note: see Step AA.3.8 for GME adjustments.*	Contract or Documentation		
AA.1.7	42 CFR 438.6(c)(4)(i) and (ii) 42 CFR 438.6(c)(2)(i) and (ii) 42 CFR 438.6(c)(1)(i)(A) and (C)	Rate Modifications - *This section is for use if the State updates or amends rates set under the new regulation at 42 CFR 438.6(c).* The State has made program and rate changes that have affected the cost and utilization under the contract. The value and effect of these programmatic service changes on the rates should be documented. Adjustments for changes in the program structure or to reflect Medical trend inflation are made. Documentation meeting the requirements in step AA.3.0 – AA.3.24 is submitted to the RO for new adjustments. The adjustments include but are not limited to: • Medical cost and utilization trend inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. Justification for the predictability of the inflation rates is given regardless of the source. Differentiation of trend rates is documented (i.e., differences in the trend by service categories, eligibility category, etc). All trend factors and assumptions are explained and documented. See	Contract		

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	42 CFR 438.6(c)(3) 42 CFR 438.6(c)(4)(ii)(A) 42 CFR 438.6(c)(1)(B) 42 CFR 438.6(c)(3)(ii) and (iv) SMM 2089.5	Step AA.3.9. • Programmatic changes include additions and deletions to the contractor's benefit package, changes in the eligible population, or other programmatic changes in the managed care program (or FFS program that affected the managed care program) made after the last set of rates were set and outlined in the regulation. The State may adjust for those changes if the adjustment is made only once (e.g., if the State projected the effect of a change in the last rate setting, then they must back out that projection before applying an adjustment for the actual policy effect) CMS allows rate changes (regardless of whether they are reductions or augmentations) and provides FFP in such changes as long as the changes are implemented through either a formal contract amendment or a multi-period contract and continue to meet all applicable statute provisions and regulations. If rate changes are implemented through a contract amendment, the amendment must receive approval by the RO before FFP in any higher payment amounts may be awarded. If the rate change is an anticipated development in a multi-year process, it must also be reviewed by the RO, consistent with guidelines for multi-year contracts. *If the amended rates use new actuarial techniques or different utilization data bases than was used and approved previously, the regional office should complete the entire checklist. Rates approved prior to the release of 42 CFR 438.6 must comply with the regulation by the period specified in the Federal Register.*			
Subsection AA.2 – Base Year Utilization and Cost Data					
AA.2.0	42 CFR 438.6(c)(3)(i) and (iv) 42 CFR 438.6(c)(1)(i)(B)	Base Year Utilization and Cost Data - The State must provide documentation and an assurance that all payment rates are: • based only upon services covered under the State Plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration) • Provided under the contract to Medicaid -eligible individuals. *In setting actuarially sound capitation rates, the State must apply the following element or explain why it is not applicable: Base utilization and cost data that are derived from the Medicaid population or if not, are adjusted to make them comparable to the Medicaid population. The base data used were recent and are free from material omission. *Base data for both utilization and cost are defined and relevant to the Medicaid population (i.e., the database is appropriate for setting rates for the given Medicaid population). States without recent FFS history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the have the highest degree of reliability, subject to RO approval.* *Examples of acceptable databases on which to base utilization assumptions are: Medicaid FFS databases, Medicaid managed care encounter data, State employees health insurance databases, and low-income health insurance program databases. Note: Some states have implemented financial reporting requirements of the health plans which can be used as a data source in conjunction with encounter data and would improve on some of the shortcomings of these other specific databases used for utilization purposes. For example, some states now require the submission of financial reports to supplement encounter data by providing cost data. It would also be permissible for the State to supplement the encounter data by using FFS cost data. The State could use the cost and utilization data from a Medicaid FFS database and would not need to supplement the data with plan financial information.*	Required Documentation		

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		Note: The CMS RO may approve other sources not listed here based upon the reasonableness of the given data source. The overall intent of these reporting requirements is to collect the same information that is available in the encounter data, but in a more complete and accurate reflection of the true cost of services. Utilization data is appropriate to the Medicaid population and the base data was reviewed by the State for similarity with the covered Medicaid population. That is, if the utilization assumptions are not derived from recent Medicaid experience, the State should explain and document the source of assumptions and why the assumptions are appropriate to the Medicaid population covered by these proposed rates. Service cost assumptions are appropriate for a Medicaid program and the base data was reviewed by the State for similarity with the Medicaid program's current costs. *Note: except in the case of payments to FQHCs that subcontract with entities, which are governed by section 1903(m)(2)(A)(ix), CMS does not regulate the payment rates between entities and subcontracting providers. Payment rates are adequate to the extent that the capitated entity has documented the adequacy of its network.* *The term "appropriate" means specific to the population for which the payment rate is intended. This requirement applies to individuals who have health care costs that are much higher than the average. Appropriate for the populations covered means that the rates are based upon specific populations, by eligibility category, age, gender, locality, and other distinctions decided by the State. Appropriate to the services to be covered means that the rates must be based upon the State plan services to be provided under the contract. There is no stated or implied requirement that entities be reimbursed the full cost of care at billed charges.*			
AA.2.1	42 CFR 438.6(c)(1)(i)(B) 42 CFR 438.6(c)(4)(ii)(B)	Medicaid Eligibles under the Contract – All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. Actuarially sound capitation rates means capitation rates are appropriate for the populations to be covered and provided under the contract to Medicaid -eligible individuals. *The State may either include only data for eligible individuals and exclude data for individuals in the base period who would not be eligible for managed care contract services or apply an appropriate adjustment factor to the data to remove ineligibles if sufficient documentation exists. The explanation and documentation should list the eligibility categories specifically included and excluded from the analysis.* *Note: for example, if mentally retarded individuals are not in the managed care program, utilization, eligibility and cost data for mentally retarded eligibles should all be excluded from the rates.* *Note: all references in this checklist to Medicaid eligibles include 1115 expansion populations approved under 1115 demonstration projects.*	Required Documentation		
AA.2.2	1905(p) (1-3) SMM 3490 (ff) SMD letter 9/30/00	Dual Eligibles (DE)–Some States include capitation payments for DE. Because the statute and CMS policy specifies that the State may only pay for Medicaid-eligible individuals, those Medicaid payment limits must be observed if the program includes DE. See the Attachment to Appendix A for additional information on Dual Eligibles. Only the following groups of DE are entitled to Medicaid Services. If they are included in a capitated managed care contract, they should have a Medicaid rate calculated separately from other DE: ■ QMB Plus ■ Medicaid (Non QMB and Non SLMB)	Contract or Documentation		

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		■ SLMB Plus Eligibles and services for beneficiaries in the four non-Medicaid DE categories ■ QMB-only ■ QDWI ■ SLMB-only ■ QI-1 should be specifically excluded from the capitated rates calculated for the 3 DE categories above (QMB Plus, Medicaid (Non QMB and Non-SLMB), and SLMB Plus). If DE beneficiaries in the non-Medicaid four categories are allowed to choose to enroll in capitated managed care, the Medicaid State Agency would continue to be liable for the same Medicare payments (e.g., Medicare fee-for-service premiums) as under FFS. The beneficiary would be liable for any Medicaid services payment because they are not eligible for Medicaid services: For QMB-only and QMB-Plus, the State may also need to calculate a separate payment to the capitated organization for Medicare cost-sharing or premium amounts. If the M+C organization charges monthly premiums,. Medicaid is liable for payment of monthly M+C premium amounts for QMB categories (QMB-only and QMB Plus) for the basic packages of Medicare covered benefits only, if so elected in the Medicaid State plan (State Plan preprint page 29, 3.2(a)(1)(i)). Medicaid is also liable for Medicare cost-sharing expenses (deductibles, coinsurance and copayments) for Medicare covered services to the payment amount specified in the Medicaid State plan (Supplement 1 to Attachment 4.19-B). When an M+C organization imposes cost-sharing charges in addition to premiums for Medicare-covered services on their enrollees, the Medicaid agency must pay those costs for QMBs regardless of whether the State elected to include premiums in cost-sharing. No Medicaid services or payments would be included in the payment calculated for the entity.			
AA.2.3	42 CFR 435.1002(b) 1903(f)(2)(A) SMM 3645	<u>Spenddown</u> – FFP is not available for expenses that are the recipient's liability for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income. Spenddown is the amount of money that an individual with income over Medicaid eligibility limits must spend on medical expenses prior to gaining Medicaid eligibility. The spenddown amount is equal to the dollar amount the individual's income is over the Medicaid income limit. 42 CFR 435 Subpart D. States have two methods for calculating spenddown. Regardless of the option selected by the State, the State should not request federal Medicaid match for expenses that are the recipient's libility. Typically this means that capitated rates must be calculated without including expenses that are the recipient's liability. 1. Regular method – The individual client collects documentation verifying that a medical expense has occurred and submits to the State. States must ensure that capitation rates for individuals with spenddown (both medically needy beneficiaries and beneficiaries in 209(b) States with spenddown amounts) are calculated without including expenses that are the recipient's liability. 2. Pay-in method – The individual client pays a monthly installment payment or lump sum payment to the State equal to the spenddown amount rather than collecting documentation on medical expenses and submitting that documentation to the case worker. The same income and resource standards apply as in the regular method. The State then tracks the client's medical costs to ensure that the costs exceed the spendown amount. Here the State sets capitation rates to include expenses that are of the recipient's	Contract or Documentation		

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		liability and must ensure that the federal government receives its share of the monthly or lump sum payment from the client.			
AA.2.4	42 CFR 438.6(c)(1)(i)(B) 42 CFR 438.6(c)(4)(ii)(A)	State Plan Services only - The State must document that the actuarially sound capitation rates are appropriate for the services to be furnished under the contract and based only upon services covered under the State Plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration). *The explanation and documentation should list the services specifically included and excluded from the analysis.* Services provided by the managed care plan that exceed the services covered in the Medicaid State Plan may not be used to set capitated Medicaid managed care rates (e.g., 1915(b)(3) waiver services or services outlined in 42 CFR 438.6(e) as referenced in AA 2.5. • *States using entity **encounter data** may base utilization and service costs on non-FFS data adjusting the data to reflect State plan services only.* • ***Services not part of the State plan** that are unilaterally contractually required or "suggested" (typically authorized as "1915(b)(3) services") may not be used to calculate actuarially sound rates and must be paid out of separate payment rates approved prospectively under the 1915(b) waiver process.* • ***EPSDT extended/supplemental services** for children are State Plan Approved services and may be built into the capitated rates* • ***1115(a)(2)** services are considered State Plan services for 1115 populations for the duration of the demonstration and may be built into capitated payments approved through the 1115 demonstration budget neutrality agreement for approved populations only.* • ***HCBS waiver services** may only be included for capitated contracts under 1915(b)/(c) concurrent waiver or in CMS RO approved 1915(a)(1)(A)/(c) capitated contracts for approved 1915(c) waiver participants. Note: for the purposes of pre-PACE under 1915(a)(1)(A) HCBS services should be included. If the population is a nursing home-certifiable population and eligible for HCBS, the State may consider HCBS as an acceptable service for long-term care managed care.* • ***1915(a)(1)(A) capitated rates** must be based on State Plan Approved services only and 1915(c) approved services for 1915(c) participants.* *Note: The inclusion of any additional Medicaid services during the term of a contract could either be handled through a contract amendment or a contract term that provides for the contingency, subject to CMS approval. Amendments must be prior approved by the CMS RO.*	Contract or Documentation		
AA.2.5	438.6(e)	Services that may be covered by a capitated entity out of contract savings - An entity may provide services to enrollees that are in addition to those covered under the State plan, although the cost of these services cannot be included when determining the payment rates. *Note: this is different than 1915(b)(3) waiver services which are contractually required by the State. When a State agency decides to contract with an entity, it is arranging to have some or all of its State plan services provided to its Medicaid population through that entity. The State has not modified the services that are covered under its State plan, nor is it continuing to pay, on a FFS basis, for each and every service to be provided by the entity. Further, entities have the ability to provide services that are in the place of, or in addition to, the services covered under the State plan, in the most efficient manner that meets the needs of the individual enrollee. These additional or alternative services do not affect the capitation rate paid to the entity by the State. The capitation rates should not be developed on the basis of these services. The State determines the scope of State plan benefits to be covered under the managed care contract, and sets payment rates based on those services. This does not affect the entities right, however, to use these payments to provide alternative services to enrollees that*	Contract		

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		would not be available under the State plan to beneficiaries not enrolled in the entity.Section 1915(b)(3) waiver authority that allows a State to share savings resulting from the use of more cost-effective medical care with beneficiaries by providing them with additional services.			
Subsection AA.3 – Adjustments to the Base Year Data					
AA.3.0	42 CFR 438.6(c)(3)(ii) and (iv)	Adjustments to the Base Year Data - The State made adjustments to the base period to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population. All regulatorily referenced adjustments are listed in 3.1 through 3.14. **Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment.** Sample Adjustments to the Base Year that may increase the Base Year: • Administration (Step AA.3.2) • Benefit, Programmatic and Policy change in FFS made after the claims data tape was cut (Step AA.3.1) • Claims completion factors (Step AA.3.2) • Medical service cost trend inflation (Step AA.3.3) • Utilization due to changes in FFS utilization between the Base Year and the contract period. Changes in utilization of medical procedures over time is taken into account (Step AA.3.11) • Certified Match provided by public providers in FFS • Cost-sharing in FFS is not in the managed care program • FFS benefit additions occurring after the extraction of the data from the MMIS are taken into account • One-time only adjustment for historically low utilization in FFS program of a State Plan Approved benefit (i.e., dental) • Patient liability for institutional care will be charged under this program • Payments not processed through the MMIS • Price increase in FFS made after the claims data tape was cut Sample Adjustments to the Base Year that may adjust the Base Year downward: • Benefit deletions in the FFS Program occurring after the extraction of the data from the MMIS are taken into account (Step AA.3.1) • Cost-sharing in managed care in excess of FFS cost-sharing • Disproportionate Share Hospital Payments (Step AA.3.5) • Financial Experience Adjustment • FQHC/RHC payments • Graduate Medical Education (Step AA.3.8) • Income Investment Factor • Indirect Medical Education Payments (Step AA.3.8) • Managed Care Adjustment • PCCM Case Management Fee	Contract or Documentation		

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		• Pharmacy Rebates • Post-pay recoveries (TPL) if the State will not collect and allow the MCE to keep TPL payments (Step AA.3.6) • Recoupments not processed through the MMIS • Retrospective Eligibility costs (Step AA.3.4) Cost-neutral Adjustments: • Data smoothing for data distortions and individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims including risk-sharing and reinsurance (Step AA.5.0) *Note: The CMS RO must review all changes for appropriateness to the data selected by the State (e.g., if the State is using encounter data, then adjustments for FFS changes may not be appropriate). Some adjustments are mandatory. They are noted as such.* ***All adjustments must be documented. Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment.***			
AA.3.1	42 CFR 438.6(c)(1)(B) 42 CFR 438.6(c)(4)(ii)(A)	Benefit Differences - Actuarially sound capitation rates are appropriate for the services to be furnished under the contract. The State must document that actuarially sound capitation rates payments are based only upon services covered under the State Plan. *Differences in the service package for the Base Period data and the Medicaid managed care covered service package are adjusted in the rates. Documentation of assumptions and estimates is required for this adjustment.*	Required Documentation		
AA.3.2	42 CFR 438.6(c)(4)(ii) (A) 42 CFR 438.6(c)(3)(ii) 42 CFR 438. 812 Family Planning FMAP 1903(a)(5) and 42 CFR 433.10(c)(1) Title XIX Financial Management Review Guide #20 Family Planning Services (See page	Administrative cost allowance calculations - The State must document that an adjustment was made to the rate to account for MCO, PIHP or PAHP administration. Only administrative costs directly related to the provision of Medicaid State Plan approved services to Medicaid-eligible members are built into the rates. *Documentation of assumptions and estimates is required.* In order to receive Federal reimbursement, administrative costs at the entity level are subject to all applicable Medicaid administrative claiming regulations and policies. Medicaid pays for the administration of Medicaid services to Medicaid beneficiaries covered under the contract. The following examples are not all inclusive. • Public entities cannot build in administrative costs to pay for non-Medicaid administration or services such as education, prisons, or roads, bridges and stadiums using the administrative cost in capitated rates. • Administrative costs for State Plan approved services can only be claimed for services to be delivered to Medicaid beneficiaries under the contract (not for 1915(b)(3) services. Administration costs in contracts must be allocated to the appropriate programs (e.g. public health must pay for the administration of public health services to non-Medicaid eligibles). CMS provides FFP only for the administration of Medicaid services to Medicaid beneficiaries covered under the contract. • Regular Medicaid matching rules apply. See 42 CFR 438.812 which states that all payments under a risk contract are medical assistance costs (FMAP rate) and which requires an allocation for non-risk contracts between service costs and administrative costs. Separate administrative costs under the State	Required Documentation		

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	1 of this guide for a complete list of statutory and regulatory references) 7/3/01 SMD Letter Indian Health Service facility FMAP 1905(b) and 42 CFR 433.10(c)(2)	Plan should not be placed under a capitated contract in order for the State to draw down the FMAP (50-80%) rate rather than the administrative rate (50%). Examples of this include: survey and certification costs or other administrative costs not associated with the plan's provision of contractually-required covered State Plan services to Medicaid enrollees. Separate administrative contracts including this administration can be written for capitated entities that will be matched at 50% by the federal government. *Note: Family planning and Indian health services enhanced matching FMAP rates and rules do apply to family planning and Indian Health services in capitated contracts. For family planning, the State must document the portion of its rates that are family planning consistent with the CMS Title XIX Financial Management Review Guide #20 Family Planning Services, especially Exhibit A. Please refer to the 7/3/01 SMD letter regarding the need for timely filing of claims.* • Paperwork costs, such as time spent writing up case notes, associated with face-to-face contact with an eligible member is already included in the direct service cost and should not be built into the capitated rates again. Medicaid State agencies should also not pay separately for this administration. This occurs when an entity contracts with a public entity to provide services. The public entity provides the direct services and then bills the State Medicaid agency or the entity for administration associated with the direct services. Schools are providing the primary examples of this practice. This could also occur if an entity builds in additional administrative costs associated with direct service that have already been built into the direct service rates to providers. *Note: CMS does not have established standards for risk and profit levels but does allow reasonable amounts for risk and profit to be included in capitated rates.*			
AA.3.3	42 CFR 438.6(c)(3)(ii)	Special populations' adjustments - Specific health needs adjustments are made to make the populations more comparable. The State may make this adjustment only if the population has changed since the utilization data tape was produced (e.g., the FFS population has significantly more high-cost refugees) or the base population is different than the current Medicaid population (e.g., the State is using the State employees health insurance data). The State should use adjustments such as these to develop rates for new populations (e.g., SCHIP eligibles or 1115 expansion eligibles). The State should document why they believe the rates are adequate for these particular new populations.	Contract or Ratesetting Documentation		
AA.3.4	42 CFR 438.6(c)(3)(ii) and (iv)	Eligibility Adjustments - The actuary analyzed the covered months in the base period to ensure that member months are parallel to the covered months for which the entities are taking risk. Adjustments are often needed to remove from the base period covered months -- and their associated claims – that are not representative of months that would be covered by an entity. For example, many newborns are retrospectively covered by FFS Medicaid at birth, and will not enroll in an entity (even in mandatory enrollment programs) until a few months after birth. Because the costs in the first months of life are very high, if retrospective eligibility periods are not removed from the base period the state could be substantially over-estimating entities' average PMPM costs in the under-1 age cohort. Similar issues exist with the mother's costs when the delivery is retrospectively covered by FFS Medicaid, and with retrospective eligibility periods in general.	Contract or Ratesetting Documentation		
AA.3.5	1923(i) BBA 4721(d)	DSH Payments *[contracts signed after 7/1/97]* – DSH payments may not be included in capitation rates. The State must pay DSH directly to the DSH facility.	Contract or Documentation		
AA.3.6	42 CFR 433 Sub D 42 CFR 447.20 SMM 2089.7	Third Party Liability (TPL) – The contract must specify any activities the entity must perform related to third party liability. The Documentation must address third party liability payments and whether the State or the entity will retain TPL collections. Rates must reflect the appropriate adjustment (i.e., if the entity	Required in Contract		

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		retains TPL collections the rates should be adjusted downward or if the State collects and retains the TPL the rates should include TPL).			
AA.3.7	42 CFR 447.58 SMM 2089.8	Copayments, Coinsurance and Deductibles in capitated rates –If the State uses FFS as the base data to set rates and the State Medicaid agency chooses not to impose the FFS cost-sharing in its pre-paid capitation contracts with entities, the State must calculate the capitated payments to the organization as if those cost sharing charges were collected. For example, if the State has a $2 copayment on FFS beneficiaries for each pharmacy prescription, but does not impose this copayment on any managed care member, the State must add back an amount to the capitated rates that would account for the lack of copayment. *Note: this would result in an addition to the capitated rates.* For 1115 expansion beneficiaries only, if the state usees FFS as the base data to set rates and imposes more deductibles, coinsurance, co-payments or similar charges on capitated members than the State imposes on its fee-for-service beneficiaries, the State must calculate the rates by reducing the capitation payments by the amount of the additional charges. *Note: this would result in a reduction to the capitated rates.*	Contract or Documentation		
AA.3.8	42 CFR 438.60 42 CFR 438.6(c)(5)(v)	Graduate Medical Education (GME) - If a State makes GME payments directly to providers, the capitation payments should be adjusted to account for the aggregate amount of GME payments to be made on behalf of enrollees under the contract (i.e., the State should not pay the entity for any GME payments made directly to providers). States must first establish actuarially sound capitation rates prior to making adjustments for GME. CMS permits such payments only to the extent the capitation rate has been adjusted to reflect the amount of the GME payment made directly to the hospital. States making payments to providers for GME costs under an approved State plan must adjust the actuarially sound capitation rates to account for the aggregate amount of GME payments to be made directly to hospitals on behalf of enrollees covered under the contract. These amounts cannot exceed the aggregate amount that would have been paid under the approved State plan for FFS. This prevents harm to teaching hospitals and ensures the fiscal accountability of these payments.	Contract or Documentation		
AA.3.9	1903(m)(2)(A)(ix) 1902(bb)	FQHC and RHC reimbursement – The State may build in only the FFS rate schedule or an actuarially equivalent rate for services rendered by FQHCs and RHCs. The State may NOT include the FQHC/RHC encounter rate, cost-settlement, or prospective payment amounts. The entity must pay FQHCs and RHCs no less than it pays non-FQHC and RHCs for similar services. In the absence of a specific 1115 waiver, the entity cannot pay the annual cost-settlement or prospective payment.	Contract		
AA.3.10	42 CFR 438.6(c)(3)(ii)	Medical Cost/Trend Inflation – Medical cost and utilization trend inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. All trend factors and assumptions are explained and documented. *Note: This also includes price increases not accounted for in inflation (i.e., price increases in the fee-for-service or managed care programs made after the claims data tape was cut). This adjustment is made if price increases are legislated by the Legislature. The RO must ensure that the State "inflates" the rate only once and does not double count inflation and legislative price increases. The State must document that program price increases since the rates were originally set are appropriately made.*	Contract or Documentation		
AA.3.11	42 CFR 438.6(c)(3)(ii) and (iv)	Utilization Adjustments - Generally, there are two types of Utilization adjustments are possible: utilization differences between base data and the Medicaid managed care population and changes in Medical utilization over time.	Contract or Documentation		

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		• Base period differences between the underlying utilization of Medicaid FFS data and Medicaid managed care data assumptions are determined. These adjustments increase or decrease utilization to levels that have not been achieved in the base data, but are realistically attainable CMS program goals. States may pay for the amount, duration and scope of State plan services that States expect to be delivered under a managed care contract. Thus, States may adjust the capitation rate to cover services such as EPSDT or prenatal care at the rate the State wants the service to be delivered to the enrolled population. The RO should check to ensure that the State has a contract clause for using mechanisms such as financial penalties if service delivery targets are not met or incentives for when targets are met. *Note:* a*n example of this adjustment is an adjustment to Medicaid FFS data for EPSDT where FFS beneficiaries have historically low EPSDT utilization rates and the managed care contract requires the entity to have a higher utilization rate. The State should have a mechanism to measure that the higher utilization occurs and the RO should verify that this measurement occurs.* • A change in utilization of medical procedures over time is taken into account. Documentation is required if this adjustment is made. The State should document 1) The assumptions made for the change in utilization. 2) How it came to the precise adjustment size. 3) That the adjustment is a unique change that could not be reflected in the utilization database because it occurred after the base year utilization data tape was cut. Examples may include: major technological advances (e.g., new high cost services) that cannot be predicted in base year data (protease inhibitors would be acceptable, a new type of aspirin would not be acceptable). *Note: These adjustments can be distinguished from each other. The first is utilization change stemming from historic under- or over-utilization that is being corrected solely by the implementation of this program. Historic access problems in FFS Medicaid programs may be addressed through this adjustment. The second is a one time only non-recurring adjustment because of a unique utilization change projected to occur (or which did occur) after the base year data tape was produced.*			
AA.3.12	42 CFR 438.6(c)(4)(ii) 42 CFR 438.6(c)(3)(iv) 42 CFR 438.6(c)(1)(i)(B)	Utilization and Cost Assumptions – The State must document that the utilization and cost data assumptions for a voluntary program were analyzed and adjusted to ensure that they are appropriate for the populations to be covered if a healthier or sicker population voluntarily chooses to enroll (compared to the population data on which the rates are set). The State must document that utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk-sharing or other appropriate cost-neutral methods *Note: this analysis is needed whenever the population enrolled in the managed care program is different than the data for which the rates were set (e.g., beneficiaries have a choice between a fee-for-service program (PCCM) and a capitated program (MCO) and the rates are set using FFS data)* .			
AA.3.13	42 CFR 435.725 (Categorically Needy) 42 CFR 435.832 (Medically Needy)	Post-Eligibility Treatment of Income (PETI) *(This applies for NF, HCBS, ICF-MR, and PACE beneficiaries in capitated programs where PETI applies only*.) If the State Plan or waiver requires that the State consider post-eligibility treatment of income for institutionalized beneficiaries, the actual rate paid to the capitated entity would be the rate for the member minus any patient liability for that specific enrolled member. The State should calculate the client participation amount specifically for each member using the FFS methodology. *Patient liability is a post-eligibility determination of the amount an institutionalized Medicaid beneficiary is liable for the cost of their care. It is also called client participation, cost of care, PE, and post-eligibility*	Contract or Documentation		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		treatment of income. 42 CFR 435 Subpart H. Client participation should not be used to reduce total costs for all participants. Client participation should be assessed individually, reducing the individual rate paid to the capitated entity, not computed in aggregate and reducing all capitation payments. If the MMIS data tape is cut to reflect only the amount the Medicaid agency paid providers, then patient liability for cost of care must be added back to the rate to determine the total cost of care for an individual. The actual rate paid to the capitated entity would be the rate for the member minus any patient liability for that specific enrolled member. The capitated entity would then need to collect the patient liability from the enrolled member. An Option under 42 CFR 435.725(f) - The State can use a projection of expenses for a prospective period not to exceed 6 months to calculate client participation. This option requires the State to reconcile estimates with incurred expenses. Even with this option, the State must reduce the capitation rate to exclude expenses that are of the recipient's liability. This procedure ensures that the federal government does not pay more that its share of costs.			
AA.3.14	42 CFR 438.6(c)(3)(ii)	Incomplete Data Adjustment– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the Actuary must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*	Contract or Documentation		
Subsection AA.4 – Establish Rate Category Groupings					
AA.4.0	42 CFR 438.6(c)(3)(iii) FR 6/14/02 p41001	Establish Rate Category Groupings (All portions of subsection AA.4 are mandatory) -- The State has created rate cells specific to the enrolled population. *The rate category groupings were made to construct rates more predictable for future Medicaid populations' rate setting. The number of categories should relate to the contracting method. Rate cells need to be grouped together based upon predictability so entities do not have incentives to market and to enroll one group over another. Multiple rate cells should be used whenever the average costs of a group of beneficiaries greatly differ from another group and that group can be easily identified. Note: The State must document that similar cost categories are grouped together to improve predictability. For example, rate cells may be combined if there is an insufficient number of enrollees in any one category to have statistical validity.*	Contract or Documentation		
AA.4.1	42 CFR 438.6(c)(3)(iii)(B)	Age - Age Categories are defined. If not, justification for the predictability of the methodology used is given.	Contract or Documentation		
AA.4.2	42 CFR 438.6(c)(3)(iii)(C)	Gender -Gender Categories are defined. If not, justification for the predictability of the methodology used is given	Contract or Documentation		
AA.4.3	42 CFR 438.6(c)(3)(iii)(D)	Locality/Region - Locality/region Categories are defined. If not, justification for the predictability of the methodology used is given	Contract or Documentation		
AA.4.4	42 CFR 438.6(c)(3)(iii)(E)	Eligibility Categories - Eligibility Categories are defined. If not, justification for the predictability of the methodology used is given.	Contract or Documentation		
Subsection AA.5 – Data Smoothing, Special Populations and Catastrophic Claims					
AA.5.0	42 CFR 438.6(c)(3)(ii), (iii) and (iv)	Data Smoothing (All portions of subsection AA.5 are mandatory) - The State has examined the data for any distortions and adjusted in a cost-neutral manner for distortions and special populations. Distortions are primarily the result of small populations, special needs individuals, access problems in certain areas of the	Contract or Ratesetting Documentation		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
	42 CFR 438.6(c)(1)(ii)	State, or extremely high-cost catastrophic claims. Costs in rate cells are adjusted through a cost-neutral process to reduce distortions across cells to compensate for distortions in costs, utilization, or the number of eligibles. This process adjusts rates toward the statewide average rate. The State must supply an explanation of the smoothing adjustment, an understanding of what was being accomplished by the adjustment, and demonstrate that, in total, the aggregate dollars accounted for among all the geographic areas after smoothing is basically the same as before the smoothing. The State has taken into account individuals with special health care needs and catastrophic claims. These populations should only be included if they are an eligible, covered population under the contract. Claim costs and utilization for high cost individuals (e. g., special needs children) in the managed care program are included in the rates.			
AA.5.1	42 CFR 438.6(c)(3)(iv)	Special Populations and Assessment of the Data for Distortions – Because the rates are based on actual utilization in a population, the State must assess the degree to which a small number of catastrophic claims might be distorting the per capita costs. Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk-sharing, or other appropriate cost-neutral methods may be necessary. If no distortions or outliers are detected by the actuary, a rate setting method that uses utilization and cost data for populations that include individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims will meet requirements for special populations without additional adjustments, since the higher costs would be reflected in the enrollees' utilization. States must document their examination of the data for outliers and smooth appropriately. The fact that the costs of these individuals are included in the aggregate data used for setting rates will not account for the costs to be incurred by a contractor that, due to adverse selection or other reasons, enrolls a disproportionately high number of these persons. CMS requires some mechanism to address this issue. Most entity contracts currently use either stop-loss, risk corridors, reinsurance, health status-based risk adjusters, or some combination of these cost-neutral approaches. *Note: The RO should verify that this assessment occurred and that distortions found were addressed in 5.2.*	Contract or Ratesetting Documentation		
AA.5.2	42 CFR 438.6(c)(1)(iii) 42 CFR 438.6(c)(3)(ii) and (iv) SMM 2089.6	Cost-neutral data smoothing adjustment -- If the State determines that a small number of catastrophic claims are distorting the per capita costs then at least one of the following cost-neutral data smoothing techniques **must** be made. Cost neutral means that the mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments. Actuarially sound risk sharing methodologies will be cost neutral in that they will not merely add additional payments to the contractors' rates, but will have a negative impact on other rates, through offsets or reductions in capitation rates, so that there is no net aggregate assumed impact across all payments. A risk corridor model where the State and contractor share equal percentages of profits and losses beyond a threshold amount would be cost neutral.	Contract or Documentation		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		The mechanism should be cost neutral in the aggregate. How that is determined, however, will differ based on the type of mechanism that is used. A stop-loss mechanism will require an offset to capitation rates under the contract, based on the amount and type of the stop-loss. Health status-based risk adjustment may require an adjustment to the capitation rate for all individuals categorized through the risk adjustment system, but the aggregate program impact will still be neutral. CMS will recognize that any of these mechanisms may result in actual payments that are not cost neutral, in that there could be changes in the case mix or relative health status of the enrolled population. As long as the risk sharing or risk adjustment system is designed to be cost neutral, it would meet this requirement regardless of unforeseen outcomes such as these resulting in higher actual payments. Data Smoothing Techniques: ___ Provision of stop loss, reinsurance, or risk-sharing (See 6.0) ___ Catastrophic Claims Adjustment – The State must identify that there are outlier cases and explain how the costs associated with those outlier cases were separated from the rate cells and then redistributed across capitation payment cells in a cost-neutral, yet predictive manner. ___ Small population or small rate cell adjustment – The State has used one of three methods: 1) The actuary has collapsed rate cells together because they are so small, 2) the actuary has calculated a statewide per member per month for each individual cell and multiplied regional cost factors to that statewide PMPM in a cost-neutral manner, or 3) the actuary bases rates on multiple years data for the affected population weighted so that the total costs do not exceed 100% of costs (e.g., 3 years data with most recent year's data weighted at 50%, 2nd most recent year's data weighted at 30% and least recent year weighted at 20%). ___ Mathematical smoothing – The actuary develops a mathematical formula looking at claims over a historical period (e.g., 3 to 5 years) that identifies outlier cost averages and corrects for skewed distributions in claims history. The smoothing should account for cost averages that are higher and lower than normal in order to maintain cost-neutrality. ___ Maternity Kick-Payment (Per delivery rate) – Non-delivery related claims were separated from delivery related claims. The non-delivery related claims were sorted into categories of service and used to base the managed care capitation payments. Delivery-related costs were removed from the total final paid claims calculations. The State developed a tabulation of per-delivery costs only. The State reviewed the data for accuracy and variance. The State develops a single, average, per-delivery maternity rate across all cohorts and across all regions unless variance warrants region-specific per-delivery maternity rates. Some states also have birth kick payments to cover costs for a newborn's birth (Per newborn rate). ___ Applying other cost-neutral actuarial techniques to reduce variability of rates and improve average predictability. If the State chooses to use a method other than the catastrophic claims adjustment or a small population or small rate cell adjustment, the State explains the methodology. The actuary assisted with the development of the methodology, the approach is reasonable, the methodology was discussed with the State, and an explanation and documentation is provided to CMS.			
AA.5.3	42 CFR 438.6(c)(1)(iii)	Risk-Adjustment – The State may employ a risk adjustment methodology based upon enrollees' health status or diagnosis to set its capitated rates. If the State uses a statistical methodology to calculate diagnosis-based risk adjusters they should use generally accepted diagnosis groupers. The RO should verify that:	Contract or Documentation		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
	42 CFR 438.6(c)(3)(iii) and (iv)	• The State explains the risk assessment methodology chosen • Documents how payments will be adjusted to reflect the expected costs of the disabled population • Demonstrates how the particular methodology used is cost-neutral • Outlines periodic monitoring and/or rebasing to ensure that the overall payment rates do not artificially increase, due to providers finding more creative ways to classify individuals with more severe diagnoses (also called upcoding or diagnosis creep). Risk-adjustment must be cost-neutral. *Note: for example, risk-adjustment cannot add costs to the managed care program. Risk adjustment can only distribute costs differently amongst contracting entities.*			
Subsection 6.0 – Stop Loss, Reinsurance, or Risk-sharing arrangements					
AA.6.0	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i) 42 CFR 438.6(c)(2)(ii)	Stop Loss, Reinsurance, or Risk-sharing arrangements (8.0 is mandatory if the State chooses to offer one of these options) *(State Optional Policy)* – The State must submit an explanation of state's reinsurance, stop loss, or other risk-sharing methodologies. These methodologies must be computed on an actuarially sound basis. *Note: If the State utilizes any of the three risk-sharing arrangements, please mark the applicable method in 8.1, 8.2, or 8.3. For most contracts, the three options are mutually exclusive and a State will use only one technique per contract. If a State or contract uses a combination of methodologies in a single contract, the State must document that the stop loss and risk-sharing do not cover the same services simultaneously. Plans are welcome to purchase reinsurance in addition to State-provided stop loss or risk-sharing, but CMS will not reimburse for any duplicative cost from such additional coverage.* The contract must specify any risk-sharing mechanisms, and the actuarial basis for computation of those mechanisms. *Note: In order for the mechanism to be approved in the contract, the State or its actuary will need to provide enough information for the reviewer to understand both the operation and the financing of the risk sharing mechanism.* Capitation rates are based upon the probability of a population costing a certain rate. Even if the entity's premium rates are sufficient to cover the probable average costs for the population to be served, the entity is always at risk for the improbable – two neonatal intensive care patients and one trauma victim in its first 100 members, or an extraordinarily high rate of deliveries. A new entity, with a small enrollment to spread the risk across, could be destroyed by one or two adverse occurrences if it were obliged to accept the full liability. FFP is not available to fund stop loss and risk-sharing arrangements on the provision of non-State Plan services.			
AA.6.1	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i)	Commercial Reinsurance – The State requires entities to purchase commercial reinsurance. The State should demonstrate that the contractor has ensured that the coverage is adequate for the size and age of the entity.	Contract		
AA.6.2	42 CFR 438.6(c)(4)(iv)	Simple stop loss program -- The State will provide stop-loss protection by writing into the contract limits on the entity's liability for costs incurred by an individual enrollee over the course of a year (either total costs or for a specific service such as inpatient care). Costs beyond the limits are either entirely or partially	Contract		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
	42 CFR 438.6(c)(5)(i) SMM 2089.6	assumed by the State. The entity's capitation rates are reduced to reflect the fact that the State is assuming a portion of the risk for enrollees. ■ The State has included in its documentation to CMS the expected cost to the State of assuming the risk for the high cost individuals at the chosen stop-loss limit (also called stop-loss attachment point). ■ An explanation of the State's stop loss program includes the amount/percent of risk for which the State versus entity will be liable. ■ The State has explained liability for payment. In some contracts, the entity is liable up to a specified limit and partially liable for costs between that limit and some higher number. The State is wholly liable for charges above the higher limit. If there is shared risk rather than either the State or the entity entirely assuming the risk at a certain point, the entity and State determine whether the services will be reimbursed at Medicaid rates, at the entities' rates, or on some other basis. The State must specify which provider rates will be used to establish the total costs incurred so that the entity clearly knows whether the reinsurance will pay (i.e., the attachment point is reached). ■ The State has deducted a withhold equal to the actuarially expected cost to the State of assuming the risk for high cost individuals. The State pays out money based on actual claims that exceed the stop loss limit (i.e., above the attachment point). ■ The State has documented whether premiums will be developed by rate cell or on a more aggregated basis.			
AA.6.3	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i) and (ii) 42 CFR 438.6(c)(1)(v)	<u>Risk corridor program</u> – Risk corridor means a risk sharing mechanism in which States and entities share in both profits and losses under the contract, outside of a predetermined threshold amount, so that after an initial corridor in which the entity is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits. If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals, plus an amount for entity administrative costs directly related to the provision of these services. The State agrees to share in both the aggregate profits and losses of an entity and protect the entity from aggregate medical costs in excess of some predetermined amount. To the extent that FFP is involved, CMS will also share in the profits and losses of the entity. In this instance, the State and CMS must first agree upon the benchmark point up to which federal match will be provided. Federal matching is available up to the cost of providing the same services under a non-risk contract (i.e., the services reimbursed on a Medicaid fee-for-service basis plus an amount for entity administrative costs related to the provision of those services). See 447.362. States typically require entities to adopt the Medicare cost-based entity principles for the purposes of calculating administrative costs under this model. *Note: For this example, let's say the payment is $100 and there are 10 members expected to enroll. The total capitated payment CMS will match is $1,000.* - *The State and the entity must then agree on the amount of risk to be shared between them (e.g., 5% or*	Contract		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		the risk corridor is between $950 and $1,050). - *The entity must calculate its overall costs at the end of the year and submit them to the State.* - *Scenario 1, the entity costs are $950: In this example, the entity's profits are within the risk corridor of $950 to $1,050, so the entity keeps the entire amount of capitated payments and no adjustment is made.* - *Scenario 2, the entity costs are $1,050: In this example, the entity's loss is within the risk corridor, so the entity keeps the entire amount of the capitated payment and no adjustment is made.* - *Scenario 3, the entity costs are $850: In this example, the entity profit is outside of the risk corridor, so the entity must pay the State the amount of the excess profit or $100.* - *Scenario 4, the entity costs are $1,150: In this example, the entity loss is outside of the risk corridor, so the State must pay the entity the amount of the excess loss or $100.* *Please note: FFP is not available for amounts in this contract over the fee-for-service cost of providing these services. In order to compute the fee-for-service cost of providing services, the State must "price" the capitated entity's encounter data through the State's fee-for-service MMIS system. Amounts exceeding the cost of providing these services through a non-risk contract are not considered actuarially sound. The State must "price" the encounter data for entities with open ended risk-corridors (meaning there is no limit to the State's liability) when the entity exceeds the aggregate of actuarially sound rates x member months by more than 25%. In practice the RO may require the "pricing" of encounter data whenever evidence suggests that the non-risk threshold has been exceeded. Similarly, the State can require documentation if evidence suggests that the entity should be profit sharing below the threshold. In this example, if the fee-for-service and entity administrative cost of providing these services were $1,100, then FFP would only be available up to $1,100. See 42 CFR 447.362 or Step AA.1.8 of this checklist.*			
Subsection AA.7.0 – Incentive Arrangements					
AA.7.0	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(iii) and (iv) SMM 2089.3 42 CFR 438.6(c)(2)(i) 42 CFR 438.6(c)(1)(iv) 42 CFR 438.6(c)(4)(ii)	<u>Incentive Arrangements (9.0 is mandatory if the State chooses to implement an incentive)</u> *(State Optional Policy)* – Incentive arrangement means any payment mechanism under which an entity may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract. The State must include an explanation of the State's incentive program. Payments in contracts with incentives may not exceed 105% of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such payments will not be considered actuarially sound. The State must document that any payments under the contract are actuarially sound, are appropriate for the populations covered and services to be furnished under the contract, and based only upon services covered under the State Plan to Medicaid-eligible individuals (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration). • All incentives must utilize an actuarially sound methodology and based upon the provision of approved services to Medicaid eligible beneficiaries. • Incentives cannot be renewed automatically and must be for a fixed time period. • The incentive cannot be conditioned upon intergovernmental transfer agreements. • Incentives must be available to both public and private contractors. *Note: Reinsurance collections from reinsurance purchased from a private vendor (See 8.1) and State provided stoploss (8.2) are actuarially calculated to be cost-neutral and should not considered to be*	Contract		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		"incentives" or included in these payments.			

Attachment to Appendix A. PAHP, PIHP, and MCO Contracts
MEDICARE/MEDICAID
DUAL ELIGIBLE CATEGORIES
(EACH MEDICAID CATEGORY IS ENTITLED TO MEDICARE)

Eligibility Category	Medicaid Benefits	Cost Limit to Medicaid (if any)	Provider	Medicaid Liability for Services
QMB only	Medicare premiums, deductibles, and coinsurance (crossover) No Medicaid services	Full Medicare	Medicare	QMB rates for Medicare deductibles and coinsurance Includes any M+C premiums if the State has chosen to cover in the State Plan on page 29.
QMB PLUS (QMB + Medicaid)	Medicare premiums, deductibles, and coinsurance (crossover) Medicaid services	Full Medicare + Medicaid	Medicare Medicaid	QMB rates for Medicare deductibles and coinsurance Medicaid rates for Medicaid only services Includes any M+C premiums if the State has chosen to cover in the State Plan on page 29.
MEDICAID (Non QMB and Non SLMB)	Medicare Part B premiums (optional for medically needy) Medicaid services	$58.70 + Medicaid	Medicare Medicaid	No liability for Medicare deductibles and coinsurance Difference between Medicare payment and Medicaid rates for Medicaid services
SLMB only	Medicare Part B premiums No Medicaid services	$58.70	Medicare	No liability for Medicare deductibles and coinsurance
SLMB PLUS (SLMB + Medicaid)	Medicare Part B premiums Medicaid services	$58.70 + Medicaid	Medicare Medicaid	No liability for Medicare deductibles and coinsurance Difference between Medicare payment and Medicaid rates for Medicaid services
QDWI (Not otherwise eligible for Medicaid)	Medicare Part A premiums	$316 http://www.medicare.gov/Basics/Amounts2002.asp	Medicare	No liability for Medicare deductibles and coinsurance
QI (Not otherwise eligible for Medicaid)	All or part of Medicare Part B premiums	Q1 – $ 58.70	Medicare	No liability for Medicare deductibles and coinsurance Effective January 1, 2003, the QI-2 benefit is no longer authorized and states should provide notice to the QI-2 beneficiaries of the termination action to be taken, consistent with the rules on advance notice at 42 CFR 431.211. States were required to pay beneficiaries $3.91 per month toward the Medicare Part B premiums for QI-2s through December 31, 2002.

APPENDIX 8: AMERICAN ACADEMY OF ACTUARIES ACTUARIAL CERTIFICATION OF RATES FOR MEDICAID MANAGED CARE PROGRAMS

Health Practice Council Practice Note

August 2005

Actuarial Certification of Rates for Medicaid Managed Care Programs

Developed by the Medicaid Rate Certification Work Group of the American Academy of Actuaries

American Academy *of* Actuaries

American Academy of Actuaries

The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the actuarial profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also supports the development and enforcement of actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

Members of the Medicaid Rate Certification Work Group include:

P. Anthony Hammond, Chairperson	M. Scott Lockwood
F. Kevin Russell, Vice Chairperson	Gary J. McCollum
Ben S. Brandon	Mary J. Murley
Thomas P. Carlson	David F. Ogden
April S. Choi	Herbert B. Olson
Robert M. Damler	Richard D. Pattinson
Timothy F. Harris	Robert Ruderman
Joann M. Hess	Martin E. Staehlin
Grace C. Kiang	Jill A. Stockard
Julia S. Lambert	Gordon R. Trapnell
Arlene E. Livingston	Todd W. Whitney

This group includes actuaries who have experience performing certifications to the Centers for Medicare and Medicaid Services (CMS) as either consultants to state Medicaid agencies or as state employees, and actuaries who have experience with Medicaid rates, as either employees of, or consultants to, HMOs that contract with states to provide managed health care to Medicaid populations. The work group acknowledges CMS actuary John D. Klemm for coordinating the efforts of the work group with CMS. The group would also like to thank staff at CMS who met with the work group including: Dianne Heffron, Ed Hutton, Brenda Jackson, Bruce Johnson, and Carrie Smith.

HEALTH PRACTICE NOTE 2005-1

August 2005

Actuarial Certification of Rates for Medicaid Managed Care Programs

Developed by the
Medicaid Rate Certification Work Group of the
American Academy of Actuaries

This practice note was prepared by a work group organized by the Health Practice Council of the American Academy of Actuaries. The work group was asked to:

> Review the Centers for Medicare & Medicaid Services (CMS) regulations that require certification of the "actuarial soundness" of Medicaid managed care premium rates;[1]
>
> Determine the extent to which the Academy has addressed the term "actuarial soundness" in any public statements (the Health Committee of the Actuarial Standards Board is reviewing the need for an Actuarial Standard of Practice on this topic); and
>
> Make a recommendation to the Health Practice Council about the best way to proceed on this issue. The work group's recommendation was to publish a practice note. The Health Practice Council approved this recommendation and directed the work to proceed with the drafting of the practice note.

The purpose of this practice note is to provide nonbinding guidance to the actuary when certifying rates or rate ranges as meeting the requirements of 42 CFR 438.6(c) for capitated Medicaid managed care programs. Examples of responses to certain situations and issues are provided. However, no representation of completeness is made; other approaches may also be reasonable and may currently be in common use. Further, appropriate alternatives to these methods may develop over time and come into common use. Events occurring subsequent to the date of publication of this practice note may make the practices described herein irrelevant or inappropriate.

Since the purpose of this practice note is to provide nonbinding guidance, this practice note has not been promulgated by the Actuarial Standards Board nor by any other authoritative body of the American Academy of Actuaries. The information in this practice note is not binding on any actuary and is not a definitive statement as to what constitutes generally accepted practice in this area. Moreover, this practice note is based upon 42 CFR 438.6(c) and current CMS requirements. To the extent that the legal requirements of a particular state impose additional or conflicting requirements, practices described in this practice note may not be appropriate for actuarial practice in that state.[2]

Comments are welcome as to the appropriateness of the practice note, desirability of updates, substantive disagreements, etc. Comments should be sent to Holly Kwiatkowski, the Academy's senior health policy analyst (federal), at kwiatkowski@actuary.org or American Academy of Actuaries, 1100 17th St. NW, 7th floor, Washington, DC 20036.

1. In this setting, the term "premium rates" refers to all payments under risk contracts and all risk-sharing mechanisms (ref. 42 CFR 438.6(c)(2)). Lump sum payments in risk contracts (and all other payments) outside of premiums are also subject to actuarial soundness certification.
2. Since these situations may exist, it is important for the actuary to bring the specific situation(s) to the attention of the appropriate state officials so a dialogue can be established to find an equitable solution.

Health Practice Council

Practice Note — August 2005

Actuarial Certification of Rates for Medicaid Managed Care Programs

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VI. Certification Language

I. Introduction

Medicaid is a program that provides health care to indigent people in the United States under Title XIX of the Social Security Act of 1965. Created at the same time as Medicare (Title XVIII), both programs are regulated by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal Department of Health and Human Services. Medicaid is financed jointly by the states and the federal government from general tax revenue, with the federal share between 50 and 80 percent of costs. The Title XXI State Children's Health Insurance Program (SCHIP) has a federal share of up to 85 percent. Primary administrative responsibility for Medicaid belongs to the state, with federal oversight. Federal rules require certain populations to be covered and a core set of services to be covered. States are permitted to expand coverage to additional populations and additional services. Medicare, in contrast, is financed and administered federally, with funds from taxes on wages, premiums paid by (or on behalf of) beneficiaries, and general tax revenue. In Federal Fiscal Year 2002, Medicaid outlays ($259 billion federal and state combined) exceeded Medicare outlays ($257 billion) for the first time.[3]

Except for some small-scale voluntary HMO enrollment in a few areas, Medicaid operated almost exclusively on a fee-for-service (FFS) basis from its inception in the 1960s until 1982. Arizona, which until that time had remained outside the Medicaid program, requested a waiver from the requirement to operate Medicaid as an FFS program. The Health Care Financing Administration (HCFA), as CMS was then called, granted Arizona's request and permitted that state to operate its Medicaid program using managed care organizations (MCOs). Other states expressed interest in using MCOs to provide Medicaid benefits, and mandatory MCO enrollment was approved in certain metropolitan areas of Minnesota, Missouri, and Wisconsin. HCFA developed a waiver process by which states could do this, with the provision that the cost of the program under managed care could not exceed the cost, known as the Upper Payment Limit (UPL), of providing the same services on a FFS basis to an actuarially equivalent non-enrolled population group. (See 42 CFR 447.361, now repealed.)

Interest in waivers for Medicaid managed care plans increased throughout the 1990s. By the late 1990s, the UPL requirement was seen as problematic. For some states, Medicaid for certain populations had been delivered exclusively through MCOs for several years, rendering FFS claim experience data on those populations out-of-date. In addition, financial requirements based on a FFS delivery system that had low levels of medical screening, vaccination, and access to health care were seen as increasingly problematic for a managed care delivery system with increased access to necessary health care services and requirements for high levels of medical screening and vaccination.

In recognition of the problem with the UPL requirement, the new 42 CFR § 438.6(c) was enacted in June 2002 to be effective for rates covering periods of August 2003 and later (see Federal Register, Vol. 67, No. 115), and § 447.361 was repealed. In summary, the requirements as stated in § 438.6 (c) are as follows:

(2) *Basic requirements.*

(i) All payments under risk contracts and all risk sharing mechanisms in contracts must be actuarially sound.

(ii) The contract must specify the payment rates and any risk sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.

(3) *Requirements for actuarially sound rates.* In setting actuarially sound capitation rates, the state must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

3. Testimony of Thomas Scully, Administrator, CMS on October 8, 2003, before the House Energy and Commerce Committee Subcommittee on Health.

(ii) Adjustments are made to smooth data and adjustments to account for such factors as medical trend inflation, incomplete data, MCO, PIHP [prepaid inpatient health plan], or PAHP [prepaid ambulatory health plan] administration, and utilization;

(iii) Rate cells are specific to the enrolled population, by—

(A) Eligibility category;

(B) Age;

(C) Gender;

(D) Locality/region; and

(E) Risk adjustments based on diagnosis or health status (if used).

(iv) Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

(4) *Documentation.* The state must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance that all payment rates are—

(A) Based only upon services covered under the state plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

(iii) The state's projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.

(iv) An explanation of any incentive arrangements, or stop-loss limits or other risk-sharing methodologies under the contract.

Section 438.6(c) defines "actuarially sound capitation rates" as capitation rates that:

- have been developed in accordance with generally accepted actuarial principles and practices;
- are appropriate for the populations to be covered and the services to be furnished under the contract; and
- have been certified as meeting the requirements of the regulation by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Section 438.6(c) also specifies what is **not** "actuarially sound" under special contract provisions. (The practitioner may wish to refer to Sections III and IV of this practice note for additional information.) For example, the following conditions would result in payments that would not be considered "actuarially sound:"

i. If risk corridor arrangements result in payments that exceed the sum of:
   a. the amount Medicaid would have paid, on a FFS basis, for the state plan services, plus
   b. administrative costs directly related to the provisions of these services.

ii. If contracts with incentive arrangements provide for payment in excess of 105 percent of the approved capitation payments.

Section 438.6(c) requirements for "actuarial soundness" are thus a combination of two types of requirements. The first is the general requirement of being developed in accordance with generally accepted actuarial

principles and practices. The second is the potentially more restrictive requirement that CMS may impose on fiscal arrangements. This practice note concentrates on issues concerning the former. For issues concerning the latter, it is acknowledged that CMS or the states may impose additional restrictions, and this practice note, therefore, addresses only the potential areas of conflict between these requirements and generally accepted actuarial principles and practices.

In a regulation as published in the Federal Register, the section on "Comments and Responses" often is a valuable resource. This preliminary section includes such topics as CMS views on rate adequacy, the establishment of standards for risk and profit levels, and data integrity. Interpretations of these views are further detailed in Section III of this practice note.[4]

The checklist is a step-by-step tool that is expected to be used by the CMS Regional Offices to assess whether the capitation rates submitted by states are "actuarially sound" per the regulatory guidelines. For purposes of this practice note, the July 22, 2003 version of the checklist has been used. It is usually prudent to obtain the most current available version of the checklist when certifying Medicaid rates. Issues concerning risk adjustment techniques (section AA. 5.3 of the checklist) are not addressed at this time, pending the release by CMS of guidance on risk adjustment.

4. The work group that developed this practice note is fully aware of the sensitive issues surrounding the interaction of "actuarial soundness" and rate adequacy. The reader may choose to refer to Section III for a discussion of the issues that are likely to arise as one performs the task of certifying to "actuarial soundness" of rates.

II. Overview of Generally Accepted Actuarial Principles and Practices, and the Term "Actuarial Soundness"

In determining what constitutes generally accepted actuarial principles and practices, the Code of Professional Conduct and, by reference, the Actuarial Standards of Practice (ASOP) have the highest standing. Other items — such as practice notes, textbooks, examination study notes, and articles in professional journals — do not have the same standing. Currently, no ASOP applies specifically to actuarial work performed to comply with CMS requirements for rate certification. Such an ASOP would be unique among health ASOPs, in that it would address actuarial work performed for a ***purchaser*** of health plan benefit coverage. Other health-related ASOPs have scopes that apply specifically to actuarial work performed on behalf of health plans (the entities that bear the risks).[5] Some health-related ASOPs are general, so that they apply both to health actuarial work performed for health plans or to health actuarial work performed for purchasers of health plan services.[6] Certain other ASOPs are general and not specific to health work, so they could be applicable.[7] Note that ASOP 32 on Social Insurance does not apply to Medicaid. ASOP 32 applies to social insurance programs (such as Medicare, listed in the scope paragraph), which have broad-based eligibility requirements. Medicaid, which is conspicuously not included in the scope paragraph, is a public assistance program with strict income and asset eligibility requirements. The reader may wish to refer to *Social Insurance and Economic Security* by George E. Rejda, chapter 2, for more on the distinction between social insurance and public assistance.

In the ASOPs, there is only one place in which "actuarial soundness" is defined – ASOP 26*, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Benefit Plans*. That standard states:

> Actuarial Soundness — Small employer health benefit plan premium rates are actuarially sound if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums in the aggregate, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.

The published comments on the exposure draft of ASOP 26 show that the issue of whether and how to describe "actuarial soundness" of small group premium rates was a significant portion of the work performed by the committee that drafted ASOP 26. That committee noted that "many applicable laws … require the actuary to address *actuarial soundness,"* so the committee found it appropriate to address the issue. Please note, however, that the definition of "actuarial soundness" in ASOP 26, like all of the definitions in all of the standards, is specific to that standard, and does not purport to provide a definition of "actuarial soundness" for all areas and types of actuarial practice.

The above discussion of "actuarial soundness" involves knowledge concerning the health benefit plan's expected costs. An actuary working on behalf of a state Medicaid agency to form an opinion concerning the "actuarial soundness" of rates offered to MCOs would not normally have MCO-specific knowledge like that of the actuary working on behalf of the MCO. A workable assessment of "actuarial soundness" for certifications performed on behalf of state Medicaid agencies would usually take into account the following:

1. The data available to develop rates for populations with current coverage:
    - FFS data for the overall program (before introduction of MCO coverage)

5. ASOPs 3, 6, 7, 8, 10, 11, 16, 18, 19, 22, 25, 26, 28, 31, 33, and 37, as well as Actuarial Compliance Guideline (ACG) 4.
6. E.g., ASOPs 5, 12, 23, and 42.
7. E.g., ASOPs 17 and 41.

- FFS data for all but those voluntarily enrolled in an MCO (choice of one or more MCOs and a Primary Care Case Management (PCCM) or other FFS program)
- FFS data for the months before all recipients are mandated to be enrolled in an MCO
- MCO financial data and/or encounter data (utilization and cost per unit service) from a voluntary MCO enrollment period
- MCO financial data and/or encounter data from a mandatory MCO enrollment period.

2. The types of rate negotiation methods that may be in use by states, such as:
   - The state develops a range for each rate category and negotiates with each potential MCO contractor to settle on a rate within the range. This may involve MCOs submitting bids to the state for each rate cell. This likely results in rates that vary among MCOs for the same rate cell. The state may offer inducements for an MCO to bid lower than the others, such as a larger market share of those recipients who decline to select a particular MCO and must therefore be assigned to one.
   - The state negotiates separately with each MCO contractor.
   - The state develops a set of rates and contracts with MCOs that accept these rates as long as these MCOs also satisfy other requirements. Rates do not vary among MCOs, except for risk-adjusted payment methods, such as the chronic illness and disability payment system (CDPS).

3. The financial condition and operations of participating MCOs:
   - Some MCOs may be Medicaid-only and one-state-only, with no other lines of business or states over which to allocate certain administrative costs. In contrast, some MCOs may have other lines of business (Medicare Advantage, commercial group, and commercial individual) or other states' Medicaid business.
   - Some MCOs may not have gained sufficient enrollment to realize efficiencies of administration, but participation of these MCOs may still be desirable for the appropriate functioning of the state's Medicaid managed care program.
   - Some MCOs may be completely independent financial entities, while others could be wholly owned by other corporations that could control a significant portion of the administrative and reinsurance expenses being allocated to their Medicaid-participating subsidiaries.
   - Some MCOs may be for-profit entities that seek to generate a return while others could be not-for-profit MCOs.
   - Some MCOs may have arms-length negotiations with providers, while other MCOs may be owned by facility and/or professional providers.
   - Some PIHPs are government owned and may not participate in competitive procurement.[8]

The work group developed, for purposes of this practice note, the following proposed definition of "actuarial soundness" to apply to Medicaid managed care rates developed on behalf of a state for submission to CMS (based on the description in ASOP 26 shown earlier):

> Actuarial Soundness—Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement

8. In these instances, while there would normally be an appropriate risk allowance, CMS also believes that it is usually appropriate to use an 'excess revenues — expenses' approach on prior-approved Medicaid waiver services to Medicaid eligibles or returned to the federal government rather than offsetting other taxpayer expenses that, by statute, should not be charged to the Medicaid program (e.g., roads, bridges, stadiums, care to non-Medicaid eligibles, non-Medicaid services under 1903(i)(17) of the SSA).

expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.[9]

This definition is only for purposes of this practice note. It is not applicable to any actuarial practice other than actuarial certification of rates for Medicaid managed care programs and does not have the binding authority of a definition in an ASOP.

Some differences between the proposed definition above and the language in ASOP 26 are addressed in the following paragraphs.

"Governmental stop-loss" is included in the practice note description of "actuarial soundness" in recognition of non-insured stop-loss programs funded by states to cover certain costs in excess of specified amounts, or for certain types of services, or for treatment of certain medical conditions.

The words "reasonable, appropriate, and attainable" clarify that the costs of the Medicaid benefit plan do not normally encompass the level of all possible costs that any MCO might incur, but only such costs as are reasonable, appropriate, and attainable for the Medicaid program. In addition, all expected costs directly related to the Medicaid benefit plan would normally be included.

An actuary may be asked to assist a MCO by providing an opinion as to whether the rates bid by the MCO or offered by a state are "actuarially sound" for that particular MCO.[10] The analysis forming the basis of such an opinion would usually include expected costs specific to that MCO. This is a separate and distinct analysis compared to the analysis performed by the actuary who, on behalf of a state, is forming an opinion concerning the "actuarial soundness" of rates to be offered to MCOs and for submission to CMS.

The paragraph above uses the words "'actuarially sound' for that particular MCO." There is no federal regulatory requirement that rates are to be "actuarially sound" for a particular MCO. However, some states may require MCOs that make rate bids or that accept offered rates to provide the state with an opinion as to the "actuarial soundness" (or an opinion addressing acceptability but not using the term "actuarial soundness") of the rates for that particular MCO. An MCO may reasonably decide to accept rates for a particular year while knowing that it expects an underwriting loss in that year. Such a decision may be a reasonable business decision, given that the MCO is entering a new market or expects underwriting gains to emerge in future periods.

Regardless of the method used to arrive at a contract between a state and an MCO, an actuary advising the MCO is usually prudent to make a reasonable effort to confirm that the MCO's management understands the risks inherent in such a contract. Some states require that MCOs produce an actuarial certification that the contracted rates are sufficient but not excessive. Some states have minimum loss ratio requirements that would apply to Medicaid MCO rates. Actuarial certifications for NAIC annual statements (and quarterly statements, in some states for some MCOs) would typically require the development of deficiency reserves if the Medicaid line of business is expected to operate at a loss until the next premium rate change. Numerous ASOPs apply to the actuarial work performed on behalf of MCOs that accept risk on Medicaid and other recipients.

The remainder of this practice note describes items an actuary may wish to consider when certifying that Medicaid rates meet CMS requirements. These include items from the regulation (including the section on "Comments and Responses") as published in the Federal Register and from the rate-setting checklist. Sample certification language is also included.

9. The work group is sensitive to the issue of, on the one hand, providing a road map to understand rate development, while on the other hand, preserving practitioners' freedom to use actuarial judgment in the setting of individual assumptions. For example, Section IV, Item AA.3.2 provides a more comprehensive list of the usual considerations for expense allowance and profit/risk levels.
10. There is no prohibition on a state relying upon an MCO actuary's opinion. In some competitive bidding instances, there may be times when the state chooses to accept and submit to CMS the plan's certification.

III. The Medicaid Managed Care Regulation (including the "Comments and Responses" section)

Overview

In developing rates for capitated Medicaid managed care programs, actuaries follow the regulatory requirements stated in 42 CFR § 438.6 (c) and are normally familiar with the guidelines stated in the CMS checklist. In particular, CMS recommends that the "Comments and Responses" section preceding the main body of the regulation be reviewed, since it represents CMS's interpretation of the statutory requirements.

This section provides additional clarification of the regulatory requirements, and identifies areas where they appear to conflict with actuarial practices and principles.

Regulatory Requirements and Issues:

1. **Section 438.6(c)(4)(ii) requires that all payment rates be based only upon services covered under the state plan (or costs directly related to providing these services).**

   What are some of the issues related to this requirement? What would CMS allow, and what would actuaries usually do?

We can classify the non-state plan services into the following categories:

a. Substituted services that cannot be built into the rate calculations;
b. Substituted services that require demonstration that their equivalent value in state plan services can be included in the rate calculations;
c. Additional services that cannot be included in the rate calculations; and
d. Additional Medicaid waiver services that can be built into the rate for individuals specifically covered in the waiver (i.e., 1115 or 1915(c) waiver) or into a separate rate for individuals under a 1915(b)(3) waiver.[11]

In the "Comments and Responses" section, it is reported that there were concerns expressed regarding the rule that the state must exclude from the rate calculations any costs related to services that are not in the state plan. The "Comments and Responses" section includes a number of comments that favored the inclusion of these amounts. In general, these comments can be summarized by the statement, "MCOs must maintain the flexibility to be able to arrange for and provide whatever services most efficiently meet the needs of their members, and these alternative services may not be in the state plan." The position of CMS is that it will prevent states from obtaining federal financial participation (FFP) for things such as new b(3) services (a reference to the authorizing clause in Section 1915 of the Social Security Act) or other state-funded services, for which FFP would not ordinarily be available, by including them in an MCO, PIHP, or PAHP contract.

When discussing rates which are based on FFS data, the "Comments and Responses" section says that managed care contractors have the ability to provide services that are in the place of, or in addition to, services covered under the state plan and that these additional or alternative services do not affect the capitation rate paid to the MCO by the state.

In response to a comment about the use of encounter data for setting rates, CMS says, "actuaries must adjust the data to reflect FFS state plan services only. States cannot use … services not part of the state plan to calculate "actuarially sound" rates. We are open to suggestions from states and their actuaries, but we will not modify the basic principle that rates be based only on services covered under the state plan."

11. Actuaries are normally prudent to verify both that the data are according to waiver/contract services and that they are appropriately interpreting policy and reflecting the impact in calculated rates.

CMS indicates that it will accept a demonstration of cost efficiency for services that are delivered at the health plan's option. For example, in the substitution of sub-acute days for inpatient days, the rate development would usually convert the non-plan services to plan services on a substitution basis. This process is based on detailed encounter data permitting a comparison of the unit cost of the substituted service with the unit cost of the state plan service. This requirement to demonstrate savings may be more difficult (and perhaps impossible) to comply with if services are offered by a health plan to replace other services but are expected to decrease *future* costs, rather than current costs. Prenatal classes might be an example of this type of service. CMS acknowledges that it is important to allow health plans and states the opportunity to justify offering services that are cost efficient. However, there may be services that are offered to provide a better product to members that cannot be easily justified on a cost efficiency basis. These services may be treated as an administrative expense, classified as member services, or viewed as marketing.[12]

The reader may also wish to refer to:

(a) Discussion in Federal Register, p. 41003.
(b) Checklist section 2.4
(c) Practice note, section IV— checklist discussion on AA. 2.4

2. **Section 438.6(c)(5)(iii) specifies that contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered "actuarially sound."**

   What are the issues and what will actuaries normally do to comply?

The requirement that the incentive arrangements may not provide for payment in excess of 105 percent of the approved cap payments is a compliance issue and, if violated, would likely result in the payments being considered by CMS as non-compliant.

3. **In the "Comments and Responses" section, there were discussions that highlight actuaries' concerns regarding "actuarial soundness" — specifically, rate adequacy vs. methodology and process.**

   How is rate adequacy normally addressed?

Rate adequacy is a component of "actuarial soundness."

State rate filings have frequently required an actuarial opinion stating that "the rates are not inadequate, excessive, or unfairly discriminatory." However, the actuary stating the opinion is normally hired by the company filing the rates, either as an employee or as a consultant, and usually has access to the data, assumptions, business plans, etc. that support those rates.

Rate adequacy for Medicaid would normally mean that rates calculated and paid by a state Medicaid agency are likely to cover the costs of the program. The actuary working for the state may only have access to publicly available financial information about the health plans that contract with the state.

12. These non-state plan services may also be covered under a b(3) waiver if the state had previously received one. These waivers were to provide FFP for non-state plan services that were paid for using savings realized in moving to managed Medicaid. However, CMS has taken the position that there will be no new b(3) waivers approved. Existing b(3) waivers have been grandfathered effective August 2003; however, CMS has stated that no new non-state plan services can be added, and that the average increase in costs for the b(3) services cannot exceed the average increases in costs for the state plan services.

It is generally difficult to set any specific administrative targets, either in percentage of capitation or amount per member per month (PMPM), without knowledge of the specific environment in each state – including such items as populations covered, services covered, medical costs, access to health care, and other factors.

The same concept applies to profit/risk levels. It is generally difficult to specify a precise value, and this practice note makes no attempt to do so. However, there would usually be appropriate profit/risk margins included in the capitation rates.

Provider reimbursement and medical management are also usually difficult for an outside observer to predict. Thus, the actuary may choose to make estimates based on what is publicly known about the level of Medicaid managed care in a specific state. The actuary may be able to reasonably estimate the level of management of health care from the encounter data.

The discussions on pp. 40998 and 41001 of the Federal Register contain information relevant to this issue.

4. **In the "Comments and Responses" section, the question is raised whether states will have the flexibility to take into account their FFS budgets, and managed care budget authority, when developing "actuarially sound" rates.**

   How would the actuary usually address this?

"Actuarially sound" rates or ranges of rates depend on the benefits provided and the population covered. These rates are normally independent of budget issues unless benefits or populations change.

In times of economic downturn, state budgets may exert pressure on rates that must be certified as "actuarially sound." This pressure can build as program expenditures are capped, yet "actuarially sound" rates are usually independently determined. In rate-setting, there is normally a range of reasonable assumptions. Budgetary constraints may influence the selection of certain assumptions toward the low end of the range. However, the actuary would usually be prudent to select assumptions that are individually reasonable and appropriate when deriving the final premium rates.

5. **Does the regulation require each rate cell to be "actuarially sound?"**

Section 438.6(c)(2) requires "all payments" to be "actuarially sound." Pages 40998–40999 of the "Comments and Response" section specifically state that "all payments" refers to individual rate cells. CMS appears to be looking for the certification of "actuarial soundness" to apply to each individual rate cell.

CMS also specifies requirements concerning the establishment of rate cells. Section 438.6(c)(3)(iii) requires states to establish rate cells by eligibility category, age, gender, region and risk adjustment (or explain why any of these factors is not applicable). Section AA.4.0 of the checklist indicates that the key principle is that rate cells should be developed *"whenever the average* [which we interpret as "expected"] *costs of a group of beneficiaries greatly differ from another group and that group can be easily identified."*

CMS expects that rates will usually be developed for appropriate rate cells, taking into account the credibility of the data for each rate cell. Where sufficient data are unavailable to establish a rate for a particular cell, the rate would normally be developed based on blended data from that cell and an adjacent cell. Further, separate rate cells would usually be established only where there is a meaningful difference in expected per capita costs.

6. **Section 438.6(c)(5)(ii) specifies that, if risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments *will not be considered "actuarially sound"* if they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the state plan services actually furnished to enrolled individuals.**

   What are the issues related to this requirement, and what would actuaries normally do?

This requirement is a compliance issue and, if violated, would likely result in the payments being unable to be determined as "actuarially sound."

State payments under risk corridor arrangements in excess of those permitted by CMS do not meet regulatory requirements. Since the contracts involved put the MCO at risk, CMS has determined that a limit on total payments should be established. Therefore, in developing both base rates and risk corridors, the actuary would usually consider the potential range of variation in experience that may emerge, so that in the aggregate the contractual arrangement meets the regulatory requirement under likely scenarios.[13]

13. In situations where there is little or no data on which to base rates, and risk corridors are being used, discussions with CMS may be appropriate to support compliance.

IV. CMS Rate-setting Checklist

CMS provides materials for regional offices to utilize in reviewing and approving contracts and capitation rates associated with Medicaid managed care programs. One of these tools is a checklist to be used by the regional offices in reviewing and approving the rates under 42 CFR 438.6(c) for all Medicaid managed care programs, excluding the PACE capitated programs. An actuary preparing capitation rates for use in Medicaid managed care programs would usually review and become familiar with the most recent version of the checklist. This section of the practice note provides a general overview of the checklist, as well as an outline of areas of the checklist that may have a potential for misinterpretation or may be counter to generally accepted actuarial practice. The comments prepared in this section relate to the checklist entitled "Appendix A. PAHP, PIHP, and MCO Contracts, Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03."

Overview

The checklist was developed by a CMS work group that had previously been involved in the development and/or review of capitation rates for managed care programs. Based on its own experience, as well as the regulatory requirements of 42 CFR 438.6(c), the work group prepared the checklist document to assist the regional offices in reviewing the materials prepared and submitted by the states and their consulting actuaries in support of their proposed Medicaid managed care capitation rates.

The checklist has been separated into seven primary sections. The rate-setting actuary would usually review the checklist document to become broadly familiar with each of these items. In reviewing the checklist, the rate-setting actuary may find it helpful to recognize that some of the items outlined may not be found in the rate-setting methodology that was used. Several of the items that are identified in the checklist relate to contractual or state regulation. The actuary may want to discuss these items with state Medicaid personnel to identify any likely impact on the rate-setting methodology. The following provides a brief description and overview of each section.

AA.1.0 — *Overview of Rate-setting Methodology*. This section requires documentation regarding the general rate-setting methodology and contract procurement and the actuarial certification. Under the contract procurement section, two methodologies are outlined: open cooperative contracting and competitive procurement. Under the open cooperative contracting methodology, the actuary may establish a single rate for each rate cell the state would use in contracting with the MCOs. Under the competitive procurement methodology, the actuary may establish a range of rates for each rate cell.[14] The actuary's range of rates would normally be used as a guide for either contract negotiations by the state or for submission of bids by the MCOs. A sample of an actuarial certification has been provided in Section VI of this practice note.

AA.2.0 — *Base Year Utilization and Cost Data*. This section outlines the types of data and information that may be used in the establishment of the capitation rate. The checklist indicates that the base year utilization and cost data should be consistent with the Medicaid services and population that will be covered by the contract. With respect to the Medicaid population selection, the actuary would normally become familiar with the different populations that are included or excluded from the MCO contract, including dual-eligibles and spend-down recipients. The checklist allows for the use of Medicaid FFS data, Medicaid managed care data, or non-Medicaid data. The checklist describes the types of services that may be used in the analysis. The checklist provides a description of the requirement for inclusion of state plan services only and possible allowances for additional services.

14. CMS has received some rate ranges based upon "Degree of Health Care Management" whereby the actuary assumed a higher or lower level of "care management" to develop the rates. CMS usually expects to see justification as to why the state or actuary expects a range of rates to be appropriate (e.g., inflation, trend, utilization variances).

AA.3.0 — *Adjustments to the Base-Year Data*. The section outlines the types of adjustments that would be allowed on the base-year data to develop the capitation rates. The checklist provides a listing of many items concerning which the actuary would usually exercise professional judgment to determine the appropriateness of the adjustment based on the underlying base-year data chosen. This section of the checklist illustrates the desirability of a movement from the prior upper payment limit rate-setting calculation methodology to the development of a capitation rate that would be "actuarially sound." For example, the factors reflect adjustments to reimbursement per unit of service,[15] utilization rates, and contractual obligation or benefit differentials so that the rates are "actuarially sound" for the covered Medicaid population. The rate-setting actuary is challenged to develop a rate that would be "actuarially sound" for a third-party entity. Usually, each of the adjustments would be carefully reviewed for applicability. The outlined adjustments typically include one for the review of the financial experience of the health plans. The rate-setting actuary would normally be familiar with the process of reviewing financial statements and interpreting the results.

AA.4.0 — *Establish Rate Category Groupings*. This section of the checklist outlines different rate-setting categories that would normally be considered in the establishment of the capitation rates. The rate-setting categories include age, gender, locality/region, and eligibility categories. The checklist indicates that each of these components would normally be used in establishing rate-setting categories, unless omitting a component or combining a rate category with an adjacent category can be justified.

AA.5.0 – *Data Smoothing, Special Populations, and Catastrophic Claims*. This section of the checklist outlines methodologies that may be used in the examination and modification of the data to reflect any data distortions or special populations. The checklist indicates that it is usually preferable for the data smoothing techniques to be cost-neutral. The checklist provides a brief definition of cost-neutrality for the actuary to review. This section also briefly discusses the use of health status-based (or diagnosis-based) risk adjustment.

AA.6.0. — *Stop Loss, Reinsurance, or Risk sharing Arrangements*. This section of the checklist includes an outline of the use of reinsurance, either commercial or state-sponsored, in the determination of the capitation rate. The regulations call for inclusion of these provisions to be determined on an "actuarially sound" basis. The risk corridor limit compares total payments to MCO state plan services provided, priced at the Medicaid FFS fee schedule, plus an amount for MCO administrative costs. A risk corridor or risk sharing mechanism may involve the actuary comparing the cost of the managed care program to a FFS program before receiving approval from CMS for the inclusion of a risk corridor program. The checklist discusses the inclusion of a risk corridor program and provides an example.

AA.7.0 — *Incentive Arrangements*. This section of the checklist outlines the use of incentive arrangements in the contract between the state and the MCO. An incentive arrangement provides additional funds in excess of the capitation rates for meeting specified targets. The checklist states that the incentive arrangement payment may not increase total payments above 105 percent of the approved capitation rates. Additionally, all incentives are expected to be determined through the use of an "actuarially sound" methodology.

Considerations in Complying with the Checklist

This section of the practice note discusses items that may be considered by the rate-setting actuary when developing the capitation rates and complying with the checklist. The checklist is a general document and probably does not cover every circumstance the actuary may encounter. Should the actuary think it appropriate to deviate from the guidance provided in the checklist, he or she would usually be prudent to describe and explain the deviation.

15. One commenter noted that "adjustments to reimbursement per unit of service" for the impact of intergovernmental transfers have been particularly problematic in the development of rates.

Section AA.2.0 — *Base-Year Utilization and Cost Data*. This section states, "States without recent FFS history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the highest degree of reliability, subject to RO approval."

Comment: The actuary should consider ASOP #23 (Data Quality) in the development of the base-year data. Generally, the actuary would consider all available data, including the Medicaid FFS data, Medicaid managed care encounter data, Medicaid managed care financial reports and Medicaid MCO financial statements. The actuary typically would compare data sources for reasonableness and check for material differences when determining the preferred source(s) for the base-period data.

The checklist refers to several data sources CMS would consider appropriate. The actuary typically would consider these data sources as well as the most recent available data that, in the actuary's professional judgment, appear to be reliable and well-suited to the assignment. The checklist acknowledges that there are instances where the commonly used data sources are unavailable.

Section AA.2.4 — *State Plan Services Only.* This section states, "The state must document that the actuarially sound capitation rates are appropriate for the services to be furnished under the contract and based only upon services covered under the state plan." Additionally, "Services provided by the managed care plan that exceed the services covered in the Medicaid state plan may not be used to set capitated Medicaid managed care rates."

Comment: The actuary may want to remove the value of non-state plan services and add in the value of any significant state-plan services that are not reflected in the data. Additionally, as FFS data erodes, data and information for developing the amount of the adjustment for substituted services may not be available.[16]

AA.3.0. — *Adjustments to Base-Year Data.* This section states, "The state made adjustments to the base period to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population."

This section includes adjustments that are more specific to the Medicaid rate-setting process than the rate-setting actuary will normally have encountered in the commercial or Medicare managed care environments. The rate-setting actuary is usually prudent to understand each of these adjustments and discuss these items with state Medicaid personnel as necessary. Additional comments related to the other adjustments are as follows.[17]

> Pharmacy rebates – State Medicaid programs, which participate in the federal drug rebate program, receive additional rebates for prescribed medications. The rebates are generally greater than rebates received by managed care organizations through their prescription drug contracts.
>
> Managed care adjustment – This adjustment may have a significant impact on the development of the capitation rate or rate ranges. The adjustment may be developed based on the reported experience of managed care organizations, be it publicly available or commercially available information. The managed care adjustments will usually affect both utilization rates and unit costs

16. Capitation rates may be based only on Medicaid state plan services to Medicaid covered eligibles, so an actuary would initially remove the value of non-state plan services. The actuary is usually careful to not reincorporate the value of these excluded services.
17. One commenter mentioned that managed care adjustment (initial or update) assumptions may also result from encounter data analysis benchmarking, or on-site operational reviews measuring the medical utilization and cost management effectiveness of the MCO(s). Assumptions could also be derived from state and/or MCO expectation of continuous improvement in the MCO's medical utilization and cost management.

Financial experience adjustment –This adjustment is most often used for a rate update approach, rather than a rate re-basing approach. These adjustments would usually arise only when calculating future rates based on prior rates.

AA.3.2. — *Administrative Cost Allowance Calculation*. This section says that the state must document that the rate was adjusted to account for MCO, PIHP, or PAHP administration.

In determining an appropriate level of an administrative cost allowance, the rate-setting actuary may want to consider the following items:

- Overall size across all lines of business
- Lines of business covered by the capitation
- Age of the health plan or years of participation in Medicaid
- Organizational structure
- Demographic mix of enrollees
- Marketing expenditures
- Claims processing expenditures
- Medical management expenditures
- Staff overhead expenses
- Member services
- Interpreter services

The section further notes, "CMS does not have established standards for risk and profit levels but does allow reasonable amounts for risk and profit to be included in capitated rates."

Comment: In the determination of an appropriate level of a profit and risk allowance, the rate-setting actuary may want to consider the following items:[18]

- Contingency margin
- Contribution to surplus
- Investment rate of return
- Profit margin

AA 3.7 — *Copayments, Coinsurance, and Deductibles in Capitated Rates.* This section says, "If the state uses FFS data as the base data to set rates and the state Medicaid agency chooses to not impose the FFS cost-sharing in its pre-paid capitation contracts with entities, the state must calculate the capitated payments to the organization as if those cost-sharing charges were collected."

Comment: When determining the appropriate adjustment for copayment amounts, an actuary considers an appropriate adjustment for a collection percentage associated with the copayment amounts.

AA.3.10 — *Medical Cost/Trend Inflation*. This section states, "Medical cost and utilization trend inflation factors are based on historical medical state-specific costs or a national/regional medical market basket applicable to the state and population. All trend factors and assumptions are explained and documented."

18. It may be appropriate for the actuary to consider the public nature of the venture (e.g., government owned PIHPs). Governmental entities without competitive procurement may not be permitted to have contribution to surplus, investment rate of return, or profit margin because this contributes to the federal Medicaid budget subsidiary programs not under Title XIX. Refer to OMB-A87 and 1903(i)(17) of the SSA. The actuary is usually prudent to have considered all relevant factors in selecting an appropriate level of profit and risk allowance.

Comment: The actuary may choose to consider a number of elements in establishing both utilization and unit cost trend rates. Utilization trend rates typically will be affected by changes in demographics, medical technology, benefit levels, and the degree and emphasis of medical management. Unit cost trends may be affected by changes in state-mandated fee schedules (if applicable), FFS cost levels, and provider contracting performed by the health plans. The contracted rates between the MCO and providers are potentially the most variable, by plan and by local market, and least likely to be known by the state's actuary. Therefore, a range of estimates may be more appropriate in accordance with the actuary's professional judgment. However, the rate-setting actuary may be requested to establish a single-point estimate for a cost trend.

Projection of future results through the projection of trend rates typically requires the most flexibility and judgment of any part of the rate analysis. Historical results from FFS or other data sources would normally be considered but not fully relied upon, because the mix of providers and services and the market landscape may have changed. In particular, FFS data may have deteriorated or may not apply in heavily managed care environments. Depending on the timing and impact of managed care implementation— and on market penetration and growth — increasing, flat, or decreasing trends may occur. Local market conditions are generally more important, but harder to determine, than statewide or nationwide trends.

Section AA.3.12 – Utilization and Cost Assumptions – This section states, "The State must document that the utilization and cost data assumptions for voluntary programs were analyzed and adjusted to ensure they are appropriate for populations to be covered if a healthier or sicker population voluntarily chooses to enroll."

Comment: The rate-setting actuary would normally consider the data used to develop the adjustment. If encounter data from the MCOs were used, the population may have shifted from the time of the base period to the time of the rate period. If some other base was used, the rate-setting actuary would usually verify that the adjustment appears to be appropriate. Examples of such adjustments would be those for a program change or expansion in the covered population.[19]

AA.5.2 – Cost-neutral data smoothing adjustment – This section states, "If the State determines that a small number of catastrophic claims are distorting the per capita costs then at least one of the following cost-neutral data smoothing techniques must be made."

Comment: The cost-neutral data smoothing techniques outlined call for the rate-setting actuary to balance the potential for adverse selection with the actual risk assumed by the managed care organizations. The checklist defines "cost neutral" as a process that results in no aggregate gain or loss across all payments categories. The rate-setting actuary may wish to select an appropriate methodology for pooling large claims or the inclusion of reinsurance.

AA.5.3 – Risk Adjustment – This section discusses the optional use of risk adjustment based upon enrollees' health status or diagnosis and requires that the risk adjustment be cost neutral.

Comment: The rate-setting actuary is usually prudent to be broadly familiar with the theory and statistical success as well as the inherent strengths and weaknesses of the risk adjustment model the state employs. Background materials on such models are frequently available through the Society of Actuaries and the American Academy of Actuaries, including several reports that outline the statistical characteristics of the models.

19. It is normally appropriate to include an analysis of whether or not the population covered under the contract has a different acuity than the data being used to set the rates.

The diagnosis-based risk adjustment methodologies generally utilize statistical models based on historical FFS or managed care base data. The reliance on diagnosis-specific data may be hindered by the capitation contracts that are often encountered in managed care programs. The capitation contracts may result in underreporting of encounter data to the managed care organization, and subsequently to the state Medicaid encounter system. The underreporting will usually result in a lower morbidity score than what might result from a review of all claims.

The rate-setting actuary would typically consider the adjustment technique that will be utilized in the rate-setting process. The diagnosis-based risk adjustment methods may be implemented using either concurrent or prospective adjustments. The actuary would usually consider the criteria for evaluating a risk adjustment mechanism that are identified by the Society of Actuaries and the American Academy of Actuaries in the reports mentioned above.

AA.7.0 – Incentive Arrangements – This section states, "CMS will not consider payment rates to be actuarially sound if incentive arrangements provide for payment in excess of 105 percent of the approved capitation rate payments attributable to the enrollees or services covered by the incentive arrangements…"

Comment: The requirement that the incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments is a compliance issue, and if violated, would normally result in the payments being unable to be determined as "actuarially sound."

In determining an "actuarially sound" incentive, the actuary would normally consider the specific criteria associated with utilization targets established within the terms of the contract. The amount of the incentive would usually reflect the cost of providing the services specified in the incentive clause. For example, if there is an incentive payment associated with increasing the number of members receiving physical examinations, then the incentive payment typically would be based in part on the cost of providing the additional physicals.

The checklist is not clear if the 5 percent limitation is by rate cell or in total. As an illustration, in the example of providing physical examinations to adults, it is unclear if this particular incentive payment is limited to 5 percent of the adult capitation payments, or if it is only the sum of all incentive payments that is limited to 5 percent of the total capitation payment made to the health plan.

V. Documentation

This section provides an overview of documentation for Medicaid managed care rate development.[20] The actuary usually develops documentation in support of the actuarial work product. The extent of the documentation is normally appropriate to the circumstances for which the rates are developed. These items are indicated on the checklist. The documentation typically describes the relevant data, sources of data, material assumptions, methods and process by which the rates were developed with sufficient clarity that another qualified actuary practicing in the same field could make an objective evaluation of the reasonableness of the work product. Note that, for an actuary working on behalf of a state Medicaid agency, the regulation does not require that the documentation be shared with any party – such as a participating MCO – other than the actuary's client (i.e., the state).

The actuary normally explains the reason(s) for and describes the effect of any material changes in sources of data, assumptions or methods from the last analysis.[21]

Generally speaking, there are four key areas to be documented:

A. Data integrity

B. Experience period data

   1. Items related to claims data

   2. Items related to administrative cost allowance

C. Trend factors

D. Risk

The extent of the documentation would usually be, at a minimum, the level required in the checklist. The required documentation identified in the checklist includes the source(s) of data, material assumptions, the methods used, and the process by which the rates were developed. The actuary would usually explain the reason(s) for and describe the effect of any material changes in the source(s) of data, assumptions, or methods from the last rate-setting.

20. The documentation would usually include, at a minimum, the following five elements: 1) The state submits the actuarial certification for the final rates to be paid to the contractors; 2) Rates may be based only on Medicaid services; 3) Rates may only pay for services to Medicaid beneficiaries; 4) The state submits an expenditure projection comparing previous and proposed rates; and 5) The State explains any incentives or risk-sharing. Additional guidance on documentation may also be obtained from ASOP No. 31. Actuaries can appropriately prepare by examining approved Medicaid State Plans, waivers and contracts in order to understand the Medicaid services and Medicaid beneficiaries that are to be covered in the rates.

21. The documentation would usually be available to the actuary. The sharing of documentation is generally under the control of the actuary's client.

A. Documentation of Data Integrity.[22] The actuary normally documents how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Choice of experience period
- Choice of experience data
- Credibility/validation of data
- Adjustments and use of external data

1. Experience Period: For documentation purposes, an explanation of the basis by which the experience period was selected would usually be provided. For Medicaid ratemaking projects, the fiscal calendar may dictate the basic parameters of the project. The experience period will usually be selected to be the most recent, with sufficient time for reasonable runout to allow the rates to be determined in the fiscal process. If a different experience period than is normally used in the fiscal process is used, its use would typically be disclosed and explained.

2. Experience Data: Documentation would usually be provided so that only State Plan approved services that are the responsibility of the managed care organization are included in the base data (AA.2.4). A data book accompanies many managed Medicaid ratemaking projects. The data book typically provides a summary of the base data, often in sufficient detail to calculate experience period PMPM rates by rate cell.

3. Credibility/Validity: The methods and procedures used to validate the data would normally be documented.

4. Adjustments Made/Use of External Data: The source and relevance of any adjustments made or external data used in "completing" or enhancing the base data would usually be provided.

B. Documentation of the Development of Experience Period Costs. The actuary would usually document how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Calculation of exposure units
- Adjustments to experience data
- Policy and provider contract provisions
- Mix of Business [23]

1. Items related to claims data

The majority of the discussion in the previous section was on claims experience, its analysis, use, and modification (or adjustment). The current section begins to make refinements to the claims data, to begin to put it in a framework of developing rates. The claims experience will generally be divided by exposure units. This step presumes an appropriate mechanism has been developed to establish rate category groupings.

22. CMS requires base utilization and cost data from a Medicaid population or similar population adjusted to reflect only Medicaid services and eligibles. CMS further requires actuaries to use actual databases instead of samples to create the base data.
23. As the actuary examines splits of eligibles by demographic category, it might be determined that a mix of business adjustment would be beneficial between two rate cells due to shifts in exposure and cost.

- Exposure Units: This step is intended to encompass several items. The rate category groupings used would normally be documented, especially if there is a change from the prior structure. If specific population sub-groupings are expected to undergo special changes (due to program changes, redefinitions, or anticipated economic shifts), the actuary may choose to disclose how these factors adjusted the expected results. Documentation would usually include a description of the impact of retroactivity and plans' contractual responsibilities, when appropriate. Adjustments made to ensure that exposures are consistent with accepted base experience data (e.g., if a plan's encounter data were removed because they were considered invalid, also remove exposures) would also usually be documented (AA.3.4).

- Adjustments to Experience Data: To the extent adjustments differ between rate cells, documentation would normally reflect the differences.

- Operational/Benefit Changes: If an operational change is expected to impact the ratemaking, it would usually be described. Examples might include carving out a formerly covered service, or bringing a formerly carved out service back into the at-risk rates. A new type of service might be added or removed from covered services since the base year. An explanation of the change and its impact would usually be provided (AA.3.1).

- Investment Income: To the extent new benefits or new population groupings are added to the managed care program, or carved-out services are added back, there might be a lag in claims versus funding and an adjustment for investment income might be appropriate. An investment income adjustment can also be used when using FFS data. If used, disclosure and documentation are normally provided.

- Special populations adjustments: The checklist states that this adjustment can only be made if the population has changed since the base period experience data. If this occurs, an explanation of the adjustment would usually be provided (AA.3.3).

- The actuary usually discloses whether any DSH payments are included in the rates (AA.3.5); typically they are not.

- With respect to third-party liability, the actuary normally explains the TPL arrangement and documents any significant adjustments (AA.3.6).

- Policy and Provider Contract Provisions: To the extent that deductible, coinsurance, copays, coverage limitations and coordination of benefits impact the Medicaid managed care population or expanded populations, it may be appropriate to model policy and contract provisions against available data and their documented impact (AA.3.7). The Medicaid checklist discusses incentive arrangements, and requires the parameters of the program and its impact to be documented (AA.7.0).

- With respect to graduate medical education (GME), the actuary usually documents any material adjustments (AA.3.8).[24]

- With respect to FQHC/RHC, the actuary usually document any material adjustments (AA.3.9).[25]

- Smoothing/Large Claims (Shock Loss Claims): The effect of large claims, including the effect

24. States may pay GME outside of capitation rates only if these payments are excluded from the capitation rate and are not more than they would have been under FFS.
25. CMS has specific requirements that the actuary usually considers in the documentation of the appropriate treatment of services rendered by FQHC/RHCs.

of large claims on the experience period data and on the projection of historical data to the rating period, and how the cost of large claims is incorporated in the ratemaking process would normally be documented. The effect of reinsurance arrangements is often related to the discussion on large claims.

Smoothing can be used to reduce distortions in the data caused by a few large claims. The checklist requires smoothing to be cost-neutral. Documentation on the technique used would usually be provided.

- Any additional material adjustments would normally be explained.

2. Items related to expense allowance

- Administrative Expenses: Expenses are usually an important part of the development of rates. In general terms, expenses are sometimes referred to as retention. Retention includes expenses, as well as risk charges (possibly for pooling or other contingencies), the cost of capital and the ability to support reserves (and capital) needs with a contribution to surplus. Assumptions used to adjust for each of these factors would normally be documented. (AA.3.2)

- The documentation may address the treatment of other items of retention, including all provision for risk charges and the cost of capital and the ability to support reserves with a contribution to surplus.[26]

C. Documentation of Trending Factors. The actuary would typically document how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Trend Measurement

- Claim Cost Trend Factors

- Other Trend Factors

The documentation of trend and its measurement and application can be a critical area to understand. The report would usually include a comparison of last year's trended rates to this year's estimates.

- Trend Measurement and Trend Selection: The method of developing cost and utilization trend factors would usually be documented in appropriate detail.

- Claim Cost Trend Factors: The factors affecting the change in claim costs over time would typically be discussed. Unless otherwise accounted for, these factors usually include, but are not limited to: general price inflation, leveraging, changes in provider contract, medical cost inflation, changes in medical practice, demographics, changes in policy provisions, and utilization.

- Other Trend Factors: The factors affecting the change of other ratemaking parameters over time would normally be disclosed.

D. Issues Related to Documentation of Risk. The actuary would normally document how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Risk Provision: In an at-risk ratemaking process, there is typically an expectation that a participant should have a reasonable probability of achieving target-operating margins. The target-operating

26. Risk charges are also addressed in Section D, Issues Related to Documentation of Risk.

margin would usually be disclosed. If the target-operating margin is 0 percent for the entire system, one scenario is that 50 percent of the participants will exceed the target and 50 percent will not. In this simple example, for plans to achieve target-operating margins, the operation of the plans as a whole would usually be expected to achieve a more efficient delivery of care than the assumptions suggest. Many actuaries prefer the target-operating margin to be positive (i.e., rather than be 0 percent). They believe that this level of target margin would normally be achievable by a health plan operating in an efficient manner within the program guidelines.

- Stop Loss, Reinsurance, or other Risk Sharing: Rates would normally be adjusted to reflect the risk the State is willing to assume. Documentation on the effect to the rates would usually be provided. This risk factor is covered in Subsection 6.0 of the checklist.

- External Influences: This factor appears to describe the pressures that might be affecting state budgets. Refer to Section III, Item 4 of this draft, for guidance on this issue. Other external influences may come to the actuary's attention. Since these circumstances will most likely not have an existing body of knowledge or data available, discussion with CMS early in the process is recommended in most instances.

- Risk Classification Plan: The issue of risk classification is directly covered in the checklist at Subsection AA.5.3 The documentation would usually include:

    - An explanation of the risk assessment methodology chosen

    - Documentation on how payments will be adjusted

    - Demonstration of cost neutrality

    - Procedures for monitoring and re-basing

Conclusion

Normally, the actuary's documentation would address the reasonableness or appropriateness of the assumptions and methodology used in the ratemaking process. The chosen data, assumptions used, and adjustments made would usually be provided. The size and effect of any significant adjustments would usually be included, as well as a statement to the effect that the adjustments are mutually exclusive and are not being applied more than once if such a statement is accurate.

VI. Certification Language[27]

Sample Certification Language
State of XXXXX
Actuarial Certification

I, {your name}, am an employee of the Division of Medical Services of the State of XXXXX. {If a consulting actuary, the actuary would usually indicate the company affiliation.} I am a Member of the American Academy of Actuaries {mandatory} and an Associate / Fellow of the Society of Actuaries {if applicable}. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board. I have been employed {either as an employee or as a consultant} by the State of XXXXX for the past YY years and am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.6(c), according to the following criteria:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42 CFR 438.6(c).

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with {either the state or the MCO}. The "actuarially sound" capitation rates / rate ranges that are associated with this certification are effective for the YY month period beginning July 1, 200X.

The "actuarially sound" capitation rates are based on a projection of future events. It may be expected that actual experience will vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency (if applicable).

The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

_____ _____
John Q. Smith Date
Member, American Academy of Actuaries

27. This sample certification language is offered solely for educational purposes and is not intended to limit in any way the content of individual actuaries' certifications. The actuary is encouraged to develop appropriate language for each certification, and is under no obligation to make use of the sample language offered here.

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