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Annual Report of Managed Care in Minnesota's Health Care Programs

REPORT FOR HEALTH CARE SERVICES IN 2011

Department of Human Services
Health Care Administration

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For more information contact:

Minnesota Department of Human Services
Health Care Administration
P.O. Box 640983
St. Paul, MN 55164-0983
651-431-2106

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I. Introduction

In 2011, Minnesota provided publicly funded health care coverage to a monthly average of approximately 860,000 Minnesotans who have low-income, disabilities or are age 65 or older. Minnesota spent more than $7.9 billion of state and federal funding to provide coverage in 2011. Much of that coverage ($3,608,315,352) is provided through private nonprofit health plans and county-based purchasing entities. Collectively, these organizations are known as managed care organizations (MCOs). MCOs are prepaid on a capitated basis, meaning that they receive a pre-arranged, fixed monthly fee to provide all of the health care services covered by Minnesota's various public health care programs.

Given the number of individuals served and the amount of taxpayer dollars used to support Minnesota's programs, it is critical that these programs are transparent and that Minnesotans are able to trust that their tax dollars are being spent wisely on high-quality, high-value programs. Transparency and trust are particularly important when significant dollars are being spent with private-sector health plans to meet the health care needs of Minnesota's most vulnerable populations.

On March 23, 2011, Minnesota Governor Mark Dayton issued an Executive Order (EO 11-06) requiring the Commissioner of Human Services to develop an annual, comprehensive managed care report to ensure that there is appropriate disclosure and accountability for state and federal spending on managed care health plans in Minnesota's public health care programs. This is the first report produced in response to that Executive Order, and includes the following sections:

Section II. **Overview and History.** This section provides a history and background of Minnesota's public health care programs and the relationship of the various programs to managed care. It includes information about state and federal laws that authorize the use of managed care in Minnesota's health care programs.

Section III. **Enrollment in Managed Care.** This section examines issues associated with enrollment in MCOs, including statistics on the number of enrollees, requirements to enroll, processes and education provided.

Section IV. **Managed Care Organization Contracting and Procurement Process.** This section provides a description of the methodologies used to procure and contract with the MCOs.

Section V. **Rate Setting and Risk Adjustment Methods.** This section provides a high-level overview of the rate setting and risk adjustment processes used in paying the MCOs the fixed capitation payments.

Section VI. **2011 Managed Care Financial Reports.** This section provides detailed information about the financial activities of all of the MCOs as reported in their 2011 audited financial statements.

Section VII. Quality, Access and Outcomes, and Performance Measurement. The final section provides an overview of the MCOs' quality as determined by performance measures and regulatory compliance assessments.

II. Overview and History

Overview

Minnesota, through its Department of Human Services (DHS), administers the Medical Assistance (MA) program under Title XIX of the Social Security Act. Medical Assistance provides health care services that address acute, chronic and long-term care needs for approximately 710,000 Minnesota residents.

In addition to Medical Assistance, Minnesota has a state-based program called MinnesotaCare, which provides acute care services for approximately 125,000 Minnesota residents. Minnesota receives federal funding, or federal financial participation (FFP), for infants, children, pregnant women, parents and caretaker adults enrolled in MinnesotaCare. Minnesota also covers adults without children in MinnesotaCare, but received no federal funding for those individuals for CY2011.

Individuals can be eligible for Medical Assistance or MinnesotaCare for many reasons. Appendix A provides an overview of requirements for the most common eligibility categories.

Managed care is an organized, coordinated health care system that provides comprehensive health care services. MCOs organize and coordinate care by using contracted provider networks, having provider payment arrangements that incent quality, and implementing administrative and clinical systems for utilization review, quality improvement and enrollee services. Managed care also uses targeted case management for certain complex and high-cost health services.

MCOs are prepaid on a capitated basis, which means that they receive a pre-arranged, fixed monthly fee to provide all health care services covered by Medical Assistance and MinnesotaCare. The capitated amount paid to MCOs varies by characteristics of enrollees (e.g., age and gender) and by health care program, but does not change based on the number of services an enrollee actually uses. Total amount of capitation payments including withhold amounts made in 2011 was $3,608,315,352.

Minnesota was one of the first states to receive a federal waiver to implement a mandatory managed care program for its Medicaid recipients. The waiver allows for the purchase of health care coverage from MCOs on a prepaid capitated basis. Currently, many Medical Assistance recipients and all MinnesotaCare recipients are required to choose an MCO serving their geographic area and then receive all health care services through the selected MCO. As of December 2012, approximately two thirds of MA recipients (499,739) were enrolled in managed care.

History

In 1985, DHS began to use MCOs on a prepaid, capitated basis through an initiative known as the Prepaid Medical Assistance Program, or PMAP. Originally, PMAP included Medical Assistance recipients in three Minnesota counties. In 1992, MinnesotaCare was established. In 1995, Minnesota received a federal waiver to require most Medical Assistance recipients and all MinnesotaCare recipients to receive health care services through MCOs. PMAP and the use of MCOs have expanded to all 87 Minnesota counties.

In 1997, the Minnesota Legislature passed a law allowing county-based purchasing entities[1], or CBPs, to contract with DHS to provide Medical Assistance services. In 2000 and 2002, Minnesota received a federal waiver that allowed South Country Health Alliance and PrimeWest Health to be MCOs as county-based purchasing entities and to provide Medical Assistance health care services on a prepaid, capitated basis.

Dual Eligibles

Since 1985, Minnesota seniors (age 65 and older) who meet eligibility criteria for Medical Assistance have been covered under PMAP. However, 95 percent of these seniors are dually eligible for both Medicare and Medicaid. For dual eligible Minnesotans, Medicare covers the individual's preventive and acute care; and Medicaid covers Medicare deductibles, copayments, and any additional Medicaid services including most long-term care services.

Programs for seniors (MSHO/SNP/MSC+): In the early 1990s, Minnesota passed a law that provided authority for the development of integrated Medicare and Medicaid programs for dually eligible people to better coordinate care and reduce conflicting financial incentives between the two programs. In 1995, the Centers for Medicare and Medicaid Services (CMS) gave Minnesota approval for a dual eligible demonstration program called the Minnesota Senior Health Options (MSHO) for Minnesota seniors in PMAP. In 1997, MSHO was implemented in the seven-county Twin Cities metro area. CMS and DHS had joint contracts with three managed care organizations to provide all dual Medicare and Medicaid services. Enrollment in MSHO was a voluntary alternative to enrollment in PMAP for Medicaid seniors.

In 2005 and 2006, as part of implementing the Medicare Part D pharmacy benefits, CMS transitioned the MSHO managed care organizations to Medicare Advantage Dual Eligible Special Needs Plans (SNPs). During this time, MSHO also expanded to all 87 Minnesota counties. At the same time, Minnesota received federal waiver authority to mandatorily transition seniors in PMAP into a new program called Minnesota Senior Care Plus (MSC+), which includes long-term care benefits. The change to MSC+ was phased in over several years and was fully implemented statewide in all 87 counties by 2009.

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[1] County Based Purchasing provides an opportunity for locally designed service delivery systems that involve the coordinated efforts of counties, providers, and consumers through a community planning process. There are currently three County Based Purchasing entities:

1. South Country Health Alliance in Brown, Dodge, Freeborn, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena, and Waseca counties.
2. PrimeWest Health System in Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens, and Traverse counties.
3. Itasca Medical Care in Itasca County.

Currently, eight MCOs participate in the MSHO and MSC+ programs. These two programs serve approximately 49,000 of Minnesota's 55,000 seniors in Medicaid. The other 6,000 are served in fee for service because of various managed care exclusions.

Currently Minnesota seniors on Medical Assistance are required to enroll in MSC+ either through an MCO, or the fee-for-service program. Approximately 37,000 seniors have voluntarily enrolled in MSHO as an alternative to MSC+. Medicaid benefits under MSHO and MSC+ are the same under both programs. The primary difference between MSHO and MSC+ is that MSHO provides all Medicare and Medicaid services through a single managed care organization, whereas, MSC+ provides Medicare services through CMS' fee-for-service program and separate Medicare Part D drug plans. A significant feature of both programs is the provision of care coordination. Each enrollee is assigned a care coordinator upon initial enrollment. Care coordinators assess enrollees' health, assist enrollees in navigating the health care system and work with enrollees to ensure that care is provided in appropriate settings.

Program for people with disabilities (SNBC): In 2006, Minnesota passed a law for an integrated Medicare and Medicaid managed care program for people age 18-64 with disabilities. The new program, called the Special Needs BasicCare (SNBC), was implemented in 2008 and was offered by eight SNPs in all 87 counties. Enrollment in SNBC was voluntary. The program initially integrated Medicare and Medicaid through state contracts with MCO SNPs. However, between 2010 and 2011, several SNBC plans dropped out of Medicare Advantage. Currently, SNBC is provided through five health plans in 78 counties. However, only three of the health plans are Medicare SNPs. Consequently, most SNBC enrollees are only enrolled in managed care for Medicaid services. Medicare services are largely provided through CMS' fee for service and separate Medicare Part D plans.

In 2011, Minnesota passed a law that requires people with disabilities receiving Medical Assistance to be assigned to an SNBC health plan unless an individual chooses to opt out of SNBC enrollment and remain in MA fee-for-service. Beginning Jan. 1, 2012, people with disabilities under age 65 who had MA fee-for-service coverage were asked to enroll in an SNBC health plan. Enrollment of adults with disabilities into SNBC was phased in between January and August 2012; enrollment of children has not yet started. In December 2011, 7 percent of the eligible adults, or 6,148 people, were enrolled in SNBC. Currently, 43 percent of the eligible adults, or 36,788 people, are enrolled in SNBC.

Authorities for Managed Care

State law authorizes the Department of Human Services to provide health care services through managed care for MA and MinnesotaCare, specifically:

- Prepaid Medical Assistance Program (PMAP)
    - Minnesota Statutes, § 256B.69
    - Minnesota Rules, Parts 9500.1450 to 9500.1464

- MinnesotaCare
  - Minnesota Statutes, § 256L.12
- Minnesota Senior Health Options (MSHO)
  - Minnesota Statutes, § 256B.69, Subdivision 23
- Special Needs BasicCare (SNBC)
  - Minnesota Statutes, § 256B.69, Subdivision 28

Federal authority for Minnesota to operate its Medical Assistance and MinnesotaCare programs is in the Balanced Budget Act of 1997 implemented under the Medicaid Managed Care Regulations at 42 CFR 438. Additionally, CMS has granted Minnesota waivers to some of the Medicaid requirements in Title XIX of the Social Security Act to allow the delivery of health care services through managed care. The waivers, granted under the authority of section 1115 of the Social Security Act, are provided in Appendix B.

III. Enrollment in Managed Care

In January 2011, 396,054 MA and 159,248 MinnesotaCare recipients were enrolled in MCOs. The numbers varied throughout the year and as of December 2011, 455,625 MA and 125,209 MinnesotaCare recipients were enrolled in MCOs.

As of December 2012, 499,739 MA and 119,908 MinnesotaCare recipients were enrolled in MCOs. In total, 619,647 individuals were enrolled in managed care. Appendices C-E show a breakdown of the enrollment by MCO and program. Current enrollment figures can be located at: http://www.dhs.state.mn.us/id_018058

Recipients Enrolled in Managed Care
In general, Minnesota Rules, Part 9500.1450 to 9500.1464 requires all Medical Assistance recipients to enroll in an MCO, unless they meet one of the criteria for an exclusion (see Part 1452 of the Rules). Similarly, Minnesota Statutes § 256L.12 requires all MinnesotaCare recipients to enroll in an MCO. The following groups are required to enroll in an MCO:

- Children under age 21 in Medical Assistance and MinnesotaCare
- Pregnant women in MA and MinnesotaCare
- Adults and parents in MA and MinnesotaCare
- Adults age 65 years and older in MA
- People with disabilities age 18 - 64 in MA, unless they choose to opt-out.

There are some situations where a recipient is in fee-for-service (FFS) prior to enrolling in managed care. This occurs when:

- New recipients are pending an MCO selection. The enrollment process allows the recipient 30 working days to select an MCO before assigning one. This results in 30-60 days FFS coverage prior to MCO enrollment.
- An enrollee moves out of the MCO service area and the MCO is not available in the new county. The enrollment process would begin again.
- There is a retroactive change in the basis of eligibility/or change in major program.
- Enrollees who are hospitalized in an acute care facility at the time of enrollment in managed care shall commence the first of the month following the month of discharge from the hospital. There is no delay in enrollment for enrollees in the integrated (Medicare/Medicaid) programs.
- There is a payment application error. If the MinnesotaCare premium payment is applied to the wrong obligation it may result in either a delay in enrollment or a non-payment cancellation. If this happens and the enrollee is given retroactive MinnesotaCare eligibility, the enrollee will have FFS coverage.

Some Medical Assistance recipients are excluded from the requirement to enroll in an MCO. These individuals receive health care services through DHS' traditional fee-for-service program, although some individuals may voluntarily enroll in an MCO. Appendix F provides a list of the groups that are excluded from enrollment in an MCO.

Enrollment Process and Education

All Medical Assistance and MinnesotaCare recipients that are potential MCO enrollees are notified about the requirements and options to enroll in an MCO, and given a deadline date for enrollment. The deadline is no less than 30 days from the date the recipient is mailed educational materials. To ensure consistency across the state, all counties are required to use a standard set of educational materials developed by the Department of Human Services.

DHS or county staff provide information to Medical Assistance and MinnesotaCare recipients about their MCO options, including if enrollment in an MCO is required or voluntary. Due to the voluntary nature of the enrollment and the role of Medicare and Medicare Part D, enrollment in MSHO and SNBC is largely handled directly by the MCOs and department staff with assistance from the Senior and Disability Linkage Lines.

The following information is sent to all potential enrollees.

- Cover letter with managed care pre-printed enrollment form
  - https://edocs.dhs.state.mn.us/lfserver/Legacy/DM-0107-ENG
- "Your Guide to Health Plan Enrollment" brochure
  - https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3354-ENG
- Pre-enrollment questionnaire (not sent to MinnesotaCare recipients)
  - https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3354C-ENG
- County contact sheet detailing where the recipient should call with questions

- Return envelope
- Primary care network listing (PCNL) for each MCO available in the county.

Assignment to a managed care organization: All Medical Assistance recipients eligible to enroll in an MCO are encouraged to choose an MCO. If the recipient does not make a choice within 30 working days, the department systematically assigns them to an MCO and the MCO may assign the enrollee to a primary care physician, dentist and pharmacy.

All MinnesotaCare recipients are encouraged to choose an MCO. If the recipient does not make a choice, the department systematically assigns them to an MCO after the enrollee pays their MinnesotaCare premium.

When a Medical Assistance or MinnesotaCare client has either chosen an MCO or been assigned to an MCO, the recipient is mailed an enrollment notice. This notice informs the client of which MCO they have been enrolled in and the effective date that coverage begins under that MCO.

There are some special circumstances where a client is automatically assigned to an MCO:

- If an MA or MinnesotaCare client loses and regains eligibility within a 12-month period, they are automatically reassigned to the same MCO that they were enrolled in at the time they lost eligibility.
- If the mother of a newborn was enrolled in an MCO at the time of birth, the newborn will be enrolled in the same MCO as the mother.

Changing enrollment between MCOs
After a Medical Assistance or MinnesotaCare client is enrolled in an MCO, there are opportunities and options for changing enrollment between MCOs. The following is a list of options for switching MCOs:

- First year change - Enrollees may change to a new MCO at any time during the first 12 months after initial enrollment in an MCO. The first day of enrollment is defined as the initial effective date of MCO enrollment.
- Open enrollment - Enrollees may change MCOs during the annual 30-day open enrollment period, which starts in the fall with the mailing of the open enrollment notices. Enrollment in the new plan is effective January 1 of the following year.
- The first 90 days after MCO enrollment - This change option is available within 90 days with each enrollment in a new MCO.
- Termination of MCO contract - An MCO must notify the state 150 days prior to terminating its contract. Enrollees are then notified of the need to choose a new MCO.
- Following a break in eligibility of more than two full calendar months - The enrollee must request the change in MCOs within 60 days of being re-enrolled.
- If the client was not eligible at the time of open enrollment.

- If the enrollee permanently relocated to another county and requests a change within 60 days from the date of relocation.
- If there is a change in health care programs (e.g., an enrollee moves from MA to MinnesotaCare) and the enrollee requests a change.
- Inaccessibility to the enrollee's primary care provider - Inaccessibility in the metro area is defined as the travel time to an enrollee's primary care provider exceeding 30 minutes or 30 miles from the enrollee's residence. In the non-metro area inaccessibility is when travel time is considered excessive by community standards. A written appeal request must be submitted to the Managed Care Ombudsman for approval.
- Agency error - Upon an enrollee's request, the county shall change an enrollee's MCO or primary care physician/dentist without a hearing when the enrollee's MCO or primary care physician/dentist choice was incorrectly designated due to local agency error.
- Good Cause and Continuity of Care - In addition to the specific instances above, federal law (42 CFR 434.27(e)(2)(1998)) allows an enrollee to change MCOs at any time for "good cause." This is a highly subjective exception and decisions are determined on a case-by-case basis. Issues involved could be, but are not limited to, poor quality of care, lack of access to providers experienced in dealing with the enrollee's health care needs, continuity of care, or other reasons satisfactory to the Department of Human Services. The request to change MCOs based on "good cause" must be made to the managed care ombudsman within DHS.
- MSHO and SNBC enrollees are allowed to enroll, disenroll or change MCOs on a monthly basis.

Hospitalization at time of enrollment: There are special policies related to MCO enrollment for enrollees who are receiving inpatient hospital services when they would otherwise enroll in an MCO:

- For Medical Assistance enrollees who have fee-for-service coverage and are receiving inpatient hospital services, MCO enrollment will not become effective until the first of the month following discharge from the hospital.
- For clients receiving inpatient hospital services when eligibility is approved for MinnesotaCare, initial enrollment into managed care will begin the first day after discharge from the hospital.
- For MSHO enrollees who are hospitalized in an acute care facility on the initial effective date of coverage, MCO enrollment will not become effective until the day following discharge. The MCO will assume responsibility for medical services effective midnight the date of discharge.
- For Medical Assistance and MinnesotaCare enrollees who are receiving inpatient hospital services on the effective date of their enrollment into a different MCO (e.g., switching MCOs), the enrollee will remain in the current MCO and not switch to the new MCO until the first of the month after discharge from the hospital. The MCO in effect at the

time of the hospital admission is liable for the enrollee's charges through the month of discharge.

- MA, MinnesotaCare and MSHO enrollees who are receiving inpatient hospital services on the effective date of fee-for-service coverage because of contract termination, or a change in basis of eligibility, will remain covered by the MCO through discharge from the hospital.

IV. Managed Care Organization Contracting and Procurement Process

Procurement timeline

Every year the Department of Human Services issues a procurement to provide managed care services to eligible MA and MinnesotaCare enrollees. Minnesota Statutes, §16B.98, Subdivision 5(b) places a five-year limitation on the procurement of grant contracts, including managed care contracts. Consequently, DHS has a rolling cycle of procurements, or Request for Proposals (RFPs), that result in one-year contracts that can be renewed for up to five years. The details of the RFP cycle are dependent on the group of recipients being served, specifically:

- For non-disabled Medical Assistance enrollees under age 65 and all MinnesotaCare enrollees, MCO services are procured for a contract known as the "Families and Children" contract. For the Families and Children contract procurement, the state is divided into five regions and each region is procured once every five years. Appendix G shows the procurement schedule from 2013 through 2017.
- For MA enrollees age 65 and older, MCO services are procured for a contract known as the "MSC+/MSHO" contract. The MSC+/MSHO contract is procured on a statewide basis.
- For MA enrollees with a disability, MCO services are procured for a contract known as the "SNBC" contract. The SNBC contract is procured on a statewide basis.

Since MSHO is operated as a Medicare and Medicaid integrated program, MCOs participating in MSHO are required to also maintain a contract with a Medicare Advantage Dually Eligible Special Needs Plan (D-SNP). In order to qualify as a D-SNP, CMS requires that SNPs maintain a state Medicaid contract. Therefore for MSHO, coordination with Medicare procurement for SNPs is required. Some considerations in the development of the procurement schedule for MSHO include the timeline for Medicare SNP application and contracting or changes in SNP service areas which is about a 14-month process, monitoring of the most recent procurement issued in each county, and the county interest in county-based purchasing (CBP). In addition, MSHO SNPs are required to offer MSC+ in the same counties to minimize disruption to enrollees who are allowed to disenroll from the MSHO SNP but may stay in the same MCO for their Medicaid services. Similarly, coordination with Medicare procurement schedules is also necessary where there is integrated coverage for dual eligibles enrolled in SNBC.

RFP respondents
Only qualified MCOs can respond to the RFP. An MCO is qualified to respond to an RFP if they meet the definition of a managed care organization in federal law at 42 CFR Part 438.2.

Provided that an organization meets the federal requirements, the Department of Human Services may contract with any non-profit managed care entity, including health maintenance organizations licensed under Minnesota Statutes, Chapter 62D; other non-profit managed care entities such as county-based purchasing entities that meet applicable requirements under Minnesota Statutes, Chapter 62D; or an accountable provider network as defined under Minnesota Statutes, § 62T.01, Subdivision 3.

Additionally, a respondent must meet the following requirements:

- The respondent must be licensed or certified by the Minnesota Department of Health (MDH) in the county or counties for which it is submitting a proposal. The licensure or certification must be complete in accordance with the MDH regulatory checklist.
    - If the respondent is expanding its service area, the proposer must get approval from MDH for the expansion area. MDH notifies DHS when the proposer is licensed, certified or approved for a service expansion. Approval of a service expansion by MDH must be completed prior to the conclusion of the evaluation of the proposals. Any service area expansion for the integrated programs (e.g., MSHO or SNBC) must be approved by CMS.
    - If a new entity seeks to submit a proposal, it must either be licensed or certified by MDH and meet MDH's regulatory checklist prior to responding to the RFP.
- HMOs, county-based purchasing entities, and other qualified provider types must participate in Minnesota Health Care Programs, including MA and MinnesotaCare as a condition of licensure by MDH (Minnesota Statutes, §§ 62D.04, Subdivision 5 and 62N.25, Subdivision 2).
- The respondent must submit its provider network to ensure that there is adequate capacity to provide access to services to the populations covered under the procurement. Additionally, the respondent's network must include health care homes, essential and community health providers and federally-qualified health centers.
- The respondent must comply with HIPAA Security, Privacy, and Electronic Transaction Standards Regulations.
- The respondent must comply with the Minnesota Health Care Simplification Act.
- The respondent must meet the solvency standards established by the state for health maintenance organizations or be licensed or certified by the state as a risk-bearing entity.
- The respondent must meet the federal conflict of interest regulations and have safeguards in place for purchases involving Medicaid funds. These safeguards must be as strict as those in federal purchasing statutes, in accordance with 41 U.S.C. 423, and 18 U.S.C. 207 and 208. Minnesota Statutes, § 256B.0914 also requires the respondent to have conflict of interest safeguards.

Procurement Process – County Participation
The Department of Human Services is required to include counties in the development and issuance of the RFP, as well as evaluation of the proposals. As part of the RFP development, DHS staff travel to each county, or group of counties, to discuss the procurement process, timelines and the county's role. These meetings involve the County Human Services Director and several county staff members.

The county must identify information regarding its county administration, demographics, how services are currently provided, and identification of health care providers that are available and accessible to county residents. The county is also asked to provide specific input regarding general health care delivery, dental, transportation, chemical dependency, mental health for adults and children, public health, special health programs, the availability of specific providers, access related concerns, and any other health related issue. The information generated by each county is included in its own county-specific section of the RFP.

County reviewers assess each respondent's proposal to evaluate it in comparison to the issues raised in the county-specific section of the RFP. This helps ensure that the evaluation addresses community needs, county advocacy activities, and the adequacy of local provider networks. When the county reviewers finish reviewing all of the proposals, they present the information to their County Board. The County Board takes an official action to make its recommendation of the MCO(s) it selects to serve its county. The County Board then submits its recommendation to the department for inclusion in the final evaluation process. For the integrated programs (e.g., MSHO and SNBC), County Board recommendations are not required since CMS determines which MCOs will provide the Medicare services in the counties.

In the event of a disagreement between the counties and the department about procurement decisions, Minnesota law calls for a mediation process (Minnesota Statutes, § 256B.69, Subdivision 3a, Paragraph (d)).

After completion of the procurement process, the department facilitates follow up meetings with county staff, county providers and the MCOs to promote good relationships and communications between all parties.

Procurement Process – MCO Selection
Many factors are considered in selecting MCOs. The specific factors and the weighting/scoring of those factors depend on the specific procurement. However, the types of issues evaluated generally include:

- County Board recommendations
- The MCO's capacity to provide access to services in the entire county
- The MCO's quality of care
- The design of the MCO and the capacity of the MCO to meet enrollees' health needs
- The MCO's quality assessment and performance improvement program
- The MCO's administrative costs

- The MCO's cost
- The value of having more than one MCO serve a specific county
- Federal legal requirements related to counties identified as Metropolitan Statistical Areas (MSAs) – these counties must have more than one choice of MCO.
- The number of current program enrollees in the county
- If the MCO is also serving the integrated programs in the county
- If a single MCO is being proposed, what are the transition issues, such as continuity of care.

The Department of Human Services issued two separate procurements in 2011 to provide health care services to Medical Assistance and MinnesotaCare recipients effective Jan. 1, 2012. The first procurement included Brown, Dodge, Freeborn, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena and Waseca counties. The second procurement included Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties (seven-county metro area). All of the counties in these two procurements were identified on the 2012 procurement schedule. The seven-county metro area procurement was a competitively bid pilot authorized under Laws 2011, First Special Session, Chapter 9, Article 6, Section 96.

The first procurement resulted in contracts with South Country Health Alliance, UCare and Blue Plus. South Country Health Alliance will provide Medical Assistance and MinnesotaCare in all 12 counties. UCare will provide MA and MinnesotaCare in Dodge and Wabasha Counties and MinnesotaCare in the remaining 10 counties. Blue Plus will provide MinnesotaCare in all 12 counties.

The second procurement resulted in contracts with Blue Plus, HealthPartners, Medica and UCare. Blue Plus will provide Medical Assistance and MinnesotaCare in Dakota and Ramsey counties. Medica will provide MA and MinnesotaCare in Hennepin County. HealthPartners and UCare will provide MA and MinnesotaCare in all seven counties.

Maps showing the MCO choices by county for PMAP, MinnesotaCare, Minnesota Senior Care Plus (MSC+), Minnesota Senior Health Options (MSHO), and Special Needs BasicCare (SNBC) are Appendices H-L.

Evaluating MCOs - County Survey

The Department of Human Services evaluates MCOs' performance in a variety of ways and will be discussed in Section VII of this report. However, one evaluation mechanism – the county survey - ties closely to the RFP and contracting. Every July, the department sends a survey to all 87 counties along with a letter to the County Human Services Directors. The purpose of the survey is to obtain feedback regarding the performance of the MCOs operating in their county. DHS seeks input for contract requirements from the counties each contract renewal and incorporates their feedback and recommendations into the contract negotiation process.

The online survey tool is designed to obtain feedback from the counties regarding the performance of each MCO operating in their county and to identify any issues or concerns with access or service delivery. The eight areas for feedback identified in the evaluation include overall service, dental, elderly waiver, chemical dependency, mental health, pharmacy, public health and transportation services. The counties are asked to complete a survey for each MCO that serves their county. The counties are also given an opportunity to provide additional written comments and feedback.

The results of the survey are reviewed with each MCO at their individual contract negotiation session. Additionally, a written response is required from the MCO specifying what action was taken to address the issues and concerns raised by the county in the survey.

Contract Renewal and Negotiations

Upon completion of each Minnesota Legislative Session, the Department of Human Services reviews and analyzes new laws for their impact on Medical Assistance and MinnesotaCare related to benefits, eligibility, withholds and incentives, enrollee cost sharing and provider payment rates. New health care initiatives and studies, legislative reports, and mandates are also identified to determine applicability to managed care and MCO activities.

Prior to the annual renegotiation of any MCO contract, the department updates the previous year's contract language to reflect necessary legislative and policy changes. A redlined, draft contract for the next contract period is provided to each MCO prior to the first negotiation session.

MCOs must provide a 150-day notice to the Department of Human Services, if they are not interested in renewing the contract. Annually, the department sends out either a notice of non-renewal or an offer to enter contract negotiations for renewal of the contract with at least a 120-day written notice to the MCO prior to the effective date of the renewed contract.

Typically, negotiations with the MCOs start in September and usually complete the process in November. As described previously, there are three separate contracts: Families and Children, MSC+/MSHO, and the SNBC. We currently negotiate with 9 MCOs, which can result in 21 contracts. Seven of the nine MCOs administer the Families and Children and eight MCOs administer the MSC+/MSHO contracts. Five of the nine MCOs administer the SNBC contracts. In 2012, one MCO administers the Families and Children contract specific to the MA non-disabled adults without children population.

Contract negotiation begins with a plenary session for all participating MCOs, where the proposed contract changes in the draft contracts are explained by Department of Human Services staff. A separate plenary session is held for each contract. After the plenary sessions, individual negotiating sessions are held for each MCO for each contract they anticipate signing. To expedite this process, the MCOs are asked to submit a written issues list prior to these individual sessions so that the Department of Human Services is aware of which particular changes are at issue for the entity.

Upon completion of the negotiation process, contracts are sent to MCOs with whom the Department of Human Services has reached a verbal contractual agreement. After signatures by the MCO executives and the Department of Human Services, the contracts must be submitted to the Centers for Medicare and Medicaid Services for final approval of contract language and capitation rates.

Contract Management and Compliance

After the completion of the contract negotiation process, DHS assigns contract management staff to review the executed contracts and to identify all reporting requirements and other contractual requirements to ensure appropriate oversight of the contracts. Currently there are 111 reports required of each MCO. Contract managers monitor and assess on a monthly, quarterly and annual basis the reports for timeliness, accuracy, completeness, and compliance with the requirements, and will follow up with the MCOs as appropriate. They review and approve all enrollee information materials (e.g., provider directories, Evidence of Coverage, marketing materials, etc.) prior to distribution to make sure the materials meet contract and legal requirements. They also assess the MCOs networks for capacity and access to ensure adequate numbers and types of providers within a specific geographic location and track additions and terminations of providers within the MCOs' networks.

Contract management staff serves as the key contact person for assigned MCOs, providers and/or enrollees with issues regarding policy coverage and service delivery. They assist all parties in providing resolution to issues. They also provide clarification and interpretations on managed care policy and development to MCOs and DHS internal staff.

Contract management oversees 21 contracts. They are responsible to assess and enforce contract compliance with state and federal regulations and contractual requirements. They research and conduct investigations and take appropriate action as needed to achieve compliance. They develop, approve and manage corrective action plans as required and recommend sanctions when appropriate to correct identified deficiencies with the MCO. In addition to the Triennial Compliance Assessments that were conducted in 2011and discussed in section VII of this report, there were two corrective action plans and two privacy and security incidents. The two corrective action plans initiated were for: 1) inaccurate submission of critical access dental data; and 2) failure to follow requirements regarding the continuation of personal care assistant services pending the state fair hearing process. The two privacy and security incidents were isolated and involved unauthorized disclosure of information regarding two separate individuals. All issues were resolved satisfactorily.

V. Rate Setting and Risk Adjustment Methods

General Rate Setting Methodology

In general, MCOs' capitation rates are set on an aggregate basis, meaning that the Department of Human Services develops capitation rates on a statewide basis (not plan-specific) using data from all of the plans. The Department of Human Services does not negotiate rates on an individual plan basis. However, MCO capitation rates vary based on the demographic mix of enrollees enrolled in a plan. The demographic factors that cause the capitation rate to vary across plans are: Age, gender, type of eligibility, health-risk status, and geographic location. Additionally for seniors, the capitation rate varies by Medicare status and living-arrangement status. While the Department of Human Services does not negotiate rates on an individual plan basis, it does make certain plan-specific adjustments to the capitation rates based on hospital utilization, medical education and legislatively mandated enhanced hospital payments.

The base capitation rates for Families and Children contract and the MSC+/MSHO contract are developed from the MCOs' actual aggregate medical claims experience and costs. The capitation rates paid are a projection of anticipated MCO costs per member per month based on past cost and service utilization over a three-year period. The base period for the 2011 rates was 2006 through 2009. The capitation rates also incorporate cost-based adjustments such as utilization changes, underlying medical inflation, fee-for-service payment changes and ratable reductions, legislative changes in eligibility and benefits, administrative adjustments, and an allowance for contributions to reserves.

The capitation rates for the 2011 MCO contracts were set using these methodologies. Detailed rate setting reports created by the Department of Human Services' actuaries are provided in Appendices M-T.

Risk Adjustment

Risk adjustment of MCO capitation rates uses enrollees' health history to more accurately target money to managed care plans, which accept higher-cost individuals than the traditional demographic, age and gender rates. Risk adjustment uses the diagnosis history of an MCO's enrollees to assign relative cost weights to each enrollee. When the enrollees' weights are averaged across all of an MCO's enrollees, the result is a measure of each MCO's relative illness burden, or risk factor.

Each MCO's risk factor is multiplied by the average statewide capitation rate to determine the dollar value of a risk add-on, which is then added to the demographic rate for the enrollee. This compensates the MCO for enrolling higher-risk individuals. MCOs with higher risk scores receive a higher-risk add-on, and thus higher capitation rates; MCOs with lower risk scores receive lower compensation.

Competitive Bidding for 2012

In 2011, the Department of Human Services used a competitive bidding process in the seven-county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington) for the selection of MCOs for 2012 contract year. The Department of Human Services issued an RFP, where MCOs were expected to compete on cost effectiveness (i.e., capitation rates), provider networks, quality performance and organizational efficiencies.

For each of the seven counties individually, MCOs submitting responses were scored equally on a technical component and a cost bid. The technical component competitively scored issues such as:

- The MCO's ability to provide accessible, quality, and timely medical care to Medical Assistance and MinnesotaCare recipients.
- The MCO's ability to deliver high quality care as demonstrated through performance measures and quality assessments.
- The accessibility and availability of covered health care services through the MCO's provider network standards.
- The ability of the MCOs to address specific health care needs and concerns outlined by each county.

The cost bid competitively scored on: 1) the MCO's administrative expenses; and 2) the MCO's proposed capitation rates.

The competitive bidding process was used to select MCOs and set capitation rates for health care services in 2012. The focus of this annual report is MCO activities in 2011. Hence, this report will not provide a more in-depth review of the competitive bidding process. However, competitive bidding is another mechanism that the Department of Human Services is using to ensure that MCOs are delivering high-quality, cost-effective health care services.

VI. 2011 Managed Care Financial Reports

Minnesota law requires MCOs to file an annual financial statement, which is certified by an independent certified public accountant. The financial statements are filed on April 1st of each year with the Minnesota Department of Health, as the regulator for Health Maintenance Organizations and County-Based Purchasing Entities (see Minnesota Statutes §§ 62D.08 and 256B.692). These reports are publicly available at the Department of Health's website at: http://www.health.state.mn.us/divs/hpsc/mcs/financial.htm

Summary of 2011 Revenue and Expenses by Health Care Program

Table VI-1 provides an overview of all of the MCOs' combined financial activity for 2011 separated by health care program. For each health care program, the Table shows: 1) Member Months – The number of enrollees for each month summed across the 12 months; 2) Premium Revenue – The total revenue received in 2011 to provide health care services to the enrollees in that health care program; 3) Medical/Hospital Expenses – The total amount of money spent in 2011 to provide medical care to enrollees; 4) Administrative Expense – The total amount of money spent in 2011 on non-medical related services associated with the health care program; and 5) Operating Income (Loss) – The total amount of money gained or lost in 2011 operating the health care program.

Important notes about Table VI-1**:**

- Member months are reported in actual terms
- The dollar amounts identified in items 2-5 are reported in thousands, meaning that a table entry of $2,112,114 is equal to $2,112,114,000.
- Accounting rules allow MSC+ to be reported in various locations. Most MCOs reported it with MSHO, however Medica reported it jointly with PMAP.
- All premium revenue for PMAP and MinnesotaCare are State and federal dollars that are paid to the MCOs as a result of their contracts with the State of Minnesota.
- A portion of the premium revenue associated with MSHO and SNBC programs is a result of the MCOs' contracts with CMS to serve Medicare enrollees. These products integrate Medicare and Medicaid for dual eligible individuals and consequently collect premium revenue from each of the respective programs.

The bottom portion of Table VI-1 provides a summary of the cumulative financial impact of all of the health care programs.

Table VI-1. Summary of MCO Audited Financial Statements – Totals
($ are in thousands)

	All MCOs Combined
PMAP	
Member Months	4,714,143
Premium Revenues	$2,112,114
Medical/Hospital Expenses	$1,823,850
Administrative Expenses	$231,171
Operating Income (loss)	$57,093
MinnesotaCare	
Member Months	1,690,873
Premium Revenues	$650,160
Medical/Hospital Expenses	$614,154
Administrative Expenses	$56,232
Operating Income (loss)	$(20,226)
MSHO/MSC+	
Member Months	531,245
Premium Revenues	$1,262,151
Medical/Hospital Expenses	$1,144,972
Administrative Expenses	$66,880
Operating Income (loss)	$50,299
SNBC (MA + Integrated)	
Member Months	71,939
Premium Revenues	$122,575
Medical/Hospital Expenses	$115,695
Administrative Expenses	$29,151
Operating Income (loss)	$(22,270)
Total - 2011	
Member Months	7,008,200
Premium Revenues	$4,147,000
Medical/Hospital Expenses	$3,698,670
Administrative Expenses	$383,434
Operating Income (loss)	$64,895

Summary of 2011 Revenue and Expenses by MCO
Tables VI-2a and VI-2b provide a breakdown of each of the MCO's financial activity for 2011 separated by health care program. The bottom portion of Tables provides a summary of the cumulative financial impact of all of the health care programs on each of the MCOs.

Important notes about Table VI-1**:**

- Member months are reported in actual terms
- The dollar amounts identified in items 2-5 are reported in thousands, meaning that a table entry of $431,682 is equal to $431,682,000
- Accounting rules allow MSC+ to be reported in various locations. When possible we have moved it into the MSHO/MSC+ portion of the Table, however Medica reported it jointly with PMAP and it was not possible to move it.
- All premium revenue for PMAP and MinnesotaCare are State and federal dollars that are paid to the MCOs as a result of their contracts with the State of Minnesota.
- A portion of the premium revenue associated with MSHO and SNBC programs is a result of the MCOs' contracts with CMS to serve Medicare enrollees. These products integrate Medicare and Medicaid for dual eligible individuals and consequently collect premium revenue from each of the respective programs.

Tables VI-2a and VI-2b indicate that all of the MCOs had positive operating income from the PMAP program ranging from $2,240,000 (Itasca) to $15,660,000 (PrimeWest). Conversely, all of the MCOs other than UCare had negative operating income from MinnesotaCare. When all health care programs are considered, all of the MCOs other than Medica showed a positive operating income.

Medical and Administrative Expenses Compared with Premium Revenue
Table VI-3 compares the medical expenses, administrative expenses, and operating income to the premium revenue for each MCO for each health care program. The Table shows: 1) Medical Expenses as % of Premium – This is an estimate of the amount of premium revenue that was used for medical expenses; 2) Administrative Expenses as % of Premium - This is an estimate of the amount of premium revenue that was used for non-medical expenses, administrative expenses; and 3) Operating Margin – This is an estimate of the amount of the premium revenue that was contributed to reserves.

Table VI-3 only provides an estimate of the amount of premiums that went for medical expenses, administrative expenses and operating margin, because the financial statements are snapshots in time. For example, MCOs need to estimate the cost of enrollees' health care that occurs in the final month or two of 2011, but are paid for in 2012. Similarly, the financial statements for 2011 reflect the reconciliation of health care that occurred in the final month or two of 2010, but was paid for in 2011. In general, accounting issues that cross calendar years tend to balance each other out, although not perfectly.

Table VI-3 shows that on average the MCOs spent 86.4% of PMAP premium revenue on medical expenses. The MCOs varied between a low of 73.7% (PrimeWest) and a high of 91.1%

(Medica). Similarly, on average the MCOs spent 10.9% of PMAP premium revenue on administrative expenses. The MCOs varied between a low of 7.5% (HealthPartners) and a high of 15% (UCare). It is important to note that UCare's administrative expense included $29.5 million of a $30 million donation to the State. Without the donation UCare's administrative expense would have been 8.7%, and the highest administrative expense percentage would have been 12.5% (BluePlus). The MCOs average operating margin for PMAP as reported in the 2011 financial statements was 2.7% of premium revenue. However, the DHS contracts with BluePlus, HealthPartners, Medica, and UCare limited their operating margin to 1% and required of operating income over 1% to be returned to the State.

Table VI-2a. Summary of MCO Audited Financial Statements ($ are in thousands)

	Blue Plus	Health Partners	Itasca	Medica
PMAP				
Member Months	960,181	552,308	52,154	1,378,029
Premium Revenues	$431,682	$221,150	$26,665	$637,484
Medical/Hospital Expenses	$375,036	$199,699	$22,288	$580,754
Administrative Expenses	$54,005	$16,620	$2,137	$51,358
Operating Income (loss)	$2,641	$4,831	$2,240	$5,372
MinnesotaCare				
Member Months	635,150	215,378	17,393	448,889
Premium Revenues	$246,862	$81,233	$6,935	$174,529
Medical/Hospital Expenses	$229,982	$75,662	$7,548	$170,624
Administrative Expenses	$24,761	$6,198	$554	$12,256
Operating Income (loss)	$(7,881)	$(627)	$(1,167)	$(8,351)
MSHO/MSC+				
Member Months	155,807	51,258	5,756	119,115
Premium Revenues	$352,830	$121,542	$13,643	$314,658
Medical/Hospital Expenses	$301,806	$101,613	$13,623	$293,873
Administrative Expenses	$16,625	$7,966	$1,092	$12,420
Operating Income (loss)	$34,399	$11,963	$(1,072)	$8,365
SNBC (MA + Integrated)				
Member Months	0	0	0	25,026
Premium Revenues	$560	$-	$-	$38,961
Medical/Hospital Expenses	$(781)	$-	$-	$36,183
Administrative Expenses	$8	$-	$-	$18,981
Operating Income (loss)	$1,334	$-	$-	$(16,203)
Total - 2011				
Member Months	1,751,138	818,944	75,303	1,971,059
Premium Revenues	$1,031,934	$423,925	$47,242	$1,165,632
Medical/Hospital Expenses	$906,043	$376,974	$43,459	$1,081,434
Administrative Expenses	$95,399	$30,784	$3,783	$95,015
Operating Income (loss)	$30,493	$16,167	$1	$(10,817)

Table VI-2b. Summary of MCO Audited Financial Statements ($ are in thousands)

	Metropolitan Health Plan	PrimeWest	South Country	UCare
PMAP				
Member Months	188,630	213,292	248,683	1,120,866
Premium Revenues	$116,546	$100,505	$106,400	$471,682
Medical/Hospital Expenses	$89,660	$74,037	$86,845	$395,531
Administrative Expenses	$13,825	$10,808	$11,892	$70,526
Operating Income (loss)	$13,061	$15,660	$7,663	$5,625
MinnesotaCare				
Member Months	24,982	25,456	22,478	301,147
Premium Revenues	$8,959	$9,325	$7,300	$115,018
Medical/Hospital Expenses	$8,222	$9,250	$8,725	$106,508
Administrative Expenses	$2,073	$1,129	$1,091	$8,170
Operating Income (loss)	$(1,336)	$(1,054)	$(150)	$340
MSHO/MSC+				
Member Months	8,530	25,946	21,846	142,987
Premium Revenues	$23,543	$57,824	$47,267	$330,844
Medical/Hospital Expenses	$21,264	$55,923	$48,132	$308,738
Administrative Expenses	$2,642	$4,057	$4,092	$17,987
Operating Income (loss)	$(363)	$(2,156)	$(4,957)	$4,119
SNBC (MA + Integrated)				
Member Months	6,425	3,332	8,988	28,168
Premium Revenues	$14,737	$5,970	$13,454	$48,893
Medical/Hospital Expenses	$12,149	$6,616	$11,953	$49,575
Administrative Expenses	$5,959	$433	$750	$3,020
Operating Income (loss)	$(3,371)	$(1,079)	$752	$(3,702)
Total - 2011				
Member Months	228,567	268,026	301,995	1,593,168
Premium Revenues	$163,785	$173,624	$174,420	$966,437
Medical/Hospital Expenses	$131,295	$145,826	$153,288	$860,352
Administrative Expenses	$24,499	$16,427	$17,852	$99,702
Operating Income (loss)	$7,991	$11,371	$3,308	$6,383

Table VI-3. Comparison of Medical and Administrative Expenses to Premium Revenue

	Blue Plus	Health Partners	Itasca	Medica	Metropolitan Health Plan	Prime West	South Country	UCare	All Plans
PMAP									
Medical Expenses as % of Premium	86.9%	90.3%	83.6%	91.1%	76.9%	73.7%	81.6%	83.9%	86.4%
Administrative Expenses as % of Premium	12.5%	7.5%	8.0%	8.1%	11.9%	10.8%	11.2%	15.0%	10.9%
Operating Margin	0.6%	2.2%	8.4%	0.8%	11.2%	15.6%	7.2%	1.2%	2.7%
MinnesotaCare									
Medical Expenses as % of Premium	93.2%	93.1%	108.8%	97.8%	91.8%	99.2%	87.1%	92.6%	94.5%
Administrative Expenses as % of Premium	10.0%	7.6%	8.0%	7.0%	23.1%	12.1%	14.9%	7.1%	8.6%
Operating Margin	-3.2%	-0.8%	-16.8%	-4.8%	-14.9%	-11.3%	-2.0%	0.3%	-3.1%
MSHO/MSC+									
Medical Expenses as % of Premium	85.5%	83.6%	99.9%	93.4%	90.3%	96.7%	101.8%	93.3%	90.7%
Administrative Expenses as % of Premium	4.7%	6.6%	8.0%	3.9%	11.2%	7.0%	8.7%	5.4%	5.3%
Operating Margin	9.7%	9.8%	-7.9%	2.7%	-1.5%	-3.7%	-10.5%	1.2%	4.0%
SNBC (MA + Integrated)									
Medical Expenses as % of Premium	NA	NA	NA	92.9%	82.4%	110.8%	88.8%	101.4%	94.4%
Administrative Expenses as % of Premium	NA	NA	NA	48.7%	40.4%	7.3%	2.8%	6.2%	23.8%
Operating Margin	NA	NA	NA	-41.6%	-22.9%	-18.1%	8.4%	-7.6%	-18.2%
Total - 2011									
Medical Expenses as % of Premium	87.8%	88.9%	92.0%	92.8%	80.2%	84.0%	87.9%	89.0%	89.2%
Administrative Expenses as % of Premium	9.2%	7.3%	8.0%	8.2%	15.0%	9.5%	10.2%	10.3%	9.2%
Operating Margin	3.0%	3.8%	0.0%	-0.9%	4.9%	6.5%	1.9%	0.7%	1.6%

Table VI-3 shows that on average the MCOs spent 94.5% of MinnesotaCare premium revenue on medical expenses. The MCOs varied between a low of 87.1% (South country Health Alliance) and a high of 108.8% (Itasca). Similarly, on average the MCOs spent 8.6% of MinnesotaCare premium revenue on administrative expenses. The MCOs varied between a low of 7.0% (Medica) and a high of 23.1% (Metropolitan Health Plan). The MCOs average operating margin for MinnesotaCare as reported in the 2011 financial statements was -3.1% of premium revenue. However, the DHS contracts with BluePlus, HealthPartners, Medica, and UCare limited their operating margin to 1% and required of operating income over 1% to be returned to the State.

1% Operating Margin Cap for PMAP and MinnesotaCare

As described previously, 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. The effect of that contract provision was that the four MCOs repaid $75,264,109 to the State. Additionally, UCare made a $30 million donation to the State prior to the contracts being amended. If UCare had not made the donation, the $30 million would have been repaid to the State under the 1% cap on operating margin. Hence, between the UCare donation and the premium revenue returned to the State, the 1% cap's effective value to the State was $105,264,109.

The 1% cap applied to PMAP and MinnesotaCare cumulatively, hence it is not possible to calculate the impact on each program specifically. However, it is possible to calculate what the combined PMAP and MinnesotaCare premium revenues and expenses would have been without the 1% cap or the $30 million UCare donation. Table VI-4 shows what the premium revenues, medical expenses, administrative expenses, and operating income would have been without the 1% cap or UCare donation. The Table then shows the impact of the 1% cap (including the UCare donation) on operating income.

Table VI-4. – Impact of the 1% Operating Margin Cap and UCare Donation on PMAP and MinnesotaCare

Impact of 1% Cap	All MCOs No Cap/Cap	% of Premium No Cap/Cap
PMAP & MNCare Combined		
Member Months	6,405,016	
Premium Revenues	$2,827,083	
Medical/Hospital Expenses	$2,438,004	86.2%
Administrative Expenses	$257,403	9.1%
Operating Income - No 1% Cap	$131,676	4.7%
Repayment to The State	$105,264	3.7%
Operating Income - With 1% Cap	$26,412	0.9%

Table VI-5 shows how the 1% cap reconciles to the MCOs' 2011 financial statements. Lines 1 and 2 show the PMAP and MinnesotaCare revenue reported in the financial statement. Line 3 removes MSC+ premium revenue, which was jointly reported with PMAP. Line 4 adds into the premium revenue those premiums, which the State paid to the MCOs, but were set aside as an accrual for repayment to the State. Line 5 shows 1% of premium revenue.

Lines 6 and 7 show the PMAP and MinnesotaCare operating expense reported in the financial statement. Line 8 removes MSC+ operating expenses, which were jointly reported with PMAP. Line 9 shows the total operating gain for PMAP and MinnesotaCare before any other necessary adjustments. Line 10 shows the amount that the total operating gain is above 1% of premium revenue as reported in Line 5.

Lines 12 and 13 add back in any premium deficiency reserves. Premium deficiency reserves are funds that are set aside to reduce expected loss in future years based on expected expenses and expected revenues. Premium deficiency reserves have the financial effect of reducing current operating margins in an effort to address future losses. Line 14 shows the total operating gain for PMAP and MinnesotaCare after adjusting for premium deficiency reserves and is the sum of lines 10, 12, and 13. Line 15 shows the amount that the adjust operating margin is over the 1% cap and is the difference of Line 14 and Line 6.

Line 16 is a restatement of line 15. Line 17 is the amount of premiums, which the State paid to the MCOs, but were set aside as an accrual for repayment to the State. Line 18 is sum of Line 16 and 17 and is the sum of the MCO's adjust operating margin after taking into account the MCO's revenue, expenses, estimated repayment to the State, and premium deficiency reserves. Line 18 is the amount the MCO repaid to the State as of December 10, 2012.

Based on independent audits of the MCOs, which were completed in December 2012, the State is reviewing the need for additional adjustments to the operating margin.

Table VI-5. - 1% Operating Margin Cap for PMAP and MinnesotaCare

1% Cap Recovered as of 12-10-12					
Line	**Revenues**	**Blue Plus**	**HealthPartners**	**Medica**	**UCare**
1	PMAP Revenue	$474,089,804	$235,728,000	$637,483,545	$497,624,690
2	MNCare Revenue	$246,862,351	$81,233,000	$174,539,434	$115,018,215
3	Remove MSC+ Revenue from PMAP	($42,407,673)	$0	($49,336,076)	$0
4	1% Cap Accrual - Add Back	$0	$31,531,000	$25,300,000	$7,978,000
5	**Total PMAP & MNCare Revenue**	**$678,544,482**	**$348,492,000**	**$787,986,903**	**$620,620,905**
6	1% of Revenue - The Cap	$6,785,445	$3,484,920	$7,879,869	$6,206,209
	Operating Gain (loss)	**Blue Plus**	**HealthPartners**	**Medica**	**UCare**
7	PMAP Gain (Loss)	$7,263,365	$922,000	$5,370,729	$7,355,999
8	MNCare Gain (Loss)	($7,881,142)	($627,000)	($8,350,659)	$275,051
9	Remove MSC+ Operating Impact	($4,621,779)	$0	$10,810,988	$0
10	**Total Operating Gain (Loss)**	**($5,239,556)**	**$295,000**	**$7,831,058**	**$7,631,050**
11	Operating Gain Over (Under) 1% Cap	($12,025,001)	($3,189,920)	($48,811)	$1,424,841
	Premium Deficiency Reserve	**Blue Plus**	**HealthPartners**	**Medica**	**UCare**
12	2012 PDR PMAP	$19,729,000	$0	$0	$0
13	2012 PDR MNCare	$3,465,000	$0	$1,100,000	$0
14	**Total Operating Gain (Loss) w/o PDR**	**$17,954,444**	**$295,000**	**$8,931,058**	**$7,631,050**
15	Operating Gain Over (Under) 1% Cap w/o PDR	$11,168,999	($3,189,920)	$1,051,189	$1,424,841
	1% Cap Amount	**Blue Plus**	**HealthPartners**	**Medica**	**UCare**
16	Operating Gain Over (Under) 1% Cap w/o PDR	$11,168,999	($3,189,920)	$1,051,189	$1,424,841
17	1% Cap Accrual	$0	$31,531,000	$25,300,000	$7,978,000
18	**Total Owed to DHS for 1% Cap**	**$11,168,999**	**$28,341,080**	**$26,351,189**	**$9,402,841**
19	**Total Owed to DHS for 1% Cap - All MCOs**			**$75,264,109**	

Provider Payment and Reimbursement Rate
The audited financial statements provide information about the total amount of funding spent on medical expenses, but unfortunately provides little information about specific provider payment or MCO reimbursement rates. A better source of data for understanding specific provider payment and reimbursement rates is the encounter data MCOs are required to submit as part of their contract with DHS.

Encounter data are the health care claims or encounters that health care providers submit to MCOs for payment after delivering health care services to enrollees. The MCOs are required to submit to DHS the health care claims and encounter data along with information about the amount that the MCO paid the health care provider. DHS has long collected health care claims data that show: 1) Which enrollee received services; 2) Who delivered those services; 3) Where the services was delivered; 4) When the services were delivered; 5) What services were delivered. Unfortunately, DHS did not begin collecting information about the amount health care providers were paid for those services until May of 2011.

Additionally, DHS and the MCOs have been working together to ensure that the information related to the provider payment is complete, accurate and consistent across MCOs. While DHS will have high quality, provider payment data for calendar 2012, the data for 2011 is not adequate for identifying issues, changes or trends in provider payments in 2011. The 2011 provider payment data is incomplete and not fully consistent across MCOs. Fortunately, these issues have been resolved for 2012 and the data will be able to be used for reporting in the future.

VII. Quality, Access and Outcomes, and Performance Measurement

Quality Overview
As part of its longstanding quality strategy, the Department of Human Services provides oversight and monitoring to MCOs' activities to ensure that they provide high quality health care services to Medical Assistance and MinnesotaCare recipients. The MCOs' contracts require the MCOs to work with their health care providers to improve quality of care for enrollees. The Department of Human Services oversees and monitors MCO quality and compliance activities to ensure enrollee health care needs are being met and the quality of the services are maintained or improved.

The Department of Human Services has a written strategy for evaluating the quality of care delivered to Medical Assistance and MinnesotaCare recipients. Helping the Department of Human Services to purchase quality health care services is the primary goal of the Quality Strategy. DHS anticipates the Quality Strategy will result in all of the following essential outcomes:

- Purchasing quality health care services
- Protecting the health care interest of managed care enrollees through monitoring
- Assisting in the development of affordable health care
- Reviewing and realigning any DHS policies and procedures that act as unintended barriers to the effective and efficient delivery of health care services

- Focusing health care improvements on enrollee demographics and cultural needs
- Improving the health care delivery system's capacity to deliver desired medical care outcomes though process standardization, improvement, and innovation
- Strengthening the relationship between patients and health care providers

The Quality Strategy can be reviewed on the DHS public website at:
http://www.dhs.state.mn.us/healthcare/studies

The Department of Human Services also ensures that MCOs comply with federal External Quality Review requirements (42 CFR Part 438, Subpart E), which include an annual, independent, and comprehensive evaluation of each MCO's performance, relative to the quality of health care services, timeliness of services, and accessibility to care for enrollees. The Department of Human Services uses the Michigan Peer Review Organization as its independent, External Quality Review Organization.

Annual Quality Review of MCO Strengths and Weaknesses

The purpose of the annual evaluation is to review the strengths and weaknesses of each MCO, provide recommendations for improvement, and produce a public annual technical report on the External Quality Review Organization's findings. The annual technical report provides insight into an MCO performance on key indicators of health care quality.

The evaluation utilizes objective information from Healthcare Effectiveness Data and Information Set (HEDIS) performance measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction surveys, to determine each MCOs' strengths and weaknesses.

- "Strength" is any performance measurement score equal to, or above, the 90th percentile of the national mean benchmark measurement score for Medicaid HMOs as reported in the National Committee for Quality Assurance's Quality Compass. Strengths are shaded green in the following tables.
- "Weakness" is any performance measurement score that is equal to, or below, the 50th percentile of the national mean benchmark measurement score for Medicaid HMOs as reported in the National Committee for Quality Assurance's Quality Compass. Weaknesses are shaded red in the following tables.

The annual technical report is designed to comprehensively chronicle and compile the annual results of quality evaluation activities from diverse sources, so a picture can emerge of quality, access, and timeliness of services provided. This overall picture allows MCOs to see their own performance and improvement efforts and to formulate strategies for future endeavors based on the recommendations of the External Quality Review Organization. The annual technical report is also designed to provide the Department of Human Services with a gauge for how the MCOs as a whole are meeting quality expectations for enrollees.

Annual Quality Review for Children's Health

The External Quality Review Organization examined aggregate MCO performance on selected indicators to determine how well the health care needs of children were being met. As seen in Table VII-1:

- Primary care provider visits for children age 12-24 months is a strength compared to Medicaid HMOs nationally.
- Primary care provider visits for other age children (i.e., 25 months to 6 years; 7-11 years; and 12-19 years) are all within an acceptable range of performance above the 50th and below the 90th National Quality Compass percentiles.
- Adolescent well child visits and childhood immunizations are both a weakness and demonstrate an aggregated performance more than 10 percentage points below the 50th percentile compared to Medicaid HMOs nationally.
- The scores for well child care visits in first 15 months and well child care visits for children age 3-6 years is also a weakness below the 50th percentile.

In the case of immunizations, low rates likely reflect a lack of incentive to submit claims when they receive the vaccines for Medicaid enrolled children free of charge the Minnesota Vaccines for Children Program. Minnesota Community Measurement has calculated statewide rates gathered from clinic medical records for the same Combo 3 measure. The rate for Medicaid enrolled children was 71.1%, while the rate for other payers was 71.6%. The difference is not statistically different.

With more than half of Medical Assistance and MinnesotaCare enrollees under 20 years of age, The Department of Human Services expects that MCOs will work to improve care and services as stated in the External Quality Review Organization's Annual Technical Report recommendations, including utilizing technical assistance provided by the EQRO. Additionally, the MCOs are requested to provide a response on their efforts to address the recommendations made in the Annual Technical Report.

Table VII-1. Summary of MN Statewide Performance on Medicaid Child-Focused Indicators

Indicators	All MCO Statewide Avg	Nat'l Medicaid Avg
Child PCP Visits (12-24mos)	**98.60%**	96.09%
Child PCP Visits (25mos-6yrs)	92.60%	88.27%
Child PCP Visits (7-11yrs)	93.30%	90.22%
Child PCP Visits (12-19yrs)	93.20%	88.14%
Adolescent Well Child Care (12-21yrs)	35.60%	48.07%
Childhood Immunizations (Combo #3 - 2yrs)	58.80%	69.94%
Well Child Care in First 15 mos (6+ Visits)	55.20%	60.19%
Well Child Care (3-6yrs)	67.30%	71.89%

Annual Quality Review for Women's Health

In aggregate, the MCOs are meeting expectations on measures for women's care as indicated by performance in the three screening indicators for chlamydia, breast cancer, and cervical cancer screening as indicated in Table VII-2.

Table VII-2. Summary of MN Statewide Performance on Woman-Focused Indicators

Indicators	All MCO Statewide Avg	Nat'l Medicaid Avg
Chlamydia Screening	60.50%	57.47%
Breast Cancer Screening	57.80%	51.35%
Cervical Cancer Screening	72.30%	67.19%

Annual Quality Review for Senior's Health

There is only one Medicaid measure that exclusively references seniors – Adult preventive visits for individuals aged 65 and older. The MCOs aggregate performance for the measure is strength and exceeds the 90th percentile in comparison to Medicaid HMOs nationally.

Other relevant performance measures, that include seniors with adults under age 65, show mixed results. For example, scores related to Antidepressant Medication Management (Acute and Continuous) are below the 50th percentile, but Comprehensive Diabetes Care (CDC) (HbA1c Testing and LDL-C Screening) have statewide average scores are within an acceptable range as indicated in Table VII-3.

However, for MSHO and for some SNBC plans, Center for Medicare and Medicaid Services also collects additional information on Special Needs Plans' performance including Medicare

Advantage Star Ratings. Special Needs Plans are required by their Medicaid contracts to share all Medicare results with the Department of Human Services. For 2011, on average MSHO Special Needs Plans had Star Ratings of 4.0, which are among the highest in the nation.

Table VII-3. Summary of MN Statewide Performance on Senior-Relevant Indicators

Indicators	All MCO Statewide Avg	Nat'l Medicaid Avg
Antidepressant Medication Management (Acute)	42.60%	50.74%
Antidepressant Medication Management (Continuous)	30.50%	34.44%
Adult Preventive Visits (65+yrs)	**96.80%**	83.66%
Comprehensive Diabetes Care (HbA1c Testing)	87.80%	82.03%
Comprehensive Diabetes Care (LDL-C Screening)	77.10%	74.71%

Annual Quality Review for People with Disabilities' Health

There are no indicators that specifically target MCO enrollees with disabilities. This makes any statements regarding performance related to this population a challenge. Instead, the External Quality Review Organization selected measures that primarily represent preventive care and chronic conditions (Table VII-4). Also included are CAHPS indicators that reflect relationships with the physician, specialist, and communication because the special needs of enrollees with disabilities require some additional coordination.

As with the senior population, performance is mixed. The MCOs aggregate scores for Antidepressant Medication Management (Acute and Continuous) and Appropriate Use of Asthma Medications are below the 50th percentile for Medicaid HMOs nationally. Satisfaction and other indicators for this population, including adult preventive care measures, are all within an acceptable range of performance, or above the 90th percentile.

Table VII-4. Summary of MN Statewide Performance on Enrollees with Disabilities Indicators[2]

Indicators	All MCO Statewide Avg	Nat'l Medicaid Avg
Antidepressant Medication Management (Acute)	42.60%	50.74%
Antidepressant Medication Management (Continuous)	30.50%	34.44%
Appropriate Use of Asthma Medications (5-50yrs)	86.80%	88.37%
CAHPS: How People Rated Their Personal Doctor	**71.61%**	61.10%
CAHPS: How People Rated Their Specialist	66.26%	61.34%
CAHPS: How Well Doctors Communicate	**95.00%**	87.84%
Adult Preventive Visits (20-44yrs)	**89.60%**	81.19%
Adult Preventive Visits (45-64yrs)	90.90%	86.04%
Comprehensive Diabetes Care (HbA1c Testing)	87.80%	82.03%
Comprehensive Diabetes Care (LDL-C Screening)	77.10%	74.71%

Annual Quality Review – MCO Enrollees Satisfaction

Based on the selected CAHPS composite satisfaction measures, overall the MCOs' performance is strong. As shown in Table VII-5, six out of eight indicators are above the 90th percentile among Medicaid MCOs nationally as indicated by NCQA Quality Compass rankings. The two indicators regarding how people rated their specialist and their health plan are both within an acceptable range of performance and there are no indicators that fall below the 50th percentile.

[2] Personal Doctor and Rating Specialist: These overall satisfaction scores are the percentage of survey respondents that responded most positively (9 or 10 rating) on a number scale from 0 to 10, where 0 = worst possible and 10 = best possible. How Well Doctor Communicated: This composite score is the percentage of survey respondents that responded most positively (or Always) on scale of never to always, where never = worst possible and always = best possible.

Table VII-5. Summary of NN Statewide Performance on Satisfaction Indicators[3]

Indicators	All MCO Statewide Avg	Nat'l Medicaid Avg
CAHPS: How People Rated Their Personal Doctor	**71.61%**	61.10%
CAHPS: How People Rated Their Specialist	66.26%	61.34%
CAHPS: How People Rated Their Health Care	**56.36%**	48.75%
CAHPS: How People Rated Their Health Plan	62.72%	54.69%
CAHPS: How Well Doctors Communicate	**95.00%**	87.84%
CAHPS: Getting Needed Care	**87.10%**	75.95%
CAHPS: Health Plan Customer Service	**86.00%**	79.74%
CAHPS: Getting Care Quickly	**86.50%**	80.56%

Annual Quality Review – Areas Needing Improvement

- There are seven indicators (Table VII-6) with aggregated MCO performance scores below the 50th percentile. Four of the indicators are related to children. These indicators require more focus and attention across all MCOs. The External Quality Review Organization recommends efforts among MCOs to explore issues and improve scores – with a special focus on Childhood Immunizations and Adolescent Well Child Care. The other low performing measures include Antidepressant Medication Management (Acute and Continuous) and Appropriate Use of Asthma Medications. Annual EQRO recommendations are made and each year MCOs are expected to address the progress made to improve care and services. The Department of Human Services expects that MCOs will work to improve care and services as stated in the External Quality Review Organization's Annual Technical Report recommendations, including utilizing technical assistance provided by the EQRO. Additionally, the MCOs are requested to provide a response on their efforts to address the recommendations made in the Annual Technical Report.

[3] Personal Doctor and Rating Specialist: These overall satisfaction scores are the percentage of survey respondents that responded most positively (9 or 10 rating) on a number scale from 0 to 10, where 0 = worst possible and 10 = best possible. How Well Doctor Communicated: This composite score is the percentage of survey respondents that responded most positively (or Always) on scale of never to always, where never = worst possible and always = best possible.

Table VII-6. MN Statewide Indicators with Rates Below 50th Percentile

Indicators	All MCO Statewide Avg	Weakness = < Medicaid 50th Percentile
Antidepressant Medication Management (Acute)	42.60%	50.09%
Antidepressant Medication Management (Continuous)	30.50%	32.73%
Appropriate Use of Asthma Medications (5-50yrs)	86.80%	88.91%
Adolescent Well Child Care (12-21yrs)	35.60%	46.11%
Childhood Immunizations (Combo #3 - 2yrs)	58.80%	71.02%
Well Child Care in First 15 mos (6+ Visits)	55.20%	61.34%
Well Child Care (3-6yrs)	67.30%	72.34%

Annual Quality Review – Quality, Access, and Timeliness

In general, the MCO performance indicators are grouped by the populations (e.g., children, women, etc). Another way to group the same measures is by the aspect of performance that is being measured. Table VII-7 shows the performance measures grouped into quality measures, access measures, and timeliness of care measures. Bold values indicate measures where the MCOs' aggregate performance exceeded the 50th percentile Medicaid MCOs nationally.

Table VII-7. Summary of Minnesota MCO Indicators and Rates for Calendar Year 2010

Indicators	Managed Care MHCP Statewide Avg.	National Medicaid Avg.
QUALTY:		
Antidepressant Medication Management (Acute)	42.60%	50.74%
Antidepressant Medication Management (Continuous)	30.50%	34.44%
Appropriate Use of Asthma Medications (5-50 yrs)	86.80%	88.37%
Chlamydia Screening	**60.50%**	57.47%
CAHPS: How People Rated Their Personal Doctor	**71.61%**	61.10%
CAHPS: How People Rated Their Specialist	**66.26%**	61.34%
CAHPS: How People Rated Their Health Care	**56.36%**	48.75%
CAHPS: How People Rated Their Health Plan	**62.72%**	54.69%
CAHPS: How Well Doctors Communicate	**95.00%**	87.84%
ACCESS:		
Adult Preventive Visits (20-44 yrs)	**89.60%**	81.19%
Adult Preventive Visits (45-64 yrs)	**90.90%**	86.04%
Adult Preventive Visits (65+ yrs)	**96.80%**	83.66%
Child PCP Visits (12-24 mos.)	**98.60%**	96.09%
Child PCP Visits (25 mos. – 6 yrs)	**92.60%**	88.27%
Child PCP Visits (7-11 yrs)	**93.30%**	90.22%
Child PCP Visits (12-19 yrs)	**93.20%**	88.14%
CAHPS: Getting Needed Care	**87.10%**	75.95%
CAHPS: Health Plan Customer Service	**86.00%**	79.74%
TIMELNESS:		
Adolescent Well Child Care (12-21)	35.60%	48.07%

Breast Cancer Screening	**57.80%**	51.35%
Cervical Cancer Screening	**72.30%**	67.19%
Childhood Immunizations (Combo #3)	58.80%	69.94%
Diabetes Care – HbA1c Testing	**87.80%**	82.03%
Diabetes Care – LDL-C Screening	**77.10%**	74.71%
Well Child Care in First 15 mos (6+ visits)	55.20%	60.19%
Well Child (3-6 yrs)	67.30%	71.89%
CAHPS: Getting Care Quickly	**86.50%**	80.56%

The entire 2010 Annual Technical Report and 2010 and 2011 Consumer Satisfaction Survey Results Summary Reports are available on the DHS website, at:
http://www.dhs.state.mn.us/healthcare/studies

MCO Disenrollment Survey

The Department of Human Services conducts monthly surveys of enrollees in the Families and Children contract who voluntarily change from one MCO to another. The purpose of the survey is to determine the reasons enrollees voluntarily change or "switch" from one MCO to another. DHS uses this information and other quality indicators to monitor the performance of MCOs and guide improvement of enrollee care and services. It is expected statewide change rates will vary over time, but remain below a 5% threshold as shown for calendar years 2010 and 2011.

- 2010 voluntary changes in MCO enrollment was 1.6% for all recipients:
  - Medical Assistance – Families and Children - 0.8%
  - MinnesotaCare = 3.2%
  - MSHO = 1.6%
  - MSC+ = 1.7%
  - SNBC = 4.2%
- 2011 voluntary changes in MCO enrollment was 1.5% for all recipients:
  - Medical Assistance – Families and Children - 0.9%
  - MinnesotaCare = 2.9%
  - MSHO = 1.4%
  - MSC+ = 2.0%
  - SNBC = 0.3%

2010 and 2011 Voluntary Changes in MCO Enrollment Reports are available on the DHS website, at: http://www.dhs.state.mn.us/healthcare/studies

MDH Quality Assurance Examination

The Minnesota Department of Health (MDH) conducts a Quality Assurance examination to determine MCOs' compliance with Minnesota Statutes in the areas of quality program administration, the internal complaints and appeals program, availability and accessibility of health services to enrollees, and compliance with Minnesota's utilization review laws. During the triennial on-site examination, the Department of Health evaluates the MCO's quality program for compliance with state laws. If an MCO's quality program is in violation of state law it is noted by a finding of a "deficiency".

The Quality Assurance examinations include an evaluation of each MCO in the following areas:

- Quality program administration, which includes a review of the quality assurance plan, work plan, quality studies and activities, organization and staffing, credentialing program, medical records management, delegated activities, and quality-of-care complaints.
- Internal complaints and appeals program, which includes monitoring systems, conducting routine quality-of-care evaluations to assess quality and processes, and checking the record-keeping systems that track complaints and appeals.
- Availability and accessibility of health services to enrollees, which includes the geographic location of providers, appointment scheduling, coordination of care activities, referrals, timely access to health services, access to emergency care, continuity of care, direct access to obstetrical and gynecological services, and equal access to chiropractic services
- Compliance with Minnesota's utilization review laws, including MCO standards, staffing, procedures, and qualifications of reviewers.

When a deficiency is identified the MCO must complete a written corrective action plan, and MDH conducts a Mid-Cycle Quality Assurance examination to ensure that the MCO has corrected the identified issues. Mid-cycle exams are generally scheduled 18 months following the original QA Examination.

During 2010 only one MCO, Itasca Medical Care had a completed Quality Assurance examination. MDH found seven deficiencies in Itasca Medical Care's Quality Program compliance examination.

During 2011, four MCO Quality Assurance examinations were finalized.

- BluePlus had nine deficiencies; three in the quality program administration section, and six in the grievance section. However, two violations were repeat violations from the 2007 Quality Assurance examination and one those was a repeat identified from the 2005 examination.
- Metropolitan Health Plan had five deficiencies; two each in the quality program administration section and grievance section, and one in the utilization review sections of the examination.
- South Country Health Alliance had six deficiencies; four in the quality program administration section, and two in the grievance section of the examination.
- UCare had three deficiencies; two in the quality program administration section, and one in the grievance section of the examination.

Table VII-8 shows the historical summary of MCO deficiencies in the Quality Assurance examination.

Table VII-8. Historical Summary of MCO Deficiencies

	2004	2005	2006	2007	2008	2009	2010	2011
BluePlus		12		**12**				**9**
HealthPartners			7			4		
IMCare	6		**11**				7	
Medica	3			10		**4**		
MHP		**15**			5			5
PrimeWest			11		2			
SCHA	6			7				6
UCare					4			3

Additional detail on the triennial QA Examination process and MCO results can be found on MDH's website: http://www.health.state.mn.us/divs/hpsc/mcs/quality.htm

DHS Triennial Compliance Assessment

The Department of Human Services conducts a Triennial Compliance Assessment of the MCOs' compliance with the Department of Human Services contractual requirements. The areas of compliance are assessed by reviewing utilization management files, quality improvement activities, grievance and appeals files, and numerous policies and procedures including review of each plans MSHO/MSC+ care plan audits and audit process.

Triennial Compliance Assessment process is comprised of three steps:

- **Collection**. Supplemental information is collected during the triennial Department of Health Quality Assurance examination. The desk and onsite examination includes collecting information on supplemental federal and public-program compliance standards.
- **Evaluation**. The Department of Human Services evaluates the supplemental information collected by Department of Health to determine if the MCO has "met" or "not met" contract standards. Following the evaluation, the MCO is allowed 14 days to review the Department of Human Services preliminary "met/not met" determinations and to identify any errors or omissions. The Department of Human Services considers the MCO's rebuttal comments before making a final determination of compliance.
- **Corrective Action Plan**. The Department of Human Services requires MCOs to submit a corrective action plan within 30 days to address identified noncompliance issues. If the MCO fails to submit a corrective action plan and does not address contractual deficiencies, then DHS may assess financial penalties.

After MDH completes the on-site audit activities for the MCO Quality Assurance examination and DHS TCA audit, these separate reports may not be completed within the same calendar year. During 2010, one Triennial Compliance Assessment audit was completed to monitor Itasca Medical Care's compliance with contract standards. Itasca Medical Care failed to meet 25 contract standards and the Department of Human Services accepted a correction plan to resolve the identified noncompliance issues.

In 2011, four MCO Triennial Compliance Assessment audits were performed:

- BluePlus failed to meet 18 contract standards.
- PrimeWest failed to meet 9 contract standards.
- South Country Health Alliance failed to meet 19 contract standards.
- UCare failed to meet 11 contract standards.

2011 Annual Triennial Compliance Assessment audit summary reports can be found on DHS' website at: http://www.dhs.state.mn.us/healthcare/studies

MCO Performance Improvement Projects

One technique to improve access, timeliness and effectiveness is to conduct performance improvement projects. Each MCO is annually required by federal law and the Department of Human Services contract to conduct a performance improvement project that identifies a health care activity and design a project that will improve the activities' operational processes resulting in better outcomes. A performance improvement project must address issues which affect a significant portion of the enrolled population; have a substantial impact on enrollee health or satisfaction, and improve high-volume, high-risk or problem-prone health delivery issues.

Annually, the Department of Human Services evaluates the new projects submitted by MCOs to ensure they demonstrate measurable and sustained improved health care processes and outcomes. A performance improvement project:

- Is a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have positive outcomes;
- Involves measuring the impacts of the interventions or activities, with a goal of improving the quality of care and service delivery with sustained improvement over time;
- Must be consistent with federal protocol, focus on either a clinical or service topic and achieve significant improvement as measured by successfully achieving the project goal and sustaining that goal for at least two additional continuous measurement periods. Usually the projects are measured annually and take three to five years to complete.

DHS also annually evaluates performance improvement projects' interim progress and when a project successfully achieves its original goals. Over the past several years, MCOs have been able to successfully change health care delivery processes to improve the delivery of care. Although not all MCO PIPs have been successful, even these non-successful projects have provided a better understanding of how to overcome barriers for future projects. Examples of PIPs during this period included colorectal cancer screening improvement, diabetes blood pressure control management improvement projects.

Details on current and past PIPs are available in two DHS reports (Performance Improvement Projects Summary Tables June 2011 and Performance Improvement Projects Annual Summary Report July 2012) that can be found on DHS's website at:
http://www.dhs.state.mn.us/healthcare/studies

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Appendix A
Eligibility Requirements for Medical Assistance and MinnesotaCare

Minnesota Department of Human Servi

Minnesota Health Care Programs
Income and Asset Limits

Effective July 1, 2012 through June 30, 2013

MinnesotaCare	Monthly Income Limit					Asset Limit
	One	Two	Three	Additional Members	Over Income	
Adults without children (if over income, see Healthy MN)	$700 – $1,861	$948 – $2,521	--	--	Do not qualify	$10,000 for one $20,000 for two
Children under 21	No income limit					No asset limit
Pregnant women	N/A[1]	$3,468	$4,376	Add $908 per member	Do not qualify	No asset limit
Parents, legal guardians, foster parents and relative caretakers of children under 21	--	$3,468	$4,376	Add $908 per member	Do not qualify. Also, do not qualify if gross annual income is over $57,500.	$20,000

Medical Assistance	Monthly Income Limit					Asset Limit
	One	Two	Three	Additional Members	Over Income	
Pregnant women	N/A[1]	$3,468	$4,376	Add $908 per member	Qualify with a spenddown[2]	No asset limit
Infants under age 2	$2,607	$3,531	$4,455	Add $924 per member		
Children ages 2–18	$1,397	$1,892	$2,387	Add $495 per member		
Children ages 19–20	$931	$1,261	$1,591	Add $330 per member		
Parents with children under 19	--	$1,261	$1,591	Add $330 per member	Qualify with a spenddown[2]	$20,000
People with a disability, blind or 65 or older	$931	$1,261	$1,591	Add $330 per member	Qualify with a spenddown[2]	$3,000 for one $6,000 for two plus $200 for each dependent
Adults without Children	$699	$947	--	--	Do not qualify	No asset limit
MA for Employed Persons with Disabilities	No income limit. Must have earned income of at least $65/month. Enrollees pay a premium based on income.					$20,000 per enrollee
MA for Breast and Cervical Cancer	No income limit for women who: ■ Have been screened by the Sage Screening Program ■ Need treatment for breast or cervical cancer ■ Do not qualify for certain categories of MA.					No asset limit

Minnesota Health Care Programs Income and Asset Limits Effective July 1, 2012 through June 30, 2013

Medicare Savings Programs	Monthly Income Limit				Over Income	Asset Limit
	One	Two	Three	Additional Members		
Qualified Medicare Beneficiaries	$951	$1,281	$1,611	Add $330 per member	Do not qualify	$10,000 for one $18,000 for two or more
Service Limited Medicare Beneficiaries	$1,137	$1,533	$1,929	Add $396 per member		
Qualifying Individuals	$1,277	$1,723	$2,169	Add $446 per member		
Qualified Working Disabled	$1,882	$2,542	$3,202	Add $660 per member		$4,000 for one $6,000 for two or more

Minnesota Family Planning	Monthly Income Limit				Over Income	Asset Limit
	One	Two	Three	Additional Members		
Family Planning Services and Supplies	$1,862	$2,522	$3,182	Add $660 per member	Do not qualify	No asset limit

Healthy Minnesota Contribution Program	Monthly Income Limit				Over Income	Asset Limit
	One	Two	Three	Additional Members		
Healthy Minnesota Contribution Program	$1,862 – $2,328	$2,522 – $3,153	--	--	Do not qualify	$10,000 for one $20,000 for two

[1] A pregnant woman counts as 2.

[2] **Spenddown:** If your income is more than the program limits, Medical Assistance may still pay part of your medical bills with a spenddown. A spenddown is like an insurance deductible. You pay for part of your medical expenses and Medical Assistance will pay the rest.

ADA3 (3-12)

This information is available in alternative formats to individuals with disabilities by calling 651-431-2670 or 800-657-3739. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

Minnesota Department of Human Servi

Minnesota Health Care Programs
Income and Asset Limits

Effective July 1, 2011 through June 30, 2012

MinnesotaCare	Federal Poverty Guidelines	Monthly Income Limit				Over Income	Asset Limit
		One	Two	Three	Additional Members		
Adults without children	Over 75% – At or below 250%	$682 – $2,269	$921 – $3,065	--	--	Not eligible	$10,000 for one $20,000 for two
Pregnant women[1] and children under 21	At or below 275%	$2,496	$3,372	$4,248	Add $876 per member	Not eligible[2]	No asset limit
Parents, legal guardians, foster parents and relative caretakers of children under 21	At or below 275%	--	$3,372	$4,248	Add $876 per member	Not eligible. Also not eligible if gross annual income is over $50,000.	$20,000

Medical Assistance	Federal Poverty Guidelines	Monthly Income Limit				Over Income	Asset Limit
		One	Two	Three	Additional Members		
Pregnant women	At or below 275%	N/A[1]	$3,372	$4,248	Add $876 per member	Eligible with a spenddown[3]	No asset limit
Infants under age 2	At or below 280%	$2,541	$3,433	$4,325	Add $892 per member		
Children ages 2–18	At or below 150%	$1,362	$1,840	$2,318	Add $478 per member		
Children ages 19–20	At or below 100%	$908	$1,227	$1,546	Add $319 per member		
Parents with children under 19	At or below 100%	--	$1,227	$1,546	Add $319 per member	Eligible with a spenddown[3]	$20,000
Elderly, blind and people with disabilities	At or below 100%	$908	$1,227	$1,546	Add $319 per member	Eligible with a spenddown[3]	$3,000 for one $6,000 for two plus $200 for each dependent
Adults without Children	At or below 75%	$681	$920	--	--	Not eligible	No asset limit
MA for Employed Persons with Disabilities	Not applicable	No income limit. Must have earned income of at least $65/month. Enrollees pay a premium based on income.					$20,000 per enrollee
MA for Breast and Cervical Cancer	No income limit	For women who: ■ Have been screened by the Sage Screening Program ■ Need treatment for breast or cervical cancer ■ Are not otherwise eligible for certain categories of MA.					No asset limit

Minnesota Health Care Programs Income and Asset Limits Effective July 1, 2011 through June 30, 2012

Medicare Savings Programs	Federal Poverty Guidelines	Monthly Income Limit				Over Income	Asset Limit
		One	Two	Three	Additional Members		
Qualified Medicare Beneficiaries	At or below 100%	$928	$1,247	$1,566	Add $319 per member	Not eligible	$10,000 for one $18,000 for two or more
Service Limited Medicare Beneficiaries	At or below 120%	$1,109	$1,491	$1,873	Add $382 per member		
Qualifying Individuals	At or below 135%	$1,246	$1,676	$2,106	Add $430 per member		
Qualified Working Disabled	At or below 200%	$1,835	$2,472	$3,109	Add $637 per member		$4,000 for one $6,000 for two or more

Minnesota Family Planning	Federal Poverty Guidelines	Monthly Income Limit				Over Income	Asset Limit
		One	Two	Three	Additional Members		
Family Planning Services and Supplies	At or below 200%	$1,815	$2,452	$3,089	Add $637 per member	Not eligible	No asset limit

[1] Pregnant woman is counted as family size of 2.

[2] Some children may remain enrolled in MinnesotaCare if they meet the specifics for the Minnesota Comprehensive Health Association exemption.

[3] **Spenddown:** If your income is more than the program limits, Medical Assistance may still pay part of your medical bills with a spenddown. A spenddown is like an insurance deductible. You pay for part of your medical expenses and Medical Assistance will pay the rest.

ADA3 (5-09)

This information is available in alternative formats to individuals with disabilities by calling 651-431-2670 or 800-657-3739. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

Appendix B
PMAP+ Waiver and Expenditure Authorities

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS
Amended July 2011

NUMBER: 11-W-00039/5

TITLE: **Minnesota Prepaid Medical Assistance Project Plus (PMAP+)**

AWARDEE: **Minnesota Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Minnesota' s Prepaid Medical Assistance Project Plus section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Minnesota Department of Human Services (DHS) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, extent of Federal involvement in the Demonstration, and the State's obligations to CMS during the life of the Demonstration. The STCs are effective July 1, 2011 unless otherwise specified. All previously approved STCs, Waivers, Expenditure Authorities and Not Applicables are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives;
III. General Program Requirements;
IV. Eligibility and Demonstration Scope;
V. Benefits;
VI. MinnesotaCare Cost Sharing;
VII. Delivery System;
VIII. Medical Education and Research Costs (MERC);
IX. General Reporting Requirements;
X. General Financial Requirements Under Title XIX;
XI. Monitoring Budget Neutrality;
XII. Evaluation of the Demonstration; and
XIII. Schedule of State Deliverables for the Demonstration Extension Period.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Minnesota's section 1115 PMAP+ demonstration was initially approved and implemented in July 1995. Minnesota was one of the early States to use health care reform waivers to cover uninsured populations. The PMAP+ demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both MinnesotaCare

Program eligibles and Medicaid State plan groups. The goal of Minnesota's health care reform effort is to provide organized and coordinated health care that includes pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. The Demonstration affects coverage for certain specified mandatory State plan eligibles, and the Demonstration also expands coverage to those that would not traditionally qualify for Medicaid, such as higher income parents/caretaker adults.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State Plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

   c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

   d) If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

   a) Demonstration Summary and Objectives: The State must provide a summary of the

demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.

b) Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

c) Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

d) Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

e) Interim Evaluation Report: The State must provide an evaluation report reflecting the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph nine, during the last 6 months of the Demonstration, the State may choose to not enroll individuals into the Demonstration who would not be eligible for Medicaid under the current Medicaid State plan. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the

terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements as outlined in the State's approved State Plan, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State.

16. **FFP.** Federal funds are not available for expenditures for this Demonstration until the effective date identified in the Demonstration approval letter. Federal funds are not available for Populations 8 and 9 until the State submits an operational protocol in accordance with STC #43 to CMS for approval assuring that all eligibility determination processes comply with all Federal law. Upon CMS' approval, CMS will notify the State in writing that it can begin to claim FFP for the MinnesotaCare Adults without Children population.

IV. ELIGIBILITY AND DEMONSTRATION SCOPE

17. **Eligibility.** Certain individuals are eligible under the PMAP+ Demonstration who either would not otherwise be eligible under the Medicaid State plan or elect not to participate in the State plan. These "demonstration eligibles" are described below:

    a) Demonstration Eligibles are individuals who meet the eligibility standards as specified in the following chart. The first group is served through the State plan and the other groups are served through the MinnesotaCare program.

GROUPS MADE ELIGIBLE UNDER THE PMAP+ DEMONSTRATION				
Participating Groups	**Expenditure Authority Population**	**Eligibility Authority**	**Income Standards**	**Income Methodology (Net income test. Medicaid deeming rules apply)**
MA One Year Olds: Infants age 12-23 months	Population 1	Section 1115	At or below 275 % FPL	• Apply methods for MA infants
MinnesotaCare Pregnant Women	Population 2	Section 1115	At or below 275 % FPL	• Gross household income per paragraph 18 and no Medicaid deeming. • No disregards /deductions
MinnesotaCare Children < 21 Years)	Population 3 Population 4	Section 1115	At or below 200% FPL Above 200 and at or below 275% FPL	• Gross household income per paragraph 18 and no Medicaid deeming. See also paragraph 21. • No disregards /deductions
MinnesotaCare Caretaker Adults (includes 3 subgroups)	Population 5	Section 1115	Subgroup 1 Up to 100% of FPL, or $57,500 of annual income, whichever is lower Subgroup 2 Between 100 % and 200% of the FPL, or $57,500 of annual income, whichever is lower Subgroup 3 Between 200% and 275% of FPL, or $57,500 of annual	• All of population 5 is funded by Title XIX • Gross household income per paragraph 18 and no Medicaid deeming. • No disregards /deductions

GROUPS MADE ELIGIBLE UNDER THE PMAP+ DEMONSTRATION				
			whichever is lower	
MinnesotaCare Foster Care Age Outs	Population 6	Section 1115	None	• Individual under age 21 who resided in foster care on the individual's 18th birthday • No income limits, insurance barriers, family enrollment requirements, or premium payment as described in paragraphs 19, 21 and 32
MinnesotaCare Juvenile Residential Correctional Facility Post-Release	Population 7	Section 1115	None	• Individual under age 21 who resided in a juvenile residential correctional facility on the individual's 18th birthday • No income limits, insurance barriers, family enrollment requirements, or premium payment as described in paragraphs 19, 21 and 32
MinnesotaCare Adults age 21 through 64 without children	Population 8	Section 1115	Above 75% and at or below 133% of FPL	• Gross household income per paragraph 18 and no Medicaid deeming.
MinnesotaCare Adults age 21 through 64 without children	Population 9	Section 1115	Above 133% and at or below 250% of FPL	• Gross household income per paragraph 18 and no Medicaid deeming. • Income disregard will be applied to all income above 133 and at or below 250% FPL

b) Medicaid State Plan Eligible Populations Affected by the Demonstration: In addition, under the PMAP+ demonstration certain Medicaid State Plan groups are mandated into mandatory managed care, which include the following**:**

i. Medicare and Medicaid Dual eligibles under 65 years who are not using a disabled basis of eligibility;

ii. American Indians, as defined in 25 U.S.C. 1603(c), who would not otherwise be mandatorily enrolled in managed care;

iii. Disabled children under age 19 who are eligible for SSI under Title XVI and who have not elected to be made eligible on the basis of disability;

iv. Children under age 19 who are in State-subsidized foster care or other out of home placement;

v. Children under age 19 who are receiving Foster Care under Title IV-E;

vi. Children under age 19 who are receiving adoption assistance under Title IV-E;

vii. Children under 19 with special health care needs who are receiving services through family-centered, community-based coordinated care system that receives grants funds under Section 501(a)(1)(D) of Title V who are not using a disabled basis of eligibility.

18. **Definitions.** The State defines the following terms differently in the eligibility determination process for MinnesotaCare than under the Medicaid State plan.

a) **MinnesotaCare Family** means a parent or parents and their children (under 21 years of age); or guardians and their wards who are children; and grandparents, foster parents, and other caretaker relatives residing in the same household; and includes children temporarily absent from the household in settings such as schools, camps or visitation with noncustodial parents. "Parents" means the birth, adoptive or stepparent of a child. For persons eligible as a MinnesotaCare Adult without Children, the MinnesotaCare Family includes the individual with a spouse residing in the same household. The definition of MinnesotaCare Family is used to determine which individuals' income must be counted as family income for purposes of determining eligibility for MinnesotaCare. The State receives FFP only for the groups listed in paragraph 17(a), with "MinnesotaCare Caretaker Adult" defined in (b) below and "MinnesotaCare Adult without Children" defined in (c) below.

b) **MinnesotaCare Caretaker Adult.** The term "caretaker adult" used in item 17 means parents and other caretaker relatives. Parent means the birth, adoptive or stepparent of a child. Caretaker relative has the same meaning as "caretaker relative" under Medicaid.

c) **MinnesotaCare Adult without Children.** A person must meet the following criteria for eligibility under this category:

i. Is at least 21 years of age but no more than 64 years of age;
ii. Is not pregnant and is not married to a pregnant woman;
iii. Is not entitled to Medicare; and
iv. Is not a parent, stepparent, relative caretaker, legal guardian, or foster parent of a child or children under age 21 in the household; or is a caretaker relative, foster parent or legal guardian applying separately for their own coverage and does not include the children as family members on the MinnesotaCare application.

d) **MinnesotaCare Assets.** The term "assets" means all cash and other personal property, as well as any real property that a family owns that has monetary value. "Net asset" means the asset's fair market value minus any encumbrances including but not limited to, liens and mortgages.

i. The net asset values of all assets owned by adult applicants and enrollees, who are not pregnant, are considered MinnesotaCare Assets, except for those assets excluded under (ii) below.

ii. The value of assets that are not considered in determining eligibility for MinnesotaCare is the same as the value of assets that are not considered in determining eligibility for Medical Assistance, with the following exceptions:

(A) The value of worker's compensation settlements are not considered in determining assets for MinnesotaCare; and

Applicant or enrollee bank accounts that contain personal income, or are used to pay personal expenses, will not be considered for the $200,000 exclusion for capital or operating assets of a trade or business.

iii. Adult applicants and enrollees who are not pregnant, who are not citizens, and whose sponsor has signed an affidavit of support must count their sponsor's assets when determining eligibility.

e) **MinnesotaCare Gross Annual Family Income.** The term "MinnesotaCare Gross Annual Family Income" means the total non-excluded income of all family members for an annual period, determined in accordance with items (i) through (v) below:

i. Self-employment income is calculated in accordance with sub items (A) and (B) below.

(A) The adjusted gross income reported on the applicant or enrollee's Federal income tax form for the previous year is summed with the depreciation,

carryover loss, and net operating loss amounts. In the case of self-employed farmers, adjusted gross income from the applicant or enrollee's Federal income tax form for the previous year is used.

(B) If the applicant or enrollee reports that income has changed since the period of their last tax return, income may be calculated using documentation such as business records or quarterly tax reports.

ii. Earned income is calculated in accordance with sub-items (A) and (B).

(A) The income of wage earners, including all wages, salaries, commissions, and other benefits received as monetary compensation from employers before any deduction, disregard, or exclusion, is calculated using the following rules:

1) Unless the conditions specified in (2) apply, income from the last 30 days is used and projected to a 12-month period.

2) If the wage earner is employed on a seasonal basis or receives income too infrequently or irregularly to be calculated under sub-item (1), total income for the past 12 months is used.

3) The earned income of full-time and part-time students under age 19 is not counted as income.

4) Federal or State tax rebates are not counted as income or assets.

(B) When an applicant or enrollee reports that earned income has changed from the amount calculated in subitem (A), the new amount is projected forward for 12 months.

iii. Unearned income is calculated in accordance with subitems (A) and (B).

(A) The following unearned income received in the preceding tax year, with any reported changes, is projected to reflect a 12 month period:

1) Supplemental security income under title XVI of the Social Security Act;

2) Social security benefits;

3) Veterans' administration benefits;

4) Railroad retirement benefits;

5) Unemployment benefits;

6) Workers' compensation benefits;

7) Child support;

8) Spousal maintenance or support payments; and

9) Income from any other source, including interest, dividends, and rent.

(B) When an applicant or enrollee reports that unearned income has changed from the amount calculated in subitem (1), the current amount is projected forward for 12 months.

(C) Lump sums are only counted as income for people who are self-employed if claimed as income on the tax return.

iv. Noncitizen applicants and enrollees whose sponsor signed an affidavit of support, as defined under United States Code, Title 8, Section 1183a, will be deemed to include their sponsor's income as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law Number 104-193 as "gross family income" to the same extent sponsor deeming applies in the Medical Assistance program.

v. If the caretaker relative, foster parent or legal guardian applies separately for the children, only the children's income is counted. If the caretaker relative, foster parent or legal guardian applies with the children, the adult's income is counted in determining gross family income. If the caretaker relative, foster parent or legal guardian applies separately for their own coverage, only the adult's income is counted.

vi. Payments made to victims under the Catastrophic Survivor Compensation Fund are not counted as income in determining gross family income.

e) **Medical Assistance (MA).** The terms "Medical Assistance" and "Medicaid" both shall refer to the coverage and benefits provided to individuals who are eligible under Minnesota's Medicaid State plan.

f) **Federal Poverty Level (FPL).** The terms "Federal Poverty Level" and "FPL" refer to the Federal Poverty Guidelines published annually by the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation

19. **MinnesotaCare Eligibility Criteria.** An applicant or enrollee must meet the following eligibility requirements in order to enroll in MinnesotaCare:

a) Is a member of the family as defined in paragraph 18(a).

b) Does not currently have other health coverage, nor had other health coverage during the 4 months immediately preceding the date MinnesotaCare coverage is to begin. An applicant or enrollee who is entitled to Medicare Part A, or enrolled in Medicare Part B coverage, is considered to have health coverage for this purpose. An applicant, or enrollee, who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare. Items (i) through (iv) below are not considered to be health coverage under this section.

   i. Medical Assistance,

   ii. Cost effective health insurance that was paid for by Medical Assistance, unless the insurance was continued after Medical Assistance determined the health insurance no longer to be cost effective, or after the individual's Medical Assistance case was closed.

   iii. General Assistance Medical Care (GAMC);

   iv. Civilian Health and Medical Program of the Uniformed Services, Tri Care (formerly CHAMPUS).

c) Does not have current access to employer-subsidized health coverage, as defined by the State.

d) Does not have lost employer-sponsored coverage due to:

   i. the employer terminating coverage during the 18 months immediately preceding the date MinnesotaCare coverage would begin, except that this provision does not apply to a family or individual who was enrolled in MinnesotaCare within 6 months or less of reapplication, and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit; or

   ii. the employee failing to take up coverage offered by the employer during an open enrollment period within the preceding 18 months.

e) Meet non-financial eligibility factors under the Medicaid State plan (e.g., State residence; citizenship and identity documentation; non-citizenship eligibility; assignment of rights to medical benefits; cooperation with establishing paternity, obtaining medical support, and identifying third party liability; and provision or application for social security number).

f) Have MinnesotaCare Gross Family Income that does not exceed 275 percent of the FPL. In addition to not exceeding 275 percent of the FPL, MinnesotaCare caretaker

adults must also not have family income that exceeds $57,500.

g) For adults, except for pregnant women, not have MinnesotaCare Assets that exceed the following limits:

   i. A household of one person must not own more than $10,000 in total MinnesotaCare Assets;

   ii. A household of two or more persons must not own more than $20,000 in total MinnesotaCare Assets; and

   iii. An eligible individual or family may accrue interest on their assets, but the total must be reduced to the maximum at the time of an eligibility redetermination.

h) Comply with the family enrollment requirements as follows:

   i. Parents who enroll in MinnesotaCare must enroll any eligible children in MinnesotaCare or Medical Assistance.

   ii. Unless other insurance is available, children may be enrolled in MinnesotaCare even if their parents do not enroll.

   iii. If one parent in a household enrolls in MinnesotaCare, both parents in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

   iv. If one child in a family is enrolled in MinnesotaCare, all children in the family must be enrolled in MinnesotaCare or Medical Assistance unless other insurance is available.

   v. If one spouse in a household is enrolled in MinnesotaCare, the other spouse in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

   vi. Except as provided in item ii above, families cannot enroll only some uninsured members in MinnesotaCare.

   vii. In families that include a caretaker relative, foster parent or legal guardian, the caretaker relative, foster parent or legal guardian may apply as a family or may apply separately for the children.

i) Not be a resident of a correctional or detention facility.

j) Pay monthly premiums, as defined in Section VII.

20. **Special Eligibility Rules for Individuals who Receive a COBRA Premium Subsidy from the State**

Individuals and their qualified family members who are eligible for the 65 percent COBRA continuation premium subsidy for health care coverage under the American Recovery and Reinvestment Act of 2009 may also be eligible for a state premium subsidy. Any individual who receives a state premium subsidy under this provision is exempt from the insurance barrier described in paragraph 19(b) if the individual or the individual's qualified beneficiaries apply for MinnesotaCare after the individual no longer receives COBRA continuation coverage.

21. **Special Eligibility Rules for Children in MinnesotaCare.**

a) A child who: (1) has been continuously enrolled in the Children's Health Program, and subsequently in MinnesotaCare, and is not a resident of a correctional or detention facility; or (2) whose gross annual family income at or below 200 percent of FPL, is eligible for MinnesotaCare without regard to the insurance barriers described in paragraph 19(b), 19(c) and 19(d), so as long as continuous enrollment is maintained from the child's initial eligibility and the child meets both (i) and (ii) below:

i. The child meets the requirements under paragraph 19(a), 19(f) and 19(h).

ii. The child is not otherwise insured for the covered health services. A child is not otherwise insured for covered health services when subitems (A), (B), or (C) apply:

(A) The child lacks coverage in two or more of the following areas: basic hospital coverage; medical/surgical coverage; major medical coverage; dental coverage; vision coverage.

(B) The child's coverage requires a deductible of $100 or more per person per year.

(C) A child with a particular diagnosis lacks coverage because the child has exceeded the maximum coverage for that diagnosis or the policy of coverage excludes that diagnosis.

b) Any individual under the age of 21 who on his or her 18th birthday resides in the foster care system, upon completion of an initial application for MinnesotaCare, is automatically deemed eligible for MinnesotaCare regardless of the income limits, insurance barriers, family enrollment requirements, and premium payment described in STC 19 and 32. MinnesotaCare coverage begins the first day of the month following the date of termination of foster care. The State will contact these

individuals annually to determine if the individual continues to reside in Minnesota and wishes to maintain his or her MinnesotaCare coverage; however the individual's first redetermination (following all standard eligibility requirements) will not occur until the month the individual attains 21 years of age.

c) Any individual under the age of 21 who on his or her 18th birthday resides in a juvenile residential correctional facility, upon completion of an initial application for MinnesotaCare, is automatically deemed eligible for MinnesotaCare regardless of the income limits, insurance barriers, family enrollment requirements, and premium payments described in STC 19 and 32. MinnesotaCare coverage begins the first day of the month following release from a juvenile residential correctional facility. The State will contact these individuals annually to determine if the individual continues to reside in Minnesota and wishes to maintain his or her MinnesotaCare coverage; however the individual's first redetermination (following all standard eligibility requirements) will not occur until the month the individual attains 21 years of age.

22. **Special Eligibility Rules for MinnesotaCare Adults without Children**

a) **Assets.** MinnesotaCare adults without children may not have MinnesotaCare assets that exceed the limits identified in paragraph 19(g).

b) **Incarceration.** An individual enrolled in MinnesotaCare will not be disenrolled if the individual is temporarily incarcerated in the period between eligibility redeterminations. The State cannot claim FFP for beneficiaries enrolled in the Demonstration during a period of incarceration, whether temporary or permanent. Incarceration includes any form of secure custody by law enforcement or corrections officials. Minnesota care eligibility shall not be renewed for an enrollee incarcerated at the time of his/her annual redetermination of program eligibility.

23. **Relationship Between MinnesotaCare and MA.** The following terms govern the relationship between MinnesotaCare and MA.

a) In order to assist applicants for MinnesotaCare in making an informed choice between MA and MinnesotaCare, application forms for MinnesotaCare must meet the following criteria.

i. Application Form with Affirmative Selection. The application forms for MA and MinnesotaCare must feature a set of check boxes, or other means, for the applicant to indicate whether he or she is applying for MinnesotaCare or both MinnesotaCare and MA. The application form may allow applicants to select more than one option. At the time of application, Minnesota must provide comparative information on MinnesotaCare and MA that describes the eligibility criteria, benefits (including retroactive eligibility), cost sharing (including

monthly premium requirements), managed care, other information on the two programs needed to make an informed choice, and instructions on how to obtain assistance in making that choice. The signature page of the form must contain an affirmation that the applicant has reviewed the available options and has exercised an informed choice.

ii. An eligibility determination for MA must be done for every application for which a choice of MA is indicated. Individuals found to be MA eligible must be enrolled in MA. If a choice of MA is not indicated on the application form, the individual is not considered an applicant for MA, and no MA eligibility determination is required. If no selection of program is made by the applicant, the State will perform MA determination first, then MinnesotaCare.

iii. A copy of the MinnesotaCare application form must be submitted with each Quarterly Progress Report required under paragraph 40. The Quarterly Progress Report must also include a description of any changes made to the MinnesotaCare application form since the previous quarter.

iv. The State must notify CMS during the bimonthly monitoring calls required under paragraph 39 of any changes to the MinnesotaCare application.

b) The State will initiate a process to facilitate MA eligibility determination requests for MinnesotaCare enrollees whose cases close for failure to pay the premium when potential MA eligibility is indicated. This process will assure up to 3 months of retroactive eligibility with no gap in coverage for those who are MA eligible. A notice informing recipients that they may be eligible for MA without a premium will be sent when cases close due to failure to pay the premium where potential MA eligibility is indicated. The notice will include an acceptance form and a stamped, return addressed envelope with which to indicate an interest in an MA eligibility determination.

c) Individuals enrolled in MinnesotaCare may at any time request and receive a determination of their eligibility for MA. An enrollee who makes such an application and is determined eligible for MA must be disenrolled from MinnesotaCare, with MinnesotaCare coverage terminating the last day of the calendar month in which Department of Human Services (DHS) receives notice of the enrollee's MA eligibility. Those determined eligible for MA may receive up to 3 months of MA retroactive eligibility prior to the date of their MA application.

d) MinnesotaCare premiums paid by an enrollee may be used as medical expenses to meet an income spend down for MA.

e.) The State must ensure that no duplicate claims are paid for enrollees who disenroll from MinnesotaCare and enroll into MA during the 3 months of retroactive coverage provided under MA that overlaps with MinnesotaCare coverage.

24. **Special Rules Pertaining to MA Eligibility**. Under the demonstration waiver, eligibility for the MA Program is consistent with Minnesota's State plan except as provided for in this section.

    a) **Coverage for Pregnant Women**. Rather than requiring multiple eligibility determinations for qualified pregnant women and all other categorically needy pregnant women, MA eligibility for pregnant women is determined using an income standard of 275 percent of the FPL. Eligibility for all pregnant women enrolled in MA is determined with no asset test and continues until the end of the month in which 60 days post-partum occurs. Medical verification of pregnancy must be provided no later than 30 days after enrollment as a pregnant woman. Coverage for pregnant women consists of the full MA benefit set for a qualified pregnant woman in accordance with section 1902(a)(10)(A)(i)(III) of the Act.

    b) **12-Month Eligibility Period for Certain Medically Needy Medicaid Eligibles.** Minnesota may provide 12 months of eligibility to individuals who qualify for Medical Assistance as medically needy, provided they have only unvarying, unearned income (UUI) or only income from sources excluded from consideration by law. Minnesota must continue to use a 6-month budget period for determining medically needy eligibility under the Medicaid State Plan. UUI is defined as income from a source other than employment or self-employment that can reasonably be anticipated to be the same amount every month and for which changes, such as periodic cost-of-living increases, can be anticipated. Examples of UUI include Social Security Disability Insurance, Reemployment Insurance (Unemployment Compensation), veterans' disability payments, and private pensions. Examples of income excluded from consideration by law include federally excluded payments such as certain tribal payments, German war reparations, Women, Infants and Children Program benefits, and earnings of a minor household member who is a full-time student. Cases with spenddowns must be reviewed every 6 months to ensure the recipient has sufficient medical expenses to meet the spenddown.

25. **MinnesotaCare Application and Enrollment Process.** The following requirements apply to the application and enrollment process for MinnesotaCare.

    a) Applicants must be allowed to apply directly to DHS, or to a local county agency (if the county elects to participate in eligibility determinations for MinnesotaCare). Applicants may also submit applications through appropriate referral sources. Appropriate referral sources include, but are not limited to: eligible provider offices; local social service agencies; school district offices; public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches; community health offices; WIC program sites. Referral sources that accept applications from applicants must send applications to DHS within 5 working days after receipt. Referral sources may not make MinnesotaCare eligibility determinations; only local county agencies and DHS may make these determinations. A family member who is age 18 or over, or an authorized representative, may apply on an applicant's behalf.

b) Applicants may be required to provide all information necessary to determine eligibility for MinnesotaCare and potential eligibility for Medical Assistance, including subitems i to vii:

   i. Social security number;

   ii. Household composition;

   iii. Availability of other health coverage, including access to employer-subsidized health coverage;

   iv. Gross annual family income;

   v. Documentation of immigration status for applicants and enrollees who are not United States citizens;

   vi. Assets of applicant caretaker adults, foster parents, and legal guardians;

   vii. Any additional information needed by DHS to determine or verify eligibility

c) An applicant must be enrolled in MinnesotaCare on the date the following are completed: (1) A complete application is received by DHS and the applicant is determined eligible; and (2) the initial premium payment is received by DHS.

d) Coverage begins the first day of the calendar month following the date of enrollment, except:

   i. Coverage for newborns is automatic and begins immediately from the moment of birth if the mother is enrolled;

   ii. Coverage for eligible adoptive children of a family enrolled in MinnesotaCare begins on the first day of the month of placement for the purpose of adoption;

   iii. Coverage for other new members of an enrolled family begins the first day of the month following the month in which the change is reported;

   iv. Coverage of enrollees who are hospitalized on the first day of the month following enrollment begins the day following the date of discharge from the hospital.

e) **Retroactive Coverage.** Applicants may pay for MinnesotaCare coverage for health care services received prior to the usual coverage start date described in (c)and (d) above. Retroactive coverage begins the first day of the calendar month for which the enrollee requests and pays for up to 3 months of retroactive coverage, after meeting the following requirements:

i. Must be a former MA or GAMC enrollee;

ii. Must apply for MinnesotaCare within 30 days following termination of MA or GAMC;

iii. Must return all requested MinnesotaCare verifications within 30 days of written request for verifications;

iv. Must be eligible for ongoing MinnesotaCare;

v. Must pay the initial MinnesotaCare premium within 30 days of the initial premium billing; and

vi. Must pay the optional premium for the retroactive months within 30 days of the optional premium billing.

26. **Disenrollment from MinnesotaCare.** The MinnesotaCare enrollees may be disenrolled from MinnesotaCare for the following reasons:

a) Enrollees may be disenrolled from MinnesotaCare who fail to pay the required premium when due, unless the enrollee is pregnant or is a child under age 2. A dishonored check is considered failure to pay the premium and the agency may demand a guaranteed form of payment to replace a dishonored check. Nonpayment of the premium results in disenrollment from the plan effective for the first day of the calendar month for which the premium was due.

b) If an enrollee who is pregnant fails to pay the premium, Minnesota Care coverage continues until the last day of the month in which 60 days post-partum occurs.

c) If the premium is not paid for an enrollee who is a child under age 2, MinnesotaCare coverage continues to the last day of the month following the month in which the child becomes 2 years of age.

d) MinnesotaCare enrollees who are members of the military and their families may voluntarily disenroll for good cause when one or more family members are called to active duty. The 4-month waiting period is eliminated.

27. **MinnesotaCare Redetermination Period.** Eligibility for MinnesotaCare must be re-determined at least every 12 months. Enrollees may be required to provide the information needed to redetermine eligibility in advance of the date in which their eligibility would otherwise expire. The redetermination period begins the first day of the month after the month in which the application is approved. Minnesota may change the redetermination period to any length of time between 6 and 12 months by notifying CMS by letter in advance of the change. Furthermore, each Quarterly Progress Report must include a statement of the current length of the enrollment period for MinnesotaCare. Enrollees may be required to report to the State any changes that affect their

MinnesotaCare eligibility, such as changes in income, access to employer-sponsored insurance, changes in household composition, and changes in assets.

28. **Re-Enrollment In MinnesotaCare.**

a) An enrollee who voluntarily terminates coverage from the program, or who is disenrolled for failure to pay the required premium, may be barred from reenrolling in MinnesotaCare until 4 calendar months after the date coverage terminates unless the person demonstrates good cause for voluntary termination or nonpayment and pays the unpaid premium for any month in which coverage is to be provided and is otherwise eligible for MinnesotaCare.

b) The 4-month penalty under (a) above may not be applied to individuals described in paragraph 26, items (b), (c), and (d).

c) Good cause for nonpayment does not exist if a person chooses to pay other family expenses instead of the MinnesotaCare premium.

d) Good cause for nonpayment and voluntary termination means, generally, circumstances that excuse an enrollee's failure to pay the required premium when due or voluntarily terminating coverage, including (but not limited to) circumstances such as:

   i. Because of serious physical or mental incapacity or illness, the enrollee fails to pay the premium;

   ii. The enrollee voluntarily disenrolls under the mistaken belief that other health coverage is available; and

   iii. The enrollee does not receive a regular source of income for which the enrollee has relied on to pay the required premium.

e) The State may determine whether good cause exists based on the weight of the corroborative evidence submitted by the person to demonstrate good cause.

f) MinnesotaCare enrollees who are members of the military and their families, who voluntarily disenroll when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty. Income and asset increases reported at the time of reenrollment are disregarded until the renewal date.

g) Enrollees who are disenrolled for nonpayment of premiums who pay all past due premiums as well as current premiums within 20 days shall be reenrolled retroactive to the first day of disenrollment.

V. BENEFITS

29. **Benefits Package: MinnesotaCare Children and Pregnant Women, and MA One Year Olds.** The benefit offered to MinnesotaCare Children, MinnesotaCare Pregnant Women, and MA One Year Olds is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid State Plan, including all services that meet the definition of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) found in section 1905(r) of the Act.

30. **Benefits Package: MinnesotaCare Caretaker Adults.** The benefit offered to MinnesotaCare Caretaker Adults (except pregnant women) is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid State Plan, except that the services listed in (1) through (8) below are excluded, and inpatient hospital services are limited for certain participants as described in (9) below.

    1. Services included in an individual's education plan;

    2. Private duty nursing;

    3. Orthodontic services;

    4. Non-emergency medical transportation services;

    5. Personal Care Services;

    6. Targeted case management services (except Mental Health targeted case management which is a covered service for MinnesotaCare caretaker adults to the degree that it is covered in the Medicaid State plan);

    7. Nursing facility services; and

    8. ICF/MR services.

    9. Inpatient Hospital Limit: MinnesotaCare Caretaker Adults (except pregnant women) with income above 215 percent of the FPL are subject to a $10,000 annual limit on inpatient hospitalization.

31. **Benefits Package: MinnesotaCare Adults without Children.** The benefit offered to MinnesotaCare Adults without Children is identical to the benefit package offered to categorically eligible individuals under Minnesota's Medicaid State plan, except that the services listed in (1) through (8) below are excluded, and inpatient hospital services are limited for certain participants as described in (9) below.

    1. Services included in an individual's education plan;

2. Private duty nursing;

3. Orthodontic services;

4. Non-emergency medical transportation services;

5. Personal Care Services;

6. Targeted case management services;

7. Nursing facility services; and

8. ICF/MR services.

9. Inpatient Hospital Limit: MinnesotaCare Adults without Children are subject to a $10,000 annual limit on inpatient hospitalization and a 10% copay on inpatient hospital stays. The copay is capped at $1,000 per year.

32. **Covered Access Services**. MinnesotaCare covers sign and spoken language interpreters who assist an enrollee in obtaining MinnesotaCare eligibility and covered services.

VI. MINNESOTACARE COST SHARING.

33. **Cost Sharing in Medicaid.** The cost sharing requirements for Medicaid eligibles under the Medicaid State plan must conform to the requirements set forth in the State plan. The cost sharing requirements for MA One Year Olds must be identical to the requirements specified for Medicaid eligible infants, as specified in the Medicaid State plan.

34. **MinnesotaCare Cost Sharing.** In general, cost sharing requirements imposed on MinnesotaCare enrollees may be no more than what would be required of the corresponding categorically needy populations under the Minnesota Medicaid State plan. The State may require cost sharing by MinnesotaCare enrollees that exceeds Medicaid State plan amounts as follows:

a) **MinnesotaCare Sliding Scale Premium Schedule.** Minnesota may establish a sliding scale premium schedule (Premium Schedule) for individuals participating in MinnesotaCare that generally exceeds the amounts that can be charged in premiums under title XIX. The State must publish the sliding scale premium schedule on a public Web site, and include a copy with the Annual Report required under paragraph 41. (As of the date of this approval, the current sliding scale premium schedule is posted to the following Web site: http://www.dhs.state.mn.us.) The State may update and revise the sliding scale premium schedule at the start of each Demonstration Year (DY) and attach a copy of the updated schedule to the Quarterly Progress Report for the quarter ending in March. The sliding scale premium schedule must meet the following requirements:

The Maximum Premium is the highest total premium that a family can be required to pay, with the exception that children in families with MinnesotaCare Gross Family Income, at or below 200 percent FPL, may be charged no monthly premium as described in paragraph 32(b)(i) below. The Maximum Premium Table below provides an upper limit on the Maximum Premium amounts that can be charged to various types of families. The upper limits are expressed as a percentage of the family's MinnesotaCare Gross Family Income. Each cell in the table gives the highest income level (expressed as a percentage of FPL) to which a given upper limit applies. (For example, for a one-person family with MinnesotaCare Gross Family Income less than or equal to 54 percent of FPL, the Maximum Premium can be no more than 1.5 percent of their MinnesotaCare Gross Family Income. For a family of the same size with MinnesotaCare Gross Family Income above 54 percent up to 82 percent, the Maximum Premium can be no more than 1.8 percent of MinnesotaCare Gross Family Income.)

Maximum Premium Table

Upper Limit	**Maximum Income Level as Expressed by Family Size**				
	1 Person Family	2 Person Family	3 Person Family	4 Person Family	5 Or More
1.5%	54%	51%	49%	48%	46%
1.8%	82%	79%	77%	76%	74%
2.3%	110%	107%	105%	104%	103%
3.1%	137%	135%	134%	133%	132%
3.8%	165%	163%	162%	161%	160%
4.8%	193%	191%	190%	190%	189%
5.9%	220%	219%	219%	218%	218%
7.4%	248%	247%	247%	247%	247%
8.8%	275%	275%	275%	275%	275%

i. The Premium Schedule amount for a one person family with one person enrolled in MinnesotaCare may not exceed the Maximum Premium for that family type.

ii. The following are the rules governing Premium Schedule amounts for two person families. When two individuals are enrolled in MinnesotaCare, the Premium Schedule amount may not exceed the Maximum Premium, as defined

in (i) above; when one individual is enrolled in MinnesotaCare, the premium will be one-half of the two-person premium.

iii. The following are the rules governing Premium Schedule amounts for families with three or more persons. When three or more individuals are enrolled in MinnesotaCare, the Premium Schedule amount may not exceed the Maximum Premium; when two individuals are enrolled in MinnesotaCare, the premium will be two-thirds of the three-or-more-person premium; with one individual enrolled in MinnesotaCare, the premium will be one-third of the three-or-more-person premium.

iv. Notwithstanding the limits described above, the percentage of gross income charged for a family of five may be applied to families of more than five with the same monthly income.

v. Notwithstanding the limits described above, the Premium Schedule amounts may be a minimum of $4 for each person enrolled in MinnesotaCare.

vi. The State may round all Premium Schedule amounts to the nearest whole dollar.

b) **Application of Premium Requirements.** The following rules govern the application of premium cost sharing.

i. MinnesotaCare Children with MinnesotaCare Gross Family Income, at or below 200 percent of FPL, may be charged no premiums.

ii. In addition to (i) above, and after excluding the children described in (i), a family may be charged premiums for their remaining MinnesotaCare eligible family members (children with MinnesotaCare Gross Family Income above 200 percent of FPL through 275 percent of FPL, Pregnant Women, Caretaker Adults and Adults without Children) based on the sliding scale described in (a) above. The excluded children do not count as family members for the purpose of determining the correct premium schedule amount for the remaining family members.

iii. An Indian who is eligible to receive or has received an item or service furnished by the Indian Health Services, an Indian Tribe or Tribal Organization or an Indian Urban Organization (I/T/U), or through referral under contract health services is exempt from premiums and similar charges.

iv. MinnesotaCare enrollees who fail to pay their monthly premiums may be disenrolled from MinnesotaCare, subject to the limitations described in paragraph 25.

v. Members of the military and their families who meet the eligibility requirements for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's active tour of duty may be allowed to participate in

MinnesotaCare without premiums for a period of up to 12 months, effective the first day of the month following the month in which eligibility was approved.

35. **Co-Payments.** Items or services furnished to an Indian directly by Indian Health Services, an Indian Tribe or Tribal Organization or an Indian Urban Organization (I/T/U), or through referral under contract health services are exempt from copayments, coinsurance, deductibles, or similar charge. All other MinnesotaCare Caretaker Adults and MinnesotaCare Adults without Children may be charged co-payments that exceed the amounts allowed in the Minnesota Medicaid State Plan, as follows:

a) Up to $3 per non-preventive visit to a physician or other primary care provider;

b) Up to $3.50 per visit for non-emergency use of a hospital emergency department;

c) Up to $3 per prescription;

d) Up to $25 for eyeglasses;

e) Co-payments totaling $30 or more paid by a pregnant woman after the date the pregnancy is diagnosed must be refunded; and

f) MinnesotaCare Adults without Children have a 10% copay on inpatient hospital stays with an annual maximum amount of $1,000.

The following table summarizes the MinnesotaCare cost sharing provisions.

Population	Premiums	Deductibles	Co-Payments
MinnesotaCare Children (at or below 200% FPL)	No premium	None	No more than State plan
MinnesotaCare children (above 200% and at or below 275% FPL)	Monthly premiums based on a sliding scale based on income and family size	None	No more than State plan
MinnesotaCare Pregnant Women (at or below 275% FPL)	Monthly premiums based on a sliding scale based on income and family size	None	No more than State plan
MinnesotaCare Caretaker Adults (at or below 275% FPL)	Monthly premiums based on a sliding scale based on income and family size	None	• $3 per visit for non-preventive visit • $3.50 per visit for non-emergency use of the emergency room • $3 for

Population	Premiums	Deductibles	Co-Payments
			prescription drugs • $25 for eyeglasses
MinnesotaCare Adults without Children (above 75% and at or below 250% FPL).	Monthly premiums based on a sliding scale based on income and family size	None	• $3 per visit for non-preventive visit • $3.50 per visit for non-emergency use of the emergency room • $3 for prescription drugs • $25 for eyeglasses10% on inpatient hospital stays (up to $1,000 per year)

VII. DELIVERY SYSTEM

36. **Pre-Paid Managed Care Delivery Systems.** All Medicaid eligible individuals described in paragraph 17(b) and MA One Year Olds may be required to participate in the PMAP pre-paid managed care delivery system, on the same basis as other Medicaid eligibles whose participation in managed care was mandated under section 1932 of the Act. MinnesotaCare eligibles may be required to participate in the PMAP managed care delivery system or in a separate prepaid managed care delivery system specifically for MinnesotaCare. All Medicaid and MinnesotaCare managed care arrangements are subject to the Federal regulations found at 42 CFR 438.

37. **American Indians**. CMS acknowledges that, in consultation with tribal governments, DHS has developed an approach to Medicaid purchasing for American Indian recipients that is different from the remainder of the Medicaid program. These approaches address issues related to tribal sovereignty, the application of Federal provisions that prevent Indian Health Services (IHS) facilities from entering into contract with managed care organizations (MCOs), and other issues that have posed obstacles to enrolling American

Indian/Alaska Native Medicaid recipients into PMAP. Minnesota will continue to abide by the terms of these agreements, as stipulated below.

(a) American Indian Medicaid recipients, whether residing on or off a reservation, will have direct access to out-of-network services at IHS, 93-638 (IHS/638) facilities, or Urban Indian Organizations. DHS will reimburse IHS and 93-638 out-of-network services at the State plan rate. Physicians at IHS and 93-638 facilities will be able to refer recipients to specialists within the MCO network. Enrollees may not be required to see their MCO primary care provider prior to accessing the referral specialist.

(b) The State will consult with tribal governments before approving marketing materials that target American Indians recipients. Certificates of Coverage (COC) will include a description of how American Indian enrollees may direct access IHS/638 providers and how they may obtain referral services. The State will consult with tribal government prior to approving the COC. MCOs will provide trainings and orientation material s to tribal governments upon request, and will make training and orientation available to interested tribal governments. Tribal governments may assist the State in presenting or developing materials describing various MCO options to their members. If a tribal government revises any MCO materials, the MCO may review them. No MCO materials will be distributed until there is agreement between the MCO and Tribal government on any revisions.

(c) MCOs may not require any prior approval or impose any condition for an American Indian to access services at IHS/638 facilities. A physician in an IHS/638 facility may refer an American Indian recipient to an MCO participating provider for services covered by Medicaid and the MCO may not require the recipient to see a primary care provider within the MCO's network prior to referral. The participating provider may determine that services are not medically necessary.

VIII. MEDICAL EDUCATION AND RESEARCH COSTS (MERC)

38. **Medical Education and Research Costs (MERC) Trust Fund.** Through expenditure authority granted under this Demonstration, total computable payments that are paid directly to medical education institutions (or to medical care providers) through the MERC Trust Fund are eligible for FFP to the extent consistent with the following limitations:

(a) Each Demonstration Year, payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC expenditures for SFY 2009. This aggregate limit applies to all MERC payments authorized under this Demonstration.

(b) The State may not include GME as a component of capitation rates or as a direct payment under the State plan for managed care enrollees while this expenditure authority exist, with the exception of GME paid outside of MERC based on hospital

services furnished to managed care enrollees through managed care products for which no carve-out existed in calendar year 2008, which includes the MinnesotaCare Program, the Minnesota Disability Health Options Program, and those capitation payments for dual eligibles enrolled in the Minnesota Senior Health Options Program. The State may also continue to make a GME adjustment to capitation rates paid to Metropolitan Health Plan in order to recognize higher than average GME costs associated with enrollees utilizing Hennepin County Medical Center , not to exceed $6,800,000 in annual total computable payments. The GME authorized to be paid outside of MERC and the adjustment to the Metropolitan Health Plan rates is in addition to the MERC adjustment and is not subject to the MERC limit. Nothing in this provision exempts Minnesota from any of the requirements of 42 CFR 438.6(c) with respect to Medicaid managed care rate setting and actuarial soundness.

(c) The amounts described in (a) may be distributed as follows:

i. Up to $2,157,000 may be paid to the University of Minnesota Board of Regents, to be used for the education and training of primary care physicians in rural areas, and efforts to increase the number of medical school graduates choosing careers in primary care;

ii. Up to $1,035,360 may be paid to Hennepin County Medical Center for graduate clinical medical education;

iii. Up to $1,121,640 may be used to fund payments to teaching institutions and clinical training sites for projects that increase dental access for under-served populations and promote innovative clinical training of dental professionals;

iv. Up to $17,400,000 may be paid to the University of Minnesota Academic Health Center for purposes of clinical GME;

v. Amounts in excess of those distributed under (i) through (iv) above, up to the prescribed limit, may be paid to eligible training sites, based on a formula that incorporates a two-part public program factor described in (vi) below.

vi. The two part public program factor is calculated as follows: (1) public program revenue for each training site eligible for the carve-out funding; and (2) a supplemental public program factor, which is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The distribution to training sites whose public program revenues accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental public program factor.

vii. Training sites that received no public program revenues are ineligible for

payments from the PMAP funding transferred to the trust fund.

(d) FFP is available for total computable amounts paid from the MERC Trust Fund to recipient entities, within the limits described in this paragraph and the expenditure authorities. The Minnesota Department of Health, which operates the MERC Trust Fund, must certify the total computable payments made from the MERC Trust fund to eligible entities in order for the State to receive FFP.

(e) The State shall provide information to CMS regarding any modifications to the existing source of non-Federal share for any GME expenditures claimed under PMAP+. This information shall be provided to CMS, and is subject to CMS approval, prior to CMS providing FFP at the applicable Federal matching rate for any valid PMAP+ expenditures.

(f) As part of the Annual Report required under paragraph 41the State must include a report on GME activities in the most recently completed DY, that must include (at a minimum):

i. A list of the sponsoring institutions and training sites receiving payments from the MERC Trust Fund under these provisions, the amount paid to each sponsoring institution/training site, the subparagraph of (c) above under which each payment was made, and the source of the non-Federal share for each payment (i.e., each payment from the MERC Trust Fund must be identified with a corresponding transfer into the fund to account for the non-Federal share). A blanket statement can be used if the source of the non-Federal share is the same for all or most of the payments. Sponsoring institutions are the entities that receive payments from the MERC Trust Fund under (c)(i) through (c)(iv) above. The amounts paid to sponsoring institutions, and by training sites under (c)(v), are the basis for Minnesota's claim of FFP.

ii. A description of the process used by the University of Minnesota Board of Regents to allocate funds they received from the MERC Trust Fund, a list of sub-grantees receiving these funds, and the amount each sub-grantee received;

iii. With respect to payments made under (c)(iii) above: (A) a description of the public process used to determine which potential sponsoring institutions will receive grants and the amount of each grant, and (B) if any of the sponsoring institutions made sub-grants, a list of the sub-grantees and the amount each received; and

iv. With respect to payments made under (c)(v) above: a description of the public process used to determine which potential training site will receive grants and the amount of each grant.

v.

IX. GENERAL REPORTING REQUIREMENTS

39. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX of the Social Security Act in Section X of the STCs.

40. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as outlined in Section X. The State must submit any corrected budget neutrality data upon request.

41. **Bi –Monthly Calls.** The State must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, changes in the MinnesotaCare application, and any Demonstration amendments, concept papers, or State plan amendments. CMS will update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.

42. **Quarterly Progress Reports.** The State must submit progress reports no later than 60 days following the end of each calendar quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include:

    (a) An updated budget neutrality monitoring spreadsheet;

    (b) Events occurring during the quarter, or anticipated to occur in the near future, that will effect health care delivery, including but not limited to: approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance; changes to the Minnesota Health Care Program application; pertinent legislative activity; and other operational issues relevant to the Demonstration.

    (c) Action plans for addressing any policy, administrative or budget issues identified;

    (d) Quarterly enrollment reports that include the member months for each demonstration population;

    (e) A sample of the current MinnesotaCare application; and

    (f) Evaluation activities and any interim findings.

43. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, any interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy, and administrative difficulties and solutions in the operation of the Demonstration. The State must submit the draft annual report no later than 120 days after the close of each DY. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

    (a) As an attachment to the annual report, the State must submit the following information regarding the managed care plans the State contracts with to provide PMAP+ services:
        i. A description of the managed care contract bidding process;
        ii. The number of contract submissions, the names of the plans, and a summary of the financial information, including detailed information on administrative expenses, premium revenues, provider payments and reimbursement rates, contributions to reserves, service costs and utilization, and capitation rate-setting and risk adjustment methods submitted by each bidder;
        iii. Annual managed care plan financial audit report summary;
        iv. A description of any corrective action plans required of the managed care plans; and
        v. A summary of any complaints received by the State from the public regarding the managed care contracting and oversight process.

44. **Operational Protocol.** Before the State may claim FFP for Populations 8 and 9, it must submit an operational protocol documenting the eligibility processes and procedures used to transition the adults without children population from the State-only funded MinnesotaCare program into the Demonstration. Through this protocol, the State will assure it complies with all Federal law, including but not limited to, citizenship verification and identification of MinnesotaCare enrollees who become incarcerated between eligibility determinations.

45. **Transition Plan**. On or before July 1, 2012, the State is required to prepare and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in paragraphs 42(a)-(e) outline below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

    (a) **Seamless Transitions**. Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the

Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

(b) **Access to Care and Provider Payments and System Development or Remediation**. As necessary to meet the State's priorities, the State should assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation.

(c) **Pilot Programs.** Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act-defined "medical homes," "accountable care organizations," and / or "person-centered health homes" to allow for more efficient and effective management of the highest risk individuals.

(d) **Progress Updates.** After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

(e) **Implementation.**

i. By July 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid,

the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

46. **Quarterly Expenditure Reports: CMS 64.** The State must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. The State must reconcile expenditures for incarcerated beneficiaries on a quarterly basis, and make any necessary adjustments on the CMS-64 to ensure that no FFP was inadvertently claimed for incarcerated beneficiaries during the reporting quarter. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI.

47. **Reporting Expenditures Under the Demonstration: CMS-64.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

(a) **Tracking Expenditures.** In order to track expenditures under this demonstration, Minnesota must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM). All Demonstration expenditures subject to the budget neutrality expenditure limit will be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). DY 1 is defined as the year beginning July 1, 1995, and ending June 30, 1996, and DY 2 and subsequent DYs are defined accordingly. All other Medical Assistance payments that are not subject to the budget neutrality expenditure limit for PMAP+, and are not part of any other title XIX waiver program, should be reported on Forms CMS-64.9 Base and/or 64.9P Base as instructed in the SMM.

(b) For monitoring purposes, cost settlements associated with expenditures subject to the budget neutrality expenditure limit may be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements not so associated, the adjustments must be reported on lines 9 or 10C, as instructed in the SMM.

(c) For each DY, beginning in waiver year 8, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted reporting expenditures for the demonstration populations, by eligibility group. Payments made to provide health care services to the eligibility groups listed below are the expenditures subject to the budget neutrality expenditure limit. The State must complete separate pages for the following eligibility groups:

i. **Minnesota Care Children < 21 Years** (which includes Populations 3, 4, 6 and 7) (waiver name: "MC Children<21");

ii. **MA Children Age One** (waiver name: "MA Children Age 1");

iii. **MinnesotaCare Pregnant Women** (waiver name: "PREGNANT WOMEN");

iv. **MinnesotaCare Caretaker Adults** (waiver name: "ADULT CARETAKERS");

v. **MinnesotaCare Adults without Children** (which includes Populations 8 and 9) (waiver name :ADULT NO CHILDREN and

(d) For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in Section IV, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

(e) **Premiums and Pharmacy Rebates.** Premiums that are collected by the State from enrollees whose expenditures are subject to budget neutrality must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. Pharmacy rebates are reported on Form CMS-64.9 base, Service Category Line 7. Neither premium collections nor pharmacy rebates figure into the calculation of net expenditures subject to the budget neutrality test.

(f) **Payments for Health Plan Performance.** The State makes annual payments to recognize health plan performance of contractual targets during the previous calendar year. Such payments should be allocated on the CMS-64 waiver pages to reflect the amounts attributable to waiver group and waiver year in the following manner. First, determine the percentage distribution of each calendar year's payment amount by waiver year and waiver group. Then apply those same proportions to the payment totals for the same calendar year.

(g) **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All such

administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using "MA Demo" as the waiver name.

(h) **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

48. **Reporting Member-Months: Quarterly Progress Report.** For the purpose of calculating the budget neutrality expenditure limit, the State will provide to CMS on a quarterly basis the actual number of eligible member/months for each of the four eligibility groups (EGs) defined in (b) below. The enrollment data will be submitted to the CMS Project Officer 60 days after the end of each quarter as part of the quarterly progress report. To permit full recognition of "in-process" eligibility, reported counts of member months shall be subject to minor revisions as needed.

(a) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

(b) Member months must be provided for the following categories of enrollees, which correspond to categories that appear in the eligibility table in paragraph 17 (Eligibility):

i. **MinnesotaCare Children < 21 years** (which includes Populations 3, 4, 6 and 7)

ii. **MA One Year Olds**

iii. **MinnesotaCare Pregnant Woman**

iv. **MinnesotaCare Caretaker Adults**

v. **MinnesotaCare Adults without Children** (which includes Populations 8 and 9)

49. **Standard Medicaid Funding Process: CMS-37.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

50. **Medical Education and Research Costs (MERC).** Claims eligible for FFP, based on payments from the MERC Trust Fund as described in paragraph 36**,** must be reported on separate Forms CMS-64.9 Waiver and 64.9 Waiver, on line 18E, using waiver name, "MERC 1115." These expenditures are not subject to the budget neutrality expenditure limit.

51. **Extent of Federal Financial Participation for the Demonstration.** CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Section X.

    (a) Administrative cost, including those associated with the administration of the PMAP+ Demonstration;

    (b) Net expenditures of the Medicaid program that are paid in accordance with the approved State Plan and waivers granted for the purpose of implementing PMAP+ ; and

    (c) Net expenditures that are paid in accordance with the approved expenditure authorities granted for the purpose of implementing PMAP+.

52. **Sources of Non-Federal Share**. The State certifies that the source of the non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Title XIX of the Social Security Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b) The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

c) Additionally, the State shall provide information to CMS regarding any modifications to the existing source of non-Federal share for expenditures claimed under PMAP+. This information shall be provided to CMS, and is subject to CMS approval, prior to CMS providing FFP at the applicable Federal matching rate for any valid PMAP+ expenditures.

d) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid or the Demonstration and in which there is no connection to Medicaid or Demonstration payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

53. **State Certification of Funding Conditions**. The State certifies that the following conditions for non-Federal share of Demonstration expenditures are met:

(a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been used as the non-Federal share of Title XIX payments.

(b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

(c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities must certify to the State the total computable amount of Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

(d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State in accordance with Title XIX of the Social Security Act and

implementing regulations. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of Title XIX payments. Additionally, all transfers must occur prior to the specific payments under the demonstration which the transfers are designated to fund. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid or the Demonstration and in which there is no connection to Medicaid or Demonstration payments, are not considered returning and/or redirecting a Medicaid or Demonstration payment.

(e) Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

54. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

55. **Program Integrity.** The State must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the Demonstration.

XI. MONITORING BUDGET NEUTRALITY

56. **Limit on Title XIX Funding.** The State will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on expenditures for the eligibility groups listed in paragraph 44(c) during the demonstration period. This limit will be determined using a per capita cost method. In this way, the State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS assures that the State demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

57. **Projecting Service Expenditures.** Each DY estimate of Medicaid service expenditures will be calculated as the product of the projected per member/per month (PMPM) cost times the actual number of eligible member months for the eligibility groups listed in paragraph 44(c) as reported to CMS by the State under the guidelines set forth in Section X, paragraph 44. The budget neutrality expenditure limit for the eligibility groups listed in paragraph 44(c) is the sum of these annual limits for all DYs.

58. **Calculation of the Budget Neutrality Expenditure Limit.** The following are the

PMPM costs for the calculation of the budget neutrality expenditure limit for the demonstration enrollees in the eligibility groups listed in paragraph 44(c) under this extension period. ***The demonstration year is July 1 through June 30.***

Eligibility Group	**Trend Rate**	**DY 17 SFY 2012 PMPM**	**DY 18 SFY 2013 PMPM**	**DY 19 SFY 2014 PMPM**
MinnesotaCare Children	4.9 %	$280.00	$293.72	$308.11
MA Children Age One	4.9 %	$324.42	$340.32	$357.00
MinnesotaCare Pregnant Women	5.3%	$861.51	$907.17	$955.25
MinnesotaCare Caretaker Adults	5.3 %	$557.64	$587.19	$618.31
MinnesotaCare Adults without Children	6.2%	$562.86	$597.76	$634.82

*** Historical PMPM limits for DY 1 (1996) through DY 16 (2011) are provided in Attachment A.**

59. **Application of the Budget Neutrality Test.** The budget neutrality limit for the eligibility groups listed in paragraph 44(c) shall consist of a comparison between the Federal share of the budget neutrality expenditure limit for the demonstration and the amount of FFP that the State has received for expenditures subject to that limit.

(a) The Federal share of the budget neutrality expenditure limit for the eligibility groups listed in paragraph 44(c) is equal to the budget neutrality limit for the demonstration multiplied by the Composite Federal Share.

(b) The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C, by total computable expenditures as reported for the same period on the same schedule. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative method based on mutual agreement.

60. **Enforcement of Budget Neutrality**. CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State's cumulative expenditures exceed the calculated budget neutrality expenditure limit by the percentage identified below for any of the Demonstration years, the State must submit a corrective

action plan for CMS for approval

Demonstration Year	Cumulative Expenditure Limit Definition	Percentage
Year 1 through 17	Budget Neutrality expenditure cap plus	1.0 percent
Year 1 through 18	Combined budget neutrality expenditure cap plus	0.5 percent
Year 1 through 19	Combined budget neutrality expenditure caps plus	0 percent

61. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period, the budget neutrality expenditure limit for the demonstration has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

62. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS' approval of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II of these STCs, as well as the specific hypotheses that are being tested, including those indicators that focus specifically on the target populations and the public health outcomes generated from the use of Demonstration funds. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

63. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

64. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design described in paragraph 59 within 60 days of receipt, and the State must submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the

quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

65. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS as requested.

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE TERM OF THIS DEMONSTRATION EXTENSION

Date	**Deliverable**
Per paragraph 62	Submit Draft Evaluation Design
Per paragraph 8	Submit to CMS Demonstration Extension Application per the timeframe requirements in paragraph 8 and Interim Evaluation Report for the current extension period
Per paragraph 44	Operational Protocol
Per paragraph 45	Submit Transition Plan
Quarterly	**Deliverables**
	Requirements for Quarterly Report, paragraph 42
	Enrollment Reports, paragraph 42
	Expenditure Reports, paragraph 46
Annual	**Deliverables**
	Submit Draft Annual Reports, paragraph 43

ATTACHMENT A

HISTORICAL PMPM FOR THE PMAP + SECTION 1115 DEMONSTRATION

DY	SFY	Pregnant Women	MinnesotaCare Children	MA Children	Caretaker Adults
1	1996	$532.85	$77.28	$480.34	$0
2	1997	$550.96	$84.84	$516.00	$0
3	1998	$780.63	$93.34	$534.46	$0
4	1999	$808.73	$98.57	$563.86 - 1st 6 m $198.10 - 2nd 6 m	$135.46
5	2000	$855.64	$105.82	$212.68	$143.32
6	2001	$905.26	$113.61	$228.33	$151.63
7	2002	$957.78	$121.97	$245.14	$160.42
8	2003	$455.17	$152.97	$177.25	$294.62
9	2004	$491.58	$164.23	$190.30	$318.19
10	2005	$530.91	$176.32	$204.30	$343.64
11	2006	$573.38	$189.30	$219.34	$371.13
12	2007	$619.25	$203.23	$235.48	$400.82
13	2008	$668.79	$218.19	$252.81	$432.89
14	2009	$715.28	$233.35	$270.38	$462.98
15	2010	$764.99	$249.56	$289.17	$495.16
16	2011	$818.15	$266.91	$309.27	$529.57

CENTERS FOR MEDICARE AND MEDICAID SERVICES
WAIVER AND EXPENDITURE AUTHORITIES
Amended July 2011

NUMBER: **11-W-00039/5**

TITLE: **Minnesota Prepaid Medical Assistance Project Plus (PMAP+)**

AWARDEE: **Minnesota Department of Human Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning July 1, 2011 through December 31, 2013.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State Plan requirements contained in section 1902 of the Act are in effect to enable Minnesota to carry out the PMAP+ demonstration:

Title XIX Waivers

1. Statewideness/Uniformity — **Section 1902(a)(1) as implemented by 42 CFR 431.50**

To the extent necessary to enable the State to provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas of the State.

2. Freedom of Choice — **Section 1902(a)(23)(A) as implemented by 42 CFR 431.51**

To the extent necessary to enable the State to restrict the freedom of choice of providers for demonstration participants who are made eligible through the State plan in order to enroll the participants into managed care.

3. Amount, Duration, and Scope — **Section 1902(a)(10)(B) of the Act as implemented by 42 CFR 440.240(b)**

To the extent necessary to enable the State to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or in the absence of managed care arrangements, and to enable the State to provide a different benefit package to persons who elect to participate in MinnesotaCare than is being offered to the traditional Medicaid population.

4. Coverage /Benefits for Pregnant Women — **Section 1902(a)(10)(A)(i)(IV) in the matter after 1902(a)(10)(G)(Vll)**

To the extent necessary to exempt the State from the requirement that it limit medical

assistance to certain pregnant
women for services related to pregnancy and conditions that may complicate pregnancy.

5. Comparability of Eligibility Standards **Section 1902(a)(17)**

To the extent necessary to permit the State to apply different eligibility standards across populations. Specifically, this waiver enables the State to perform annual income reviews for certain medically needy recipients who have only unvarying unearned income or whose sole income is from a source excluded by law, whereas other medically needy recipients are subject to 6-month income reviews. This waiver also allows the State to impose an exclusion on certain assets for applicants and enrollees who are engaged in a trade or business.

6. Resource Methodologies **Section 1902(r)(2)(A) as implemented by 42 CFR 435.601**

To the extent necessary to permit the State to exclude up to $200,000 capital or operating assets of a trade or business during the eligibility determination process, provided that the individual's bank accounts contain no personal income, or are not used to pay personal expenses.

Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) will be regarded as expenditures under the State's title XIX plan for the period of this extension.

The following expenditure authorities shall enable Minnesota to operate its section 1115 demonstration.

1. Population 1: Expenditures for Medicaid coverage to children age 12 to 23 months with family incomes at or below 275 percent of the Federal poverty level (FPL) who would not be otherwise eligible for Medicaid.

2. Population 2: Expenditures for MinnesotaCare coverage for pregnant women with incomes at or below 275 percent of the FPL, who would not otherwise be eligible for Medicaid or who would be eligible under the State plan but who have elected not to apply under the State plan.

3. Expenditures for Medicaid coverage for pregnant women described in section 1902(a)(10)(A)(i)(IV) of the Act, to the extent that services are provided that are in addition to services related to pregnancy and conditions which may complicate pregnancy.

4. Expenditures for Medicaid coverage for pregnant women with incomes at or below 275 percent of the FPL who would not otherwise be eligible for Medicaid.

5. Population 3: Expenditures for MinnesotaCare coverage for children through age 20

at or below 200 percent of the FPL who (a) either would not be otherwise eligible for Medicaid under the State Plan or would be eligible under the State plan but who have elected not to apply under the State plan and (b) are not entitled to Medicare.

6. Population 4: Expenditures for MinnesotaCare coverage for children through age 20 above 200 and at or below 275 percent of the FPL who (a) either would not be otherwise eligible for Medicaid under the State Plan or would be eligible under the State plan but who have elected not to apply under the State plan, (b) are not entitled to Medicare, and (c) meet other eligibility criteria described in paragraphs 19 and 20 of the STCs.

7. Population 5: Expenditures for MinnesotaCare coverage for caretaker adults of children who are eligible for Medicaid, CHIP or MinnesotaCare with family incomes at or below 275 percent of the FPL or $57,500 per year (whichever is lower), and who (a) either would themselves not be otherwise eligible for Medicaid under the State Plan or who would be eligible under the State plan but who have elected not to apply under the State plan, (b) are not eligible for Medicare, and (c) meet other eligibility criteria described in paragraphs 19 and 20 of the STCs.

8. Expenditures for Medicaid coverage for medically needy individuals who have unvarying unearned income or whose sole income is from a source excluded from consideration by law, to the extent that they would be ineligible under the State plan using a 6-month budget period instead of a 12-month budget period.

9. Population 6: Expenditures for MinnesotaCare coverage for individuals under the age of 21 who, on their 18th birthday, reside in a foster care placement and who have completed an initial application for MinnesotaCare, regardless of whether other MinnesotaCare requirements are met, beginning the first day of the month following the date of termination of foster care.

10. Population 7: Expenditures for MinnesotaCare coverage for individuals under the age of 21 who on their 18th birthday reside in a juvenile residential correctional facility, who have completed an initial application for MinnesotaCare, regardless of whether other MinnesotaCare requirements are met, beginning on the first day of the month following release from a juvenile residential correctional facility.

11. Population 8: Expenditures for MinnesotaCare coverage for adults age 21 to 64 years old, without children with family incomes above 75 percent and at or below 133 percent of the FPL, and who (a) would not be otherwise eligible for Medicaid under the State Plan, (b) are not entitled to Medicare, and (c) meet other eligibility criteria described in STC 19 and 22.

12. Population 9: Expenditures for MinnesotaCare coverage for adults age 21 to 64 years old, without children with family incomes above 133 percent and at or below 250 percent of the FPL, and who (a) would not be otherwise eligible for Medicaid under the State Plan, (b) are not entitled to Medicare, and (c) meet other eligibility criteria described in STC 19 and 22.

13. Expenditures for payments made directly to medical education institutions or medical providers and restricted for use to fund graduate medical education (GME) of the recipient institution or entity through the Medical Education and Research Costs (MERC) Trust Fund. In each Demonstration Year, payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC expenditures for SFY 2009. Except as specifically authorized in paragraph 36 of the STCs, the State may not include GME as a component of capitation rates or as the basis for other direct payment under the State plan. This expenditure authority will be subject to changes in Federal law or regulation that may restrict the availability of Federal financial participation for GME expenditures.

Requirements Not Applicable to the Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the list below, shall apply to the expenditure authorities beginning July 1, 2011 through December 31, 2013. The list below is applicable to demonstration participants receiving MinnesotaCare coverage who would not otherwise be eligible for Medicaid or who would be eligible under the State plan but who have elected not to apply under the State plan. This list does not pertain to MA One Year Olds.

1. Cost Sharing — **Sections 1902(a)(14) insofar as it incorporates 1916**

To enable the State to impose premiums and cost sharing that are above the limits in current Medicaid statutes.

2. Financial Responsibility/Deeming — **Section 1902(a)(17)(D)**

To exempt the State from the limits on whose income and resources may be used in determining the eligibility of family members.

3. Methods of Administration: Transportation — **Section 1902(a)(4), insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable the State to not assure transportation to and from providers for non-pregnant adults ages 21-64.

4. Reasonable Promptness — **Section 1902(a)(8)**

To the extent necessary to allow the State not to provide coverage until the first day of the month following an individual's first premium payment.

To the extent necessary to allow the State to impose a period of ineligibility on applicants who currently have other health insurance coverage or had other health insurance coverage during the 4 months immediately preceding the effective date of MinnesotaCare coverage.

5. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to allow the State to not provide coverage for any time prior to the first of the month following an individual's first premium payment.

6. Managed Care Payment **Section 1903(m)(2)(A)(ii)**
Section 1902(a)(4)

To the extent necessary to allow the State to make payments directly to providers, outside of the capitation rate, for graduate medical education through the Medical Education and Research Costs (MERC) Trust Fund.

7. Income Disregard **Section 1902(r)(2)**

To the extent necessary to allow the State to apply an income disregard to Population 9 adults without children applicants who have family income above 133 and up to and including 250 percent of the FPL.

Appendix C
Managed Care Enrollment January 2011

January 2011 Managed Care Enrollment Total Summary - By Benefit Set

		Blue Plus	Health Partners	Itasca Medical Care	Medica	Metro-politan Health Plan	PrimeWest Health	South Country Health Alliance	UCare	Total
Minnesota Care										
Basic Plus		771	185	23	489	9	37	22	305	**1,841**
Basic Plus 1		25,551	10,770	837	19,556	1,913	1,359	1,367	15,375	**76,728**
Basic Plus 2		13,576	3,958	362	9,285	374	509	477	5,616	**34,157**
Expanded		18,816	5,518	450	12,772	556	466	438	7,506	**46,522**
PMAP										
Medical Assistance (MA)		68,983	38,808	3,890	100,206	13,034	15,491	18,593	80,962	**339,967**
Non-Citizen Medical (NM)		404	364	1	738	320	29	76	604	**2,536**
Seniors and Special Needs Plans										
Minnesota Senior Care Plus (MSC+)	**Duals[1]**	2,454	968	129	2,288	596	798	710	1,530	**9,473**
	Non Duals	197	226	1	435	87	10	22	1,005	**1,983**
Minnesota Senior Health Option (MSHO)		10,234	2,888	463	9,771	693	2,171	1,801	8,948	**36,969**
Special Needs Basic Care (SNBC)[2]	**Duals**				888	219	204	688	875	**2,874**
	Non Duals				638	247	71	65	894	**1,915**
Preferred Integrated Network (PINs)	**Children**				20					**20**
	Adults				317					**317**
Program Totals										
MinnesotaCare		58,714	20,431	1,672	42,102	2,852	2,371	2,304	28,802	**159,248**
PMAP		69,387	39,172	3,891	100,944	13,354	15,520	18,669	81,566	**342,503**
MSC Plus		2,651	1,194	130	2,723	683	808	732	2,535	**11,456**
MSHO		10,234	2,888	463	9,771	693	2,171	1,801	8,948	**36,969**
SNBC		0	0	0	1,526	466	275	753	1,769	**4,789**
PINs					337					**337**
Total Enrollment		**140,986**	**63,685**	**6,156**	**157,403**	**18,048**	**21,145**	**24,259**	**123,620**	**555,302**

[1] Duals include enrollees with both Part A and B, Part A only, Part B only

[2] Blue Plus no longer SNBC, Medica not integrated (as of 1/1/11)

[3] No MnDHO as of 1/1/11

Appendix D
Managed Care Enrollment December 2011

December 2011 Managed Care Enrollment Summary - By Benefit Set

		Blue Plus	Health Partners	Itasca Medical Care	Medica[2]	Metro-politan Health Plan	PrimeWest Health	South Country Health Alliance	UCare	Total
Minnesota Care										
Basic Plus		785	221	20	555	27	40	35	324	**2,007**
Basic Plus 1		14,741	5,694	433	10,118	543	698	549	8,193	**40,969**
Basic Plus 2		13,278	4,215	375	9,482	329	589	523	5,918	**34,709**
Expanded		18,515	5,921	407	13,127	608	610	504	7,832	**47,524**
Medical Assistance (MA)		70,622	39,165	3,655	97,865	12,067	14,917	17,354	84,342	**339,987**
MA Expansion (MA/AX)		11,440	9,934	670	15,905	3,158	2,140	2,453	13,255	**58,955**
Non-Citizen Medical (NM)		323	247	2	540	214	23	45	574	**1,968**
NM Expansion (NM/AX)		37	58		86	15		1	87	**284**
Minnesota Senior Care Plus (MSC+)	**Duals[1]**	2,790	933	133	2,316	550	755	711	1,666	**9,854**
	Non Duals	197	247	1	389	88	9	23	954	**1,908**
Minnesota Senior Health Option (MSHO)		9,756	2,926	484	9,719	701	2,129	1,767	9,039	**36,521**
Special Needs Basic Care (SNBC)[2]	**Duals**				1,085	280	206	639	1,058	**3,268**
	Non Duals				716	272	69	68	1,363	**2,488**
Preferred Integrated Network (PINs)	**Children**				21					**21**
	Adults				371					**371**
Program Totals										
MinnesotaCare		47,319	16,051	1,235	33,282	1,507	1,937	1,611	22,267	**125,209**
MA Total (includes the following programs)		95,165	53,510	4,945	129,013	17,345	20,248	23,061	112,338	**455,625**
PMAP		82,422	49,404	4,327	114,396	15,454	17,080	19,853	98,258	**401,194**
MSC Plus		2,987	1,180	134	2,705	638	764	734	2,620	**11,762**
MSHO		9,756	2,926	484	9,719	701	2,129	1,767	9,039	**36,521**
SNBC		0	0	0	1,801	552	275	707	2,421	**5,756**
PINs					392					**392**
Total Enrollment		**142,484**	**69,561**	**6,180**	**162,295**	**18,852**	**22,185**	**24,672**	**134,605**	**580,834**

[1] Duals include enrollees with both Part A and B, Part A only, Part B only

[2] Medica SNBC/PINs not integrated (as of 1/1/11)

Appendix E
Managed Care Enrollment December 2012

December 2012 Managed Care Enrollment Summary - By Benefit Set

		Blue Plus	Health Partners	Hennepin Health	Itasca Medical Care	Medica	Metropolitan Health Plan	PrimeWest Health	South Country Health Alliance	UCare[2]	Total
Minnesota Care											
Basic Plus		811	352		25	462		41	24	649	**2,364**
Basic Plus 1		11,747	5,716		355	6,635		682	392	9,804	**35,331**
Basic Plus 2		11,291	5,184		337	6,096		623	457	9,098	**33,086**
Expanded		17,229	7,262		410	9,564		754	571	13,337	**49,127**
Medical Assistance (MA)		66,944	49,286		3,780	72,606		15,363	14,953	124,172	**347,104**
MA Expansion (MA/AX)		11,260	11,442	6,142	775	12,606		2,277	2,277	19,574	**66,353**
Non-Citizen Medical (NM)[3]		169	97			462		23	31	460	**1,242**
Minnesota Senior Care Plus (MSC+)	**Duals[1]**	3,078	1,079		147	2,618	527	770	767	2,184	**11,170**
	Non Duals	157	237		2	363	75	10	13	952	**1,809**
Minnesota Senior Health Option (MSHO)		9,182	3,015		490	9,575	666	2,096	1,770	9,007	**35,801**
Special Needs Basic Care (SNBC)[2]	**Duals**					8,403	1,322	969	1,361	7,785	**19,840**
	Non Duals					6,344	1,311	423	480	7,403	**15,961**
Preferred Integrated Network (PINs)	**Children**					11					**11**
	Adults					448					**448**
Program Totals											
MinnesotaCare		41,078	18,514	0	1,127	22,757	0	2,100	1,444	32,888	**119,908**
MA Total (includes the following programs)		90,790	65,156	6,142	5,194	113,436	3,901	21,931	21,652	171,537	**499,739**
PMAP		78,373	60,825	6,142	4,555	85,674	0	17,663	17,261	144,206	**414,699**
MSC Plus		3,235	1,316	0	149	2,981	602	780	780	3,136	**12,979**
MSHO		9,182	3,015	0	490	9,575	666	2,096	1,770	9,007	**35,801**
SNBC		0	0	0	0	14,747	2,633	1,392	1,841	15,188	**35,801**
PINs		0	0	0	0	459	0	0	0	0	**459**
Total Enrollment		**131,868**	**83,670**	**6,142**	**6,321**	**136,193**	**3,901**	**24,031**	**23,096**	**204,425**	**619,647**

[1] Duals include enrollees with both Part A and B, Part A only, Part B only

[2] UCare SNBC not integrated (as of 1/1/12)

[3] Non-Citizen Medical - beginning 3/1/12 - enrollment in managed care for pregnant women only

Appendix F
Medical Assistance Populations Excluded from Managed Care

The following groups and individuals are excluded from the requirement to enroll in a Managed Care Organization, but may voluntarily enroll:

- Adults who are identified to the State as seriously and persistently mentally ill pursuant to Minnesota Statutes, § 245.462, Subdivision 20, Paragraph (c) and eligible to receive Medical Assistance covered mental health case management services according to § 256B.0625, Subdivision 20.

- Children who are identified to the State as severely emotionally disturbed pursuant to Minnesota Statutes, § 245.487 to 245.4887 and eligible to receive Medical Assistance covered mental health case management services.

- IV-E and non IV-E adoption assistance children.

The following groups and individuals are excluded from the requirement to enroll in a Managed Care Organization:

- Persons under 65 years of age who are eligible for medical assistance due to blindness or disability (including developmentally disabled) as determined by SSA or the State Medical Review Team. (Note: These individuals are excluded under the Families and Children contract, but may enroll under the SNBC contract.)

- Persons receiving benefits under the Federal Refugee Assistance Program and have no other basis of Medical Assistance eligibility.

- Medical Assistance Residents of State Institutions, including: Regional Treatment Centers, Institutions for Mental Disease and State operated facilities who reside in the institution at the time of initial enrollment. (Note: Recipients already enrolled in managed care who enter state institutions will remain enrolled in their MCO if the placement has been approved by the MCO, including court ordered placement.)

- Persons terminally ill as defined in Minnesota Rules, Part 9505.0297, Subpart 2, Item N (i.e., Prognosis of six months or less to live) and who, at the time of enrollment in Medical Assistance has an established relationship with a primary care physician who is not part of an MCO.

- Qualified Medicare Beneficiaries, Qualified Working Disabled Adult, Service Limited Medicare Beneficiaries, and Qualified Individuals who are not otherwise eligible for Medical Assistance.

- Medical Assistance recipients with private health insurance coverage through a Health Maintenance Organization. These individuals may enroll in PMHCP on a voluntary basis if the private HMO is the same as the MCO the recipient will select under PMHCP.

- Medical Assistance recipients with private health insurance which has been determined to be cost-effective.

- Individuals eligible for Medical Assistance with a medical spenddown. Note - MSHO and SNBC enrollees who acquire an automated monthly medical spenddown or a combination long-term care/medical spenddown while enrolled in MSHO may remain voluntarily enrolled in MSHO.

- Individuals who, at the time of notification of mandatory enrollment in an MCO: 1) has a communicable disease; 2) the prognosis of the communicable disease is terminal illness, however, for the purpose of this subitem, "terminal illness" may exceed six months; 3) the person's primary physician is not a participating provider in any MCO; and 4) the physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.

- American Indians eligible for Medical Assistance living on the Indian Reservation, unless the tribal government of that reservation chooses to enroll these persons.
- Non-documented persons eligible for Emergency Medical Assistance.

- Persons who are eligible while receiving care and services from a non-profit center established to serve victims of torture.

- Women receiving Medical Assistance through the Breast and Cervical Cancer Control Program.

Appendix G
Families and Children Contract Procurement Schedule

Managed Care 5-year PMAP & MinnesotaCare Procurement Schedule by County (2013-2017)

DHS is required to procure for managed care every five years. The information below indicates the year of procurement for the counties listed. The year in parentheses indicates the last procurement in that county.

2013 Procurement (13 counties)

Big Stone (03)
Beltrami (08)
Clearwater (08)
Douglas (03)
Grant (03)
Hubbard (08)
McLeod (03)
Meeker (03)
Pipestone (03)
Pope (03)
Renville (03)
Stevens (03)
Traverse (03)

2014 Procurement (28 counties)

Aitkin (09)
Benton (09)
Carlton (09)
Chisago (10)
Cook (09)
Fillmore (09))
Houston (09)
Isanti (09)
Itasca (09)
Kittson (09)
Koochiching (09)
Lake (09)
Lake of the Woods (08)
Mahnomen (09)
Marshall (09)
Mille Lacs (09)
Mower (09)
Norman (09)
Olmsted (08)
Pennington (09)
Pine (09)
Polk (09)
Red Lake (09)
Roseau (09)
Sherburne (09)
St. Louis (09)
Stearns (09)
Winona (0

2015 Procurement (18 counties)

Blue Earth (10)
Chippewa (10)
Cottonwood (10)
Faribault (10)
Jackson (10)
Kandiyohi (10)
Lac Qui Parle (10)
Lincoln (10)
Lyon (10)
Martin (10)
Murray (10)
Nobles (10)
Redwood (10)
Rock (10)
Swift (10)
Watonwan (10)
Wright (10)
Yellow Medicine (10)

2016 Procurement (7 counties)

Becker (11)
Clay (11)
LeSueur (11)
Nicollet (11)
Ottertail (11)
Rice (11)
Wilkin (11)

2017 Procurement (21 counties)

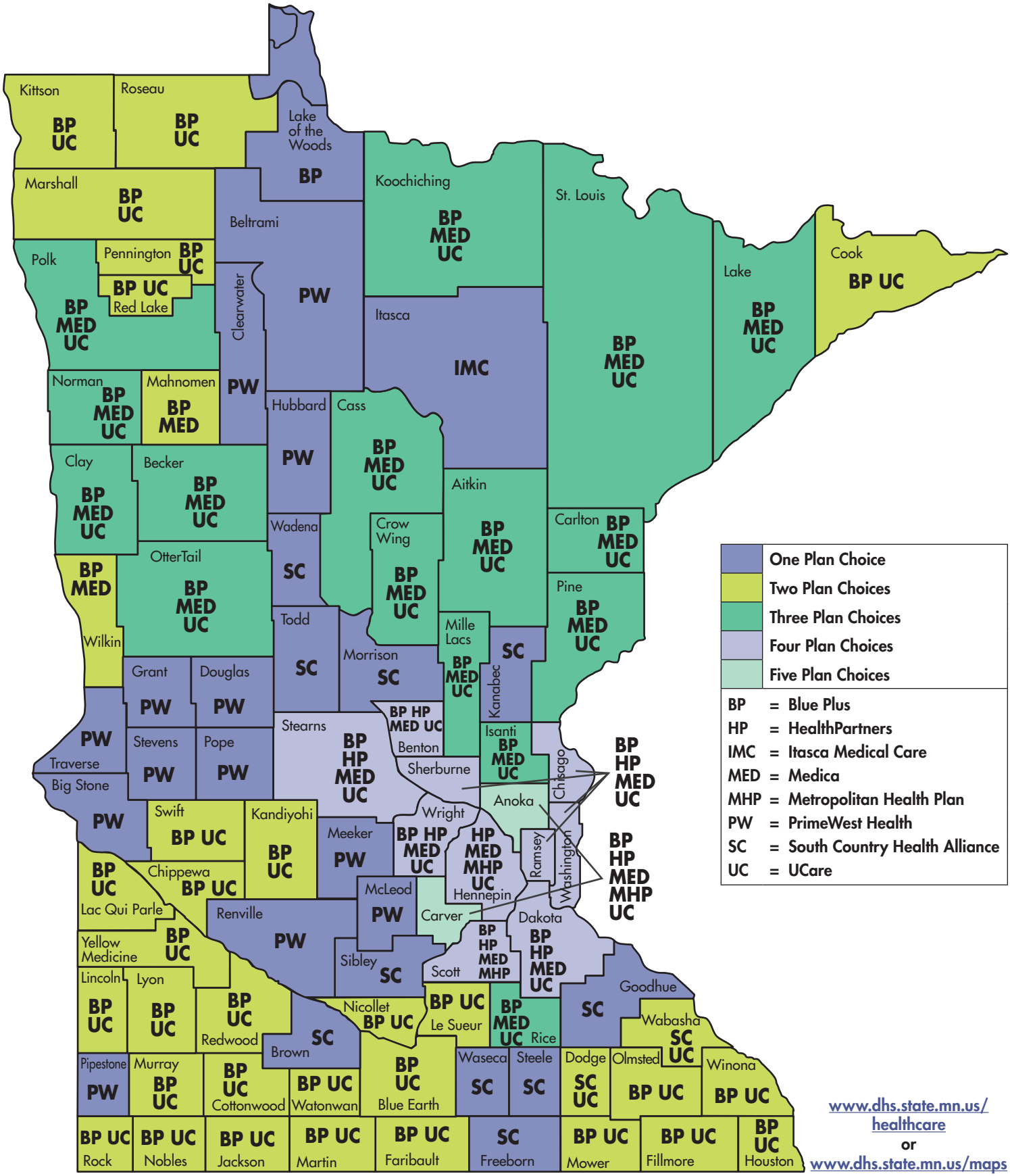
Anoka (12)
Brown (12)
Carver (12)
Cass (12)
Crow Wing (12)
Dakota (12)
Dodge (12)
Freeborn (12)
Goodhue (12)
Hennepin (12)
Kanabec (12)
Morrison (12)
Ramsey (123)
Scott (12)
Sibley (12
Steele (12)
Todd (12
Wabasha (12)
Wadena (12
Waseca (12)
Washington (12)

Appendix H
MCO Choices by County for PMAP

Minnesota Department of Human Servi

Prepaid Medical Assistance Program (PMAP)
Health Plan Choices by County

Effective April 1, 2011

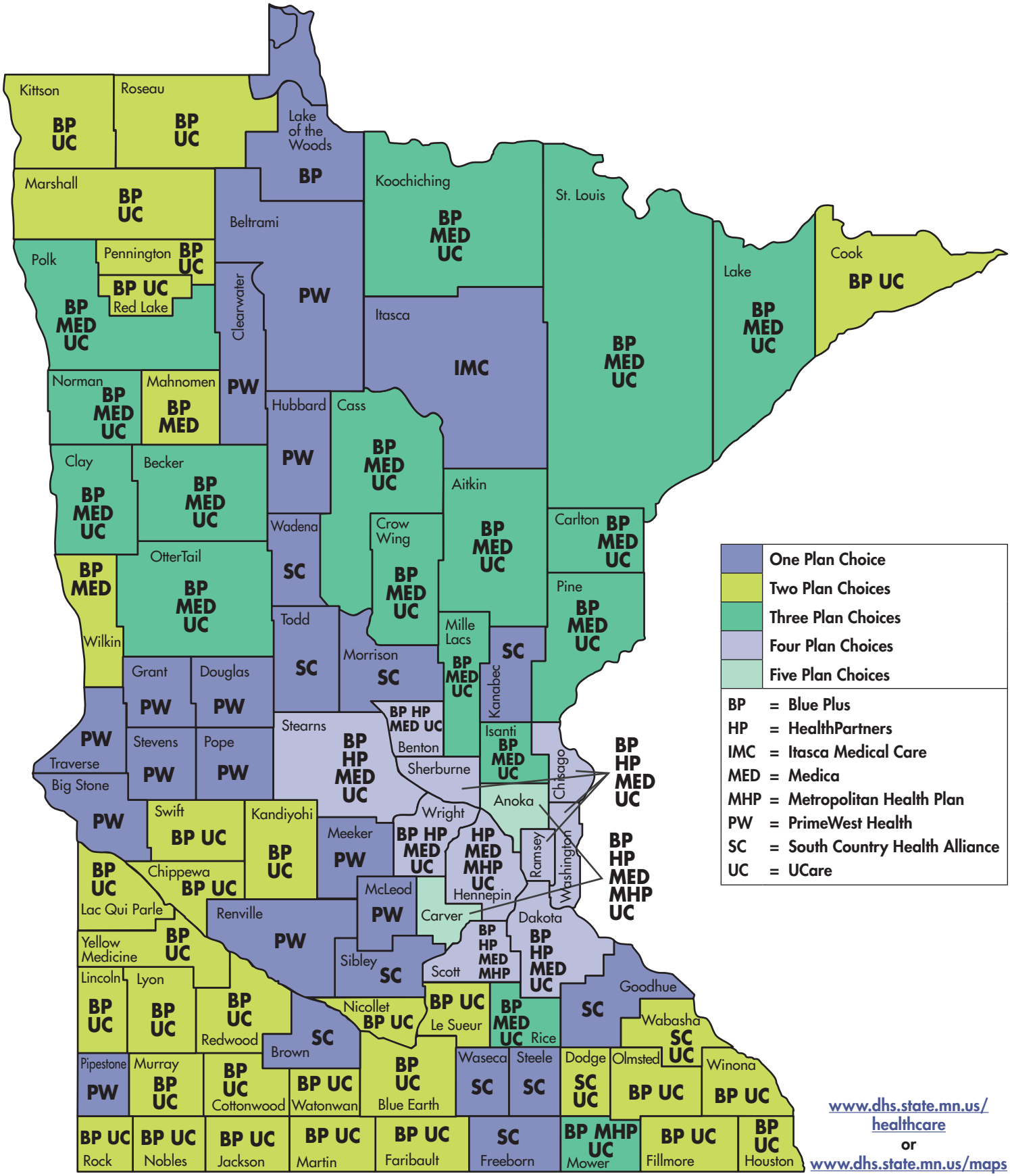


www.dhs.state.mn.us/healthcare
or
www.dhs.state.mn.us/maps

Minnesota Department of Human Servi

Prepaid Medical Assistance Program (PMAP)
Health Plan Choices by County

Effective January 1 through March 31, 2011



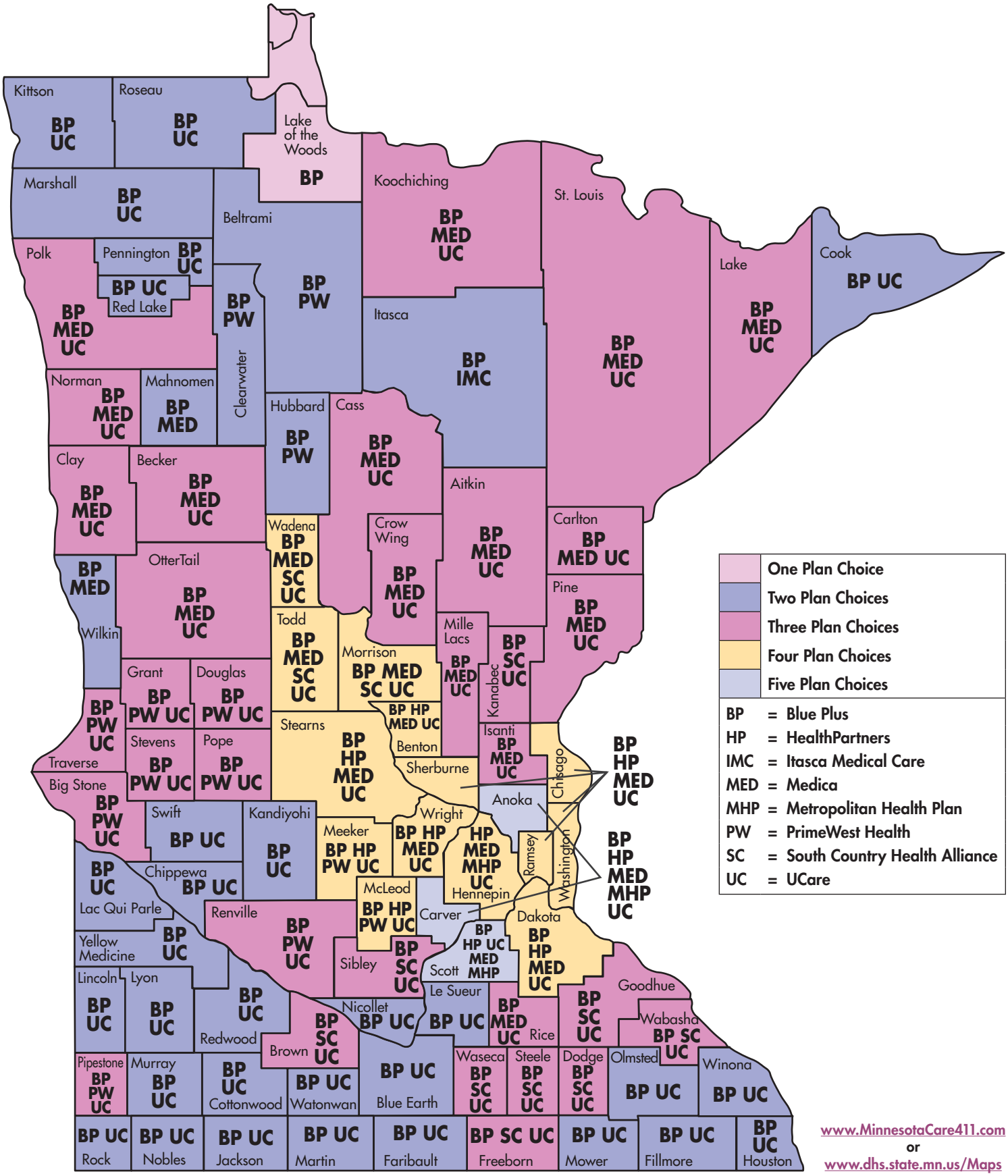
www.dhs.state.mn.us/healthcare
or
www.dhs.state.mn.us/maps

Appendix I
MCO Choices by County for MinnesotaCare

Minnesota Department of Human Servi

MinnesotaCare
Health Plan Choices by County

Effective April 1, 2011

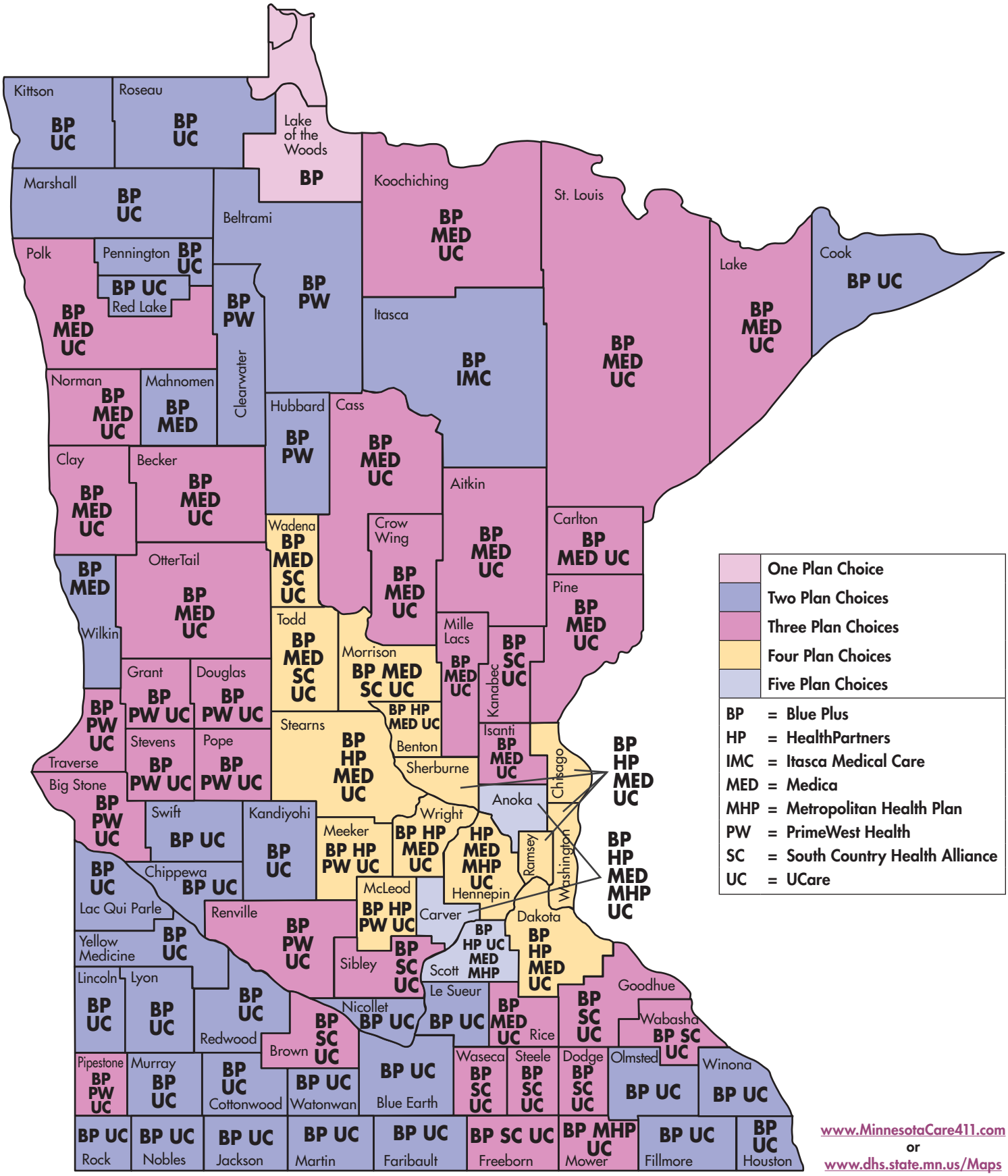


www.MinnesotaCare411.com
or
www.dhs.state.mn.us/Maps

Minnesota Department of Human Servi

MinnesotaCare
Health Plan Choices by County

Effective January 1 through March 31, 2011



www.MinnesotaCare411.com
or
www.dhs.state.mn.us/Maps

Appendix J
MCO Choices by County for
Minnesota Senior Care Plus (MSC+)

Minnesota Department of Human Servi

Minnesota SeniorCare Plus (MSC+)
Health Plan Choices by County

Effective April 1, 2011

Kittson BP UC
Roseau BP UC
Lake of the Woods BP
Marshall BP UC
Beltrami PW
Koochiching BP MED UC
St. Louis BP MED UC
Lake BP MED UC
Cook BP UC
Polk BP MED UC
Pennington BP UC
BP UC Red Lake
PW
Clearwater PW
Itasca IMC
Norman BP MED UC
Mahnomen BP MED
Hubbard PW
Cass BP MED UC
Clay BP MED
Becker BP MED
Aitkin BP MED UC
Wadena SC
Crow Wing BP MED UC
Carlton BP MED UC
OtterTail BP MED UC
BP MED
Wilkin
Pine BP MED UC
Todd SC
Morrison SC
Mille Lacs BP MED UC
Kanabec SC
Grant PW
Douglas PW
BP HP MED UC
Stearns BP HP MED UC
Benton
Isanti BP MED UC
PW
Traverse
Stevens PW
Pope PW
Sherburne
Chisago
BP HP MED UC
Big Stone PW
Swift BP UC
Kandiyohi BP UC
Wright
Anoka
Meeker PW
BP HP MED UC
HP MED MHP UC
Ramsey
Washington
BP HP MED MHP UC
BP UC Lac Qui Parle
Chippewa BP UC
Hennepin
McLeod PW
Carver
Renville PW
Dakota BP HP MED UC
Yellow Medicine BP UC
Sibley SC
Scott BP HP MED MHP
Lincoln BP UC
Lyon BP UC
BP UC Redwood
Nicollet BP UC
BP UC Le Sueur
BP MED UC
Rice
SC
Goodhue
Wabasha SC UC
Brown SC
Pipestone PW
Murray BP UC
BP UC Cottonwood
BP UC Watonwan
BP UC Blue Earth
Waseca SC
Steele SC
Dodge SC UC
Olmsted BP UC
Winona BP UC
BP UC Rock
BP UC Nobles
BP UC Jackson
BP UC Martin
BP UC Faribault
SC Freeborn
BP UC Mower
BP UC Fillmore
BP UC Houston

One Plan Choice	
Two Plan Choices	
Three Plan Choices	
Four Plan Choices	
Five Plan Choices	

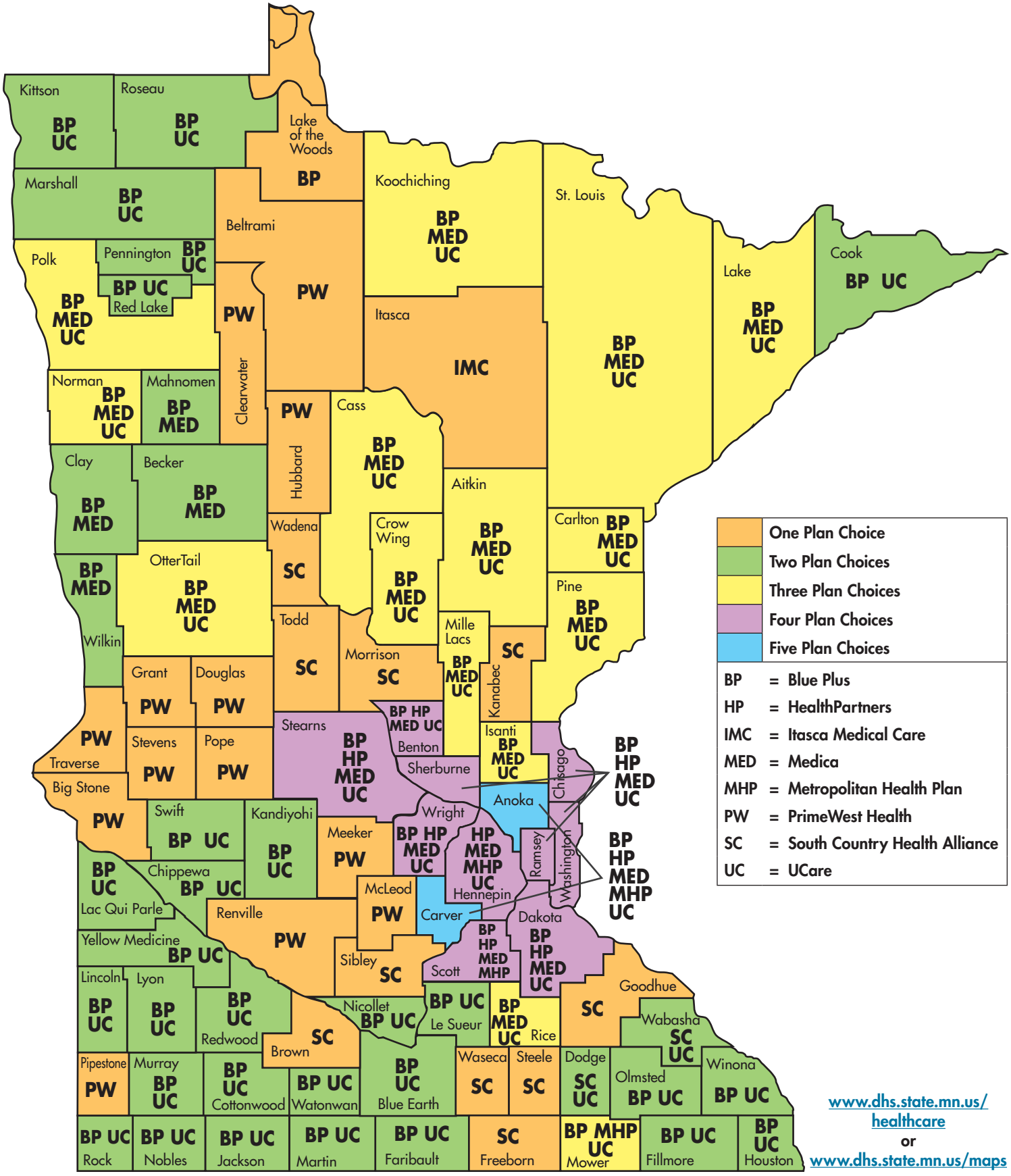
BP	=	Blue Plus
HP	=	HealthPartners
IMC	=	Itasca Medical Care
MED	=	Medica
MHP	=	Metropolitan Health Plan
PW	=	PrimeWest Health
SC	=	South Country Health Alliance
UC	=	UCare

www.dhs.state.mn.us/healthcare
or
www.dhs.state.mn.us/maps

Minnesota Department of Human Servi

Minnesota SeniorCare Plus (MSC+)
Health Plan Choices by County

Effective January 1 through March 31, 2011



One Plan Choice	
Two Plan Choices	
Three Plan Choices	
Four Plan Choices	
Five Plan Choices	

BP	=	Blue Plus
HP	=	HealthPartners
IMC	=	Itasca Medical Care
MED	=	Medica
MHP	=	Metropolitan Health Plan
PW	=	PrimeWest Health
SC	=	South Country Health Alliance
UC	=	UCare

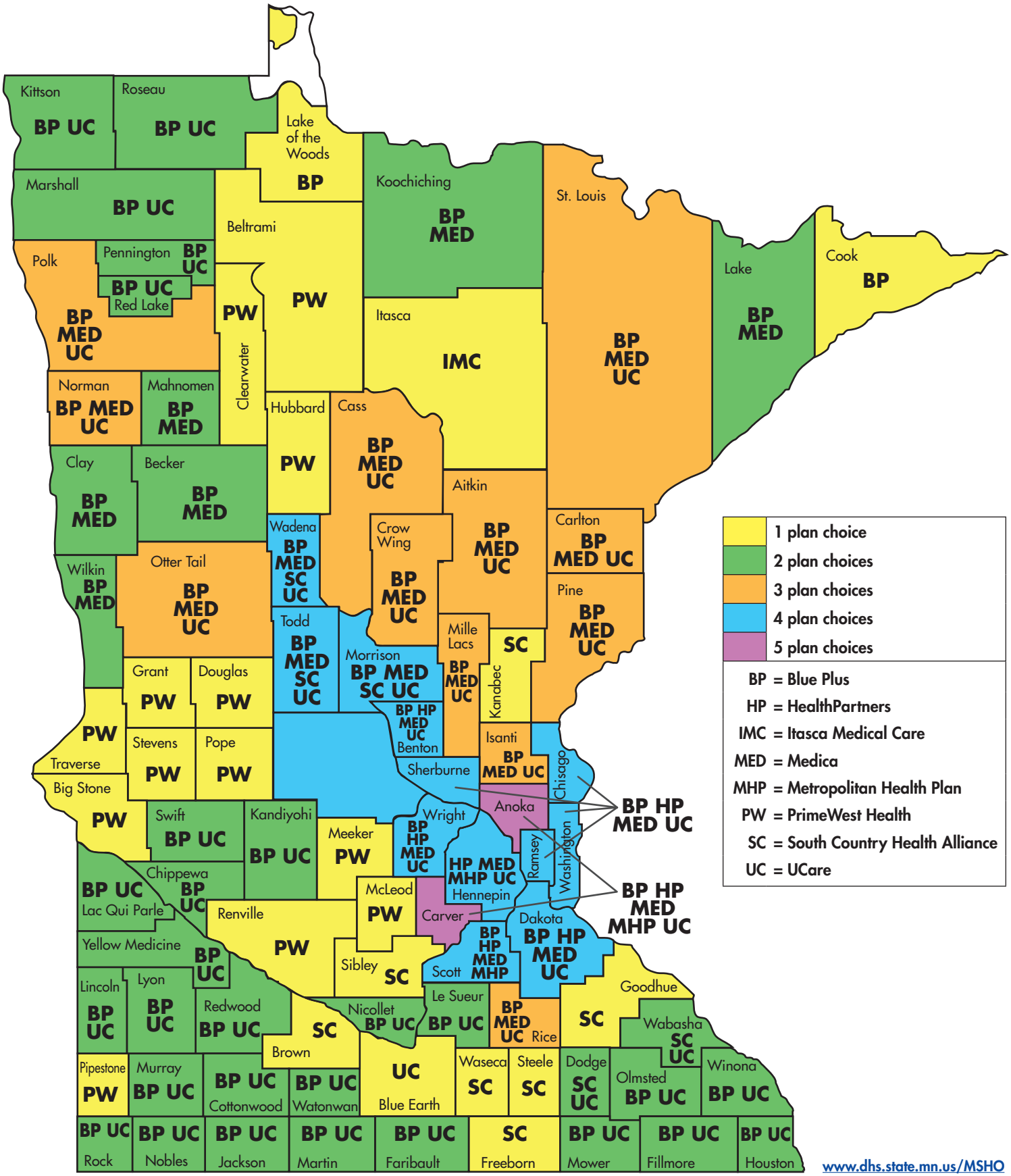
www.dhs.state.mn.us/healthcare
or
www.dhs.state.mn.us/maps

Appendix K
MCO Choices by County for
Minnesota Senior Health Options (MSHO)

Minnesota Department of Human Servi

Health Plan Choices by County for Minnesota Senior Health Options (MSHO)

Effective Jan. 1, 2011



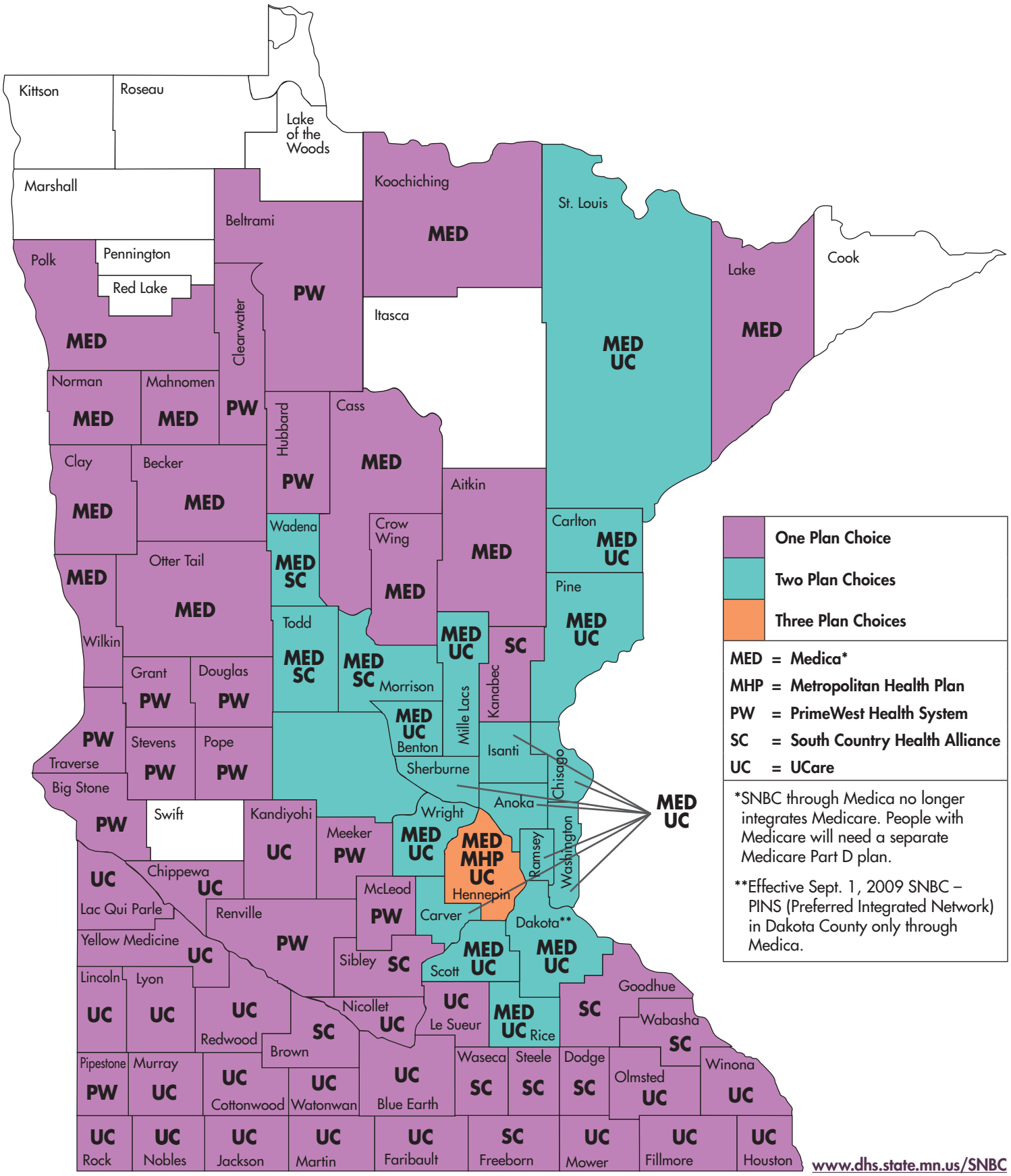
www.dhs.state.mn.us/MSHO

Appendix L
MCO Choices by County for
Special Needs Basic Care (SNBC)

Minnesota Department of Human Servi

Health Plan Choices by County for Special Needs BasicCare (SNBC)

Effective Jan. 1, 2011



www.dhs.state.mn.us/SNBC

Appendix M
Rate Setting Report
PMAP and MinnesotaCare - Capitation Rate Adjustments

Milliman

8500 Normandale Lake Blvd.
Suite 1850
Minneapolis, MN 55437
USA

Tel +1 952 897 5300
Fax +1 952 897 5301

milliman.com

August 19, 2011

Mr. R. Jason Wiley
Managed Care Rate Setter
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55101-2208

Re: September 2011 Rate Adjustments – PMAP and MNCare

Dear Jason:

Recently, the State of Minnesota legislated specified reductions in capitation rate changes, to be effective September 1, 2011. These include:

- MA Families and Children – 2.82%
- MA Adults without Children – 10.10%
- MNCare Families and Children – 6.00%

No rate changes were specified for MNCare Adults without Children, and I understand those rates will not be changed.

A number of other legislative changes impacting provider payment rates, MCO capitation rates, and benefits were also passed with 2011 effective dates. This includes a change to eligibility requirements for PCA services for enrollees with a dependency in one activity of daily living (ADL) or Level 1 behavior, which is included in the MCO contract amendment for September. However, I understand that DHS does not intend to adjust 2011 capitation rates for these changes.

You have requested I provide an amendment to my 2011 rate certification recognizing these changes.

My development of current 2011 capitation rate levels is detailed in two prior letters including:

- 2011 Trend & Surplus, Benefit Changes 1217.pdf,
- MA Expansion Rate Letter 0309 Rev.pdf

These are attached to this letter for reference.

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

In assessing the continued actuarial soundness of the 2011 rates, I considered that the original Families and Children rates for both PMAP and MNCare included a margin of 1.18%. (The original PMAP Adults without Children rates included no margin.) I also considered that subsequent analysis indicates recent trend rates, including 2010 experience, have been lower than assumed in the original analysis completed before the more recent data was available.

Finally, I considered that the legislature has also made changes to the eligibility criteria for PCA services to include recipients who have a dependency in one ADL or Level I behavior, which will increase costs slightly, but for which no rate adjustment is planned. After considering all of these changes together, I anticipate that the average rate paid in 2011 will continue to be actuarially sound even with the reductions summarized above.

An amendment to my original actuarial certification is attached to this letter.

Data Reliance

In performing this analysis, I have relied on data and other information provided to me by DHS and the MCOs regarding the legislated changes and 2010 experience, including the rate adjustments to be implemented in September. I also continue to rely on the information provided for the development of current 2011 rates as listed in my letters 2011 Trend & Surplus, Benefit Changes 1217.pdf and MA Expansion Rate Letter 0309 Rev.pdf. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

I have performed a limited review of the data used directly in my analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Variability

Differences between estimates and actual amounts depend on the extent to which experience conforms to the assumptions made for this analysis. It is almost certain that actual experience does not conform exactly to the assumptions used in this analysis.

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

❖❖❖

Jason, I am available for questions by phone at (952) 820-2481 and by e-mail at leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal & Consulting Actuary

Attachments (3)

LMW/mtf

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Appendix N
Rate Setting Report
PMAP – Medicaid Expansion

Milliman

8500 Normandale Lake Blvd.
Suite 1850
Minneapolis, MN 55437
USA

Tel +1 952 897 5300
Fax +1 952 897 5301

milliman.com

March 9, 2011

Mr. R. Jason Wiley
Managed Care Rate Setter
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55101-2208

Re: Capitation Rates for Medicaid Expansion

Dear Jason:

This letter contains preliminary capitation rates for Minnesota's new PMAP expansion rate cells for adults without children, to be effective April 1, 2011. These rates were developed using historical data and a number of key assumptions as described herein.

The purpose of this analysis is to assist the Minnesota Department of Human Services (DHS) with setting payment rates for contracting health plans for these programs. The results may not be appropriate for other purposes.

The results contained in this letter are intended only for use by DHS and CMS, the federal agency that must approve the capitation rates used for the PMAP expansion program. This analysis should be considered preliminary until the resulting capitation rates are approved by DHS and CMS. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. This letter should be reviewed only in its entirety. It assumes the reader is familiar with Minnesota's Medicaid programs and managed care rating principles.

The results in this letter are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon specific assumptions and methods nor upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Data Reliance

In performing this analysis, I have relied on data and other information provided to me by DHS and the plans with which it contracts. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

For this analysis, I relied on the following data and information:

- 2009 Enrollment and Capitation reports from DHS that provide detail by rate cell for each health plan and area;
- Projected 2011 enrollment by "look-alike" population, as defined below;
- Restated net hospital and medical expenses for Medicaid-covered services provided by the health plans, based on more recent experience. I also requested from each health plan a certification by a qualified actuary that the restatement reflects a best estimate;
- 2009 Aggregate Provider Reports, Tables 1, 2, and 4.
- Rate sheets with rate adjustment factors for October 2009, January 2010, September 2010, and January 2011;
- Plan data estimating the impact of the hospital cap on claim costs for the MNCare limited benefit set;
- Various summaries of risk factors from DHS;
- Certifications, provided by the health plans, of the percentage of expenses that were for non-State Plan services;
- Benefit descriptions for 2009 PGAMC and MNCare Limited Hospital Benefit Sets and 2011 MA Expansion Benefit Set; and
- Miscellaneous data and information provided by DHS and the health plans.

I have performed a limited review of the data used directly in my analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Variability

Differences between estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is almost certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience is different than expected. Accordingly, DHS should continue to carefully monitor actual experience and make adjustments as necessary.

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Background

DHS is projecting that approximately 99,000 people will eventually be enrolled in this expansion of the state's MA program, with approximately 75% enrolled in managed care. Of these, approximately 27,000 are expected to shift from the GAMC program, 60,000 are expected to shift from MNCare, and 12,000 are additional eligibles who are not currently enrolled in a Minnesota Medicaid program.

- GAMC-- Current GAMC enrollees will be automatically enrolled in the MA expansion on a fee-for-service basis on March 1 and then moved to managed care in May. GAMC recipients who were enrolled with an MCO on March 1, 2010 will be automatically enrolled with that same MCO, assuming it is still an option in the area. (I understand that enrollees will have the option of changing MCOs, but I have assumed that will not have a material impact on the rate.)

- MNCare – Approximately 49,000 people enrolled in MNCare as of March 1 are expected to be migrated to MA over six months, beginning in March 2011. DHS projects this group will grow to 60,000 by the end of 2011.

  Enrollees with significant health needs (particularly those requiring hospitalization) will be migrated first. However, all enrollees who are eligible for the expansion program will receive the new benefit set starting March 1, including those who have not yet been transitioned to MA. Prior to migration, services provided by the MNCare limited hospital benefit set will be covered by the MCOs, while other services will be covered on a FFS basis. Enrollment in managed care is expected to start April 1. New enrollees who would have previously been eligible for MNCare will be enrolled directly into MA instead.

- Additional – DHS is expecting 12,000 additional enrollees will eventually join the program. DHS is projecting approximately 9,000 will be enrolled in managed care by the end of the year. These are people who would have been eligible for GAMC and/or MNCare in the past, but who did not enroll in either program. DHS assumes that these enrollees will look like MNCare enrollees in terms of morbidity. I used monthly projected managed care enrollment figures provided by DHS for this group, which are shown in exhibits later in this letter.

Risk adjustment, MERC add-ons, and enhanced hospital payments will not apply to the expansion rates in 2011. The current MA withhold of 9.5% will apply. Ratable reductions will also apply.

I first developed an average 2011 capitation rate for the expansion rate cells. I then developed rate cell specific capitation rates. Each of these steps is described separately below.

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Development of 2011 Average Capitation Rate

I developed an average capitation rate for this population by adjusting MCO 2009 per member per month (PMPM) claim cost experience for the PGAMC and MNCare Adults without Children populations. (All references in this letter to MNCare are specific to the Adults without Children population, unless stated otherwise.) Claim cost adjustments were made for trend, benefit changes, and expected morbidity levels. Additional adjustments were made to provide for expected administrative costs and a contribution to surplus.

Exhibit A to this letter summarizes each of these steps. The exhibit includes separate projections for each of three populations—PGAMC, MNCare, and Additional. The development of costs and factors shown for each is described below.

Average 2009 Claim Cost (Row (2))

Capitation rates were developed by adjusting MCO 2009 per member per month (PMPM) claim cost experience for the PGAMC and MNCare Adults without Children programs. This claim cost experience was taken from two data sources: (1) data received from the MCOs and used to develop 2011 capitation rates for the PMAP and MNCare programs (the "Rating Data") and (2) data provided to DHS by the MCOs in the Aggregate Provider Payment report.

I used the rating data, except when it was not available for a particular MCO. In those cases, I used the Aggregate Provider Payment report data. In general, I preferred to use the rating data where it was available to be consistent with the data source used to price the PMAP Families and Children rate cells and because that data was provided along with an actuarial certification attesting that the data represented the MCO's best estimate of actual cost. However, I did compare the two data sources where they were both available and followed up with the MCOs regarding any significant differences.

Adjustment for Missing Experience (Row (3))

The starting average claim cost for each program (2009 PGAMC and 2009 MNCare Adults without Children) is shown on row (2) of Exhibit A attached to this letter. Because I did not have 2009 claim data for First Plan, which discontinued participation in the program in 2010, I adjusted the claim cost in row (2) to estimate what the claim cost would have been had First Plan data been included. To do this, I used (1) 2009 enrollment by rate cell, area, and MCO, (2) the current demographic and area adjustment factors for each program and (3) the average cost for the other plans to estimate what the average cost was in 2009, including First Plan's experience. The adjustment factor and resulting average cost are shown in rows (3a) and (3b), respectively.

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Trend (Row (4))

Next, I applied 25.5 months of trend to project claim cost to August 15, 2011, the midpoint of the effective period for these rates assuming coverage begins on April 1, 2011. I used an annual trend rate of 6.23%. This value includes an underlying annual trend rate of 5.0% and an additional trend of 1.23% to account for potential differences between PGAMC and PMAP provider payment levels. The underlying trend rate of 5% is just slightly lower than the trend rate used to project claim cost for the PMAP and MNCare Families and Children rate last year.

The additional trend, when applied over 25.5 months, effectively adds 2.5% to the expected cost level for this group. The state's fee-for-service fee schedule for GAMC is lower than its MA fee schedule for many services. Although the MCOs are not required to use the state's fee schedules, I expect their provider payment levels for PGAMC enrollees may also have been somewhat lower than payment levels for PMAP enrollees because PGAMC capitation rates have historically been set at a level that produces a financial loss to the MCOs.

I also considered the impact of recent changes to the state's RBRVS fee-for-service fee schedule. Based on comments from a number of MCOs and a high level review of the changes, I do not expect that the changes would result in significantly higher payments for the childless adult population covered by the rates developed in this letter. (In fact, it is possible that the change may result in lower costs for this population.) In addition, the MCOs are not required to use the state's fee-for-service fee schedule, so whatever impact the change might have on the state's fee-for-service costs would not necessarily be directly correlated to expected costs among the MCOs. Therefore, I am not making an adjustment for this change.

The trend rate and resulting claim cost are shown in rows (4a) and (4b) of Exhibit A.

Also shown in row (4b) is a projected rate for the Additional population, which is equal to the rate for the MNCare population since DHS expects the morbidity of this group to be consistent with that of the MNCare group.

Benefit Adjustment Factors (Row (5))

I then adjusted the projected claim cost to reflect benefit and provider reimbursement changes between 2009 and 2011. A summary of the benefit differences between PGAMC and MNCare in 2009 and the MA expansion in 2011 is provided in Exhibit B. The adjustments to the PGAMC and MNCare experience appear in row (5) and are discussed separately below.

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MNCare

I adjusted the MNCare experience data to reflect differences between the 2009 MNCare limited hospital benefit set and the 2011 PMAP benefit set. I first made adjustments to the 2009 MNCare experience to reflect benefit and provider reimbursement changes that occurred between 2009 and 2011, including:

- Changes in provider reimbursement levels (e.g. ratable reductions for various inpatient and professional services and an increase in dental rates for SO clinics);
- Estimated changes in rebates collected by the plans due to the Affordable Care Act; and
- Benefit changes including mental health targeted case management, dental benefits, Gardasil for boys, chiropractic services, and health care homes.

The adjustment factor applied to claims for these changes was 0.9925. The development of the factors I used for each change is described in detail in prior letters. These factors can also be found in the Excel capitation rate spreadsheets provided by DHS to the MCOs for rate changes effective January 1, 2010 and later.

I then made an adjustment for differences between the 2011 MNCare benefit set and the 2011 PMAP benefit set, including:

- Removing the 10% cost sharing and $10,000 benefit maximum applicable to most inpatient services. I applied an adjustment factor to total plan claim cost of 1.15 for this change. I have substantial uncertainty regarding the impact this change will have on claim costs. I reviewed data provided by the plans estimating what claims would have been without the cap. However, it was not clear to me what this data represented in many cases, so I did not want to rely on it exclusively. I also considered that actual experience with a cap is likely to be understated due to missing claims for enrollees who have met their limit and due to reduced utilization of the benefit due to the cap.

  I also did some modeling of the potential impact of removing the cap, using an internal claim probability distribution after making adjustments to tailor it to this population. Finally, I considered that the relative projected claim cost between the MNCare and PGAMC populations after making all of the adjustments in this letter, including this adjustment, are reasonably consistent with past estimates of the morbidity differences between these groups.

- Removing other copays, as summarized in Exhibit B. I estimate that removing these copays will increase per member per month costs by approximately 1.15%. This estimate is based on some simplified modeling (since I did not have encounter data) and a review of the adjustments made for these copays when they were initially introduced;

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- Adding coverage for common carrier and specialty ambulance transportation. I estimate these benefits will increase claim cost by approximately 0.80%.

- Adding coverage for PCA coverage. I estimate this benefit will increase claim cost by approximately 1.7%, based on discussions with DHS.

PGAMC

For PGAMC, I first made an adjustment for differences between the 2009 PGAMC benefit set and the 2009 PMAP benefit set, including:

- Adding coverage for home care (including PCA) services. DHS estimates adding this benefit will increase claim cost by approximately 3.5%.

- Adding coverage for specialty carrier transportation. I estimate adding this benefit will increase claim cost by approximately 0.5%.

I did not make an adjustment for the impact of decreasing the copay for non-emergency benefits to the ER from $25 to $6.00. I understand that this copay is rarely collected because it is only applied in the case of a non emergency, with "emergency" being subject to a layman's standard.

I then made adjustments to the experience to reflect PMAP benefit and provider reimbursement changes that occurred between 2009 and 2011. I used adjustment factors previously developed for the PMAP Families and Children adult population for this purpose. Adjustments are included for:

- Changes in provider reimbursement levels (e.g. ratable reductions scheduled through 2011 for various inpatient and professional services and an increase in dental rates for SO clinics);
- Estimated changes in rebates collected by the plans due to the Affordable Care Act; and
- Benefit changes including mental health targeted case management, dental benefits, Gardasil for boys, chiropractic services, health care homes, and PCA behavioral threshold changes.

The adjustment factor applied to claims for these changes was 0.9787. Again, the development of the factors I used is described in detail in prior letters.

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Morbidity Adjustments (Row (6))

To develop morbidity assumptions for these rates, I asked DHS to provide a mapping of the 99,000 people expected to be covered by the expansion program to the 2009 PGAMC and MNCare experience I used as a basis for projection. The assumptions DHS provided are summarized in Table 1 below. These figures represent total average monthly enrollment by the end of 2011. DHS is assuming that 75% of the member months for new enrollees will be in managed care and the other 25% in fee-for-service.

Table 1: Distribution of DHS Expansion Population by 2009 Program Fee-for-Service and Managed Care

2009 Program	DHS Expansion Population			
	GAMC	MNCare	Additional	Total
PGAMC	27,000	0	0	27,000
MNCare G	0	18,000	0	18,000
MNCare B	0	42,000	0	42,000
Not Enrolled	0	0	12,000	12,000
Total	27,000	60,000	12,000	99,000

Because new people are always being enrolled while others discontinue coverage, the 27,000 GAMC enrollees shown in the 2009 PGAMC program are not necessarily the actual people enrolled in PGAMC in 2009. However, the 75% of them (20,250) in managed care are assumed to look like the 2009 PGAMC enrollees in terms of their healthcare status and benefit utilization profile so that we can use that experience for a basis for projection. (I will refer to them as "look-alikes" in this letter.)

Exhibit C-1 shows projected managed care enrollment by month. As mentioned above, GAMC enrollees will be enrolled beginning in May. The MNCare look-alikes are first broken into the "G" and "B" groups and each of those is then subdivided into two groups--(1) those who were assumed to be enrolled with an MCO on March 1 and who will be migrated to the new rate cells over six months and (2) new enrollees who were not enrolled in MNCare on March 1 who will be enrolled directly into the new program. Additional detail behind the enrollment figures is provided in Exhibit C-2.

Each of these four groups (G vs B and existing vs new enrollees) has different morbidity levels, also shown in Exhibit C-2. Because the 2009 MNCare experience I am using as a basis for projection includes MNCare enrollees over 75% of the federal proverty level (FPL) who will not be migrating, I developed morbidity adjustments to reflect the relatively higher expected cost of those who will be moving out of MNCare. I first developed relative morbidity factors for the MNCare G rate cell enrollees and for the MNCare B rate cell enrollees over and under 75% of FPL.

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To develop these factors, I used the same model that was used to develop MNCare rate cell factors in 2009. I used 2007 experience data provided by the MCOs for the MNCare G, B-1, and B-3 rate cells which was the last year enrollees below and above the 75% of FPL threshold were in different rate cells--B-1 and B-3, respectively. (The model includes adjustment factors for benefit changes that occurred between 2007 and 2009.)

The relative factors I developed were 0.900 for MNCare B enrollees over 75% of the FPL, 0.977 for MNCare B enrollees under 75%, and 1.159 for MNCare G enrollees. Using 2009 enrollment, the average factor for the MNCare B and G rate cells, including those over and under 75%, is 0.978. Therefore, I assumed that MNCare G enrollees had morbidity (and cost) 1.185 (= 1.159/0.978) times the average cost of the MNCare group and that MNCare B rate cell enrollees under 75% of the FPL had costs 0.999 (= 0.977 / 0.978) times the average cost of the MNCare group.

I made further morbidity adjustments that varied by month to the MNCare G and B enrollees who will be migrated to the expansion program over six months, to reflect that sicker enrollees will likely be moved first. To develop these additional morbidity factors, I used stratified risk score data for the limited hospital plan provided by DHS. DHS provided average risk scores for each of six cohorts (excluding those with fewer than six months of enrollment), after ordering enrollees from lowest to highest by risk score. (In other words, the first cohort includes the 1/6 of enrollees with the lowest risk score, the second cohort includes the 1/6 of enrollees with the next highest risk scores, and so on.)

I averaged the risk score for each cohort with the average risk score across all cohorts, using weights of 2/3 and 1/3, respectively. I used these averages to estimate the relative morbidity of enrollees transitioning to MA in each migration month (March through August), assuming those migrating first would have the highest risk score, those migrating in the second month the next highest risk score, and so on. I then calculated a morbidity factor for each experience month, taking into account the mix of enrollees by month of migration. The resulting morbidity factors for each MNCare group are summarized in Exhibit C-2.

Exhibit A also includes a morbidity adjustment for the Additional group. As mentioned above, the Additional group is expected to look like the MNCare enrollee group in terms of morbidity. The factor differs from the factor for the MNCare group because the Additional group is not subject to the phase in adjustments.

Administrative Cost (Row (7))

Next I included a provision for administrative cost as shown in rows (7a) and (7b) of Exhibit A. I chose this assumption taking into consideration the recent prior experience of the MCOs, Minnesota's statutory limit on administrative costs for managed Medicaid programs, the relatively

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high level of claim cost for this population, and that administrative costs associated with managing the MCO's investments should be excluded since no adjustment is being made to rates for expected investment income.

Contribution to Surplus (Row (8))

Row (8) shows that these rates include no provision for a contribution to surplus. In other words, the rates are being set so that the MCOs, as a group, are projected to break even after covering their claim and administrative expenses. DHS is not including a provision for contribution to surplus in these rates due to the state's current fiscal situation.

Average 2011 Capitation Rate (Row (9))

Row 9 shows the average capitation rate required for each sub group.

Capitation Rates by Rate Cell

I have developed rates for two areas, "Metro" and "non-Metro" and for four demographic groups, including:

- Females Ages 21 – 49;
- Females Ages 50 – 64;
- Males Ages 21 – 49;
- Males Ages 50 – 64.

The metro area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties, which are the same counties included in the MNCare Metro region. The non-Metro area includes all other counties.

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I developed three separate sets of rates—one for each of the groups shown on Exhibit A (PGAMC, MNCare, and Additional) and then blended them together using weights that tie to the member months in row (1) of Exhibit A. Additional detail is provided in Exhibit D:

- MNCare (Exhibit D-1): The total projected member months in this exhibit ties to that shown in row (1) of Exhibit A. Calendar year 2009 membership by program (B or G), age, gender, and area was used to distribute the members by rate cell. The rate cell factors are those developed in 2009 and currently in use. A rate was determined for each rate cell by applying the ratio of the rating factor for that cell to the average rating factor applied to the MNCare rate from row (9) of Exhibit A.

- PGAMC (Exhibit D-2): Average area factors were calculated for the metro and non-metro area using 2009 PGAMC enrollment along with the PGAMC area factors developed in 2009. As mentioned above, the metro area includes the Core Metro (Anoka, Dakota, Scott, and Washington counties), along with Carver, Hennepin, and Ramsey counties.

  The morbidity factors for the expansion rate cells are the average PGAMC risk scores for each group (F 21-49, F 50-64, M 21-49, and M 50-64) using assessment data for the year ending March 31, 2010. The member counts by age and gender underlying the risk scores were used to allocate projected member months from row (1) of Exhibit A to the rate cells. The allocation by area is based on 2009 PGAMC enrollment data. Capitation rates were developed for each rate cell by applying the appropriate area factor and morbidity factor to the PGAMC rate in row (9) of Exhibit A.

- Additional (Exhibit D-3): Projected enrollment and capitation rates are proportional to the values in Exhibit D-1.

- Total (Exhibit D-4): Enrollment and rates from Exhibits D-1 through D-3 is shown for each group (PGAMC, MNCare, Additional), along with total enrollment and overall average rates by rate cell.

Appendix II-E Tables

As requested, I am including Appendix II-E tables as Exhibit E to this letter. There are three tables—one for metro and both county based and non-county based tables for non metro. The tables include rateable reductions equal to approximately 2.5% (1-0.99 x 0.99 x 0.995) and the withhold of 9.5%.

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Jason, I am available for questions by phone at (952) 820-2481 and by e-mail at leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal & Consulting Actuary

LMW/mtf

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Exhibit A: Development of Average Premium Rate

			PGAMC		MNCare		Additional		Combined
(1)	Expected Member Months		162,000		368,257		55,722		585,979
(2)	Average 2009 Claim Cost	$	1,158.60	$	522.71				
	Adjustment for Missing Experience								
(3a)	Adjustment Factor		1.002		0.999				
(3b)	Adjusted Claim Cost	$	1,160.54		522.31				
	Apply two years of trend								
(4a)	Annual Trend Rate		6.23%		5.00%				
(4b)	Trended Claim Cost	$	1,319.50	$	579.37	$	579.37		
	Benefit Difference Adjustments								
(5a)	Factor		1.019		1.178		1.178		
(5b)	Adjusted Claim Cost	$	1,344.64	$	682.71	$	682.71		
	Apply morbidity factor								
(6a)	Factor		1.000		1.150		1.055		
(6b)	Adjusted Claim Cost	$	1,344.64	$	784.97	$	720.08	$	933.52
	Add Provision for Administrative Cost								
(7a)	Administrative Cost Factor		7.00%		7.00%		7.00%		7.00%
(7b)	Administrative Margin	$	101.21	$	59.08	$	54.20	$	70.27
	Add Provision for Contribution to Surplus								
(8a)	Factor for Contribution to Suprlus		0.00%		0.00%		0.00%		0.00%
(8b)	Contribution to Surplus	$	-	$	-	$	-	$	-
(9)	Average 2011 Capitation Rate	$	1,445.85	$	844.05	$	774.27	$	1,003.79

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Exhibit B: Summary of Benefits

Rate Cell Year Eligibility	MA Expansion 2011 Childless Adults	PGAMC 2009	BB (M1)/G 2009 Adults without Children
Chem Dependency	No Cost Sharing	No Cost Sharing	10% copay up to $1K and $10K annual limit apply only to the treatment portion of residentially lisc program
Child and Teen Checkup	NA	NA	NA
Chiropractic	No Cost Sharing	No Cost Sharing	$3 copay
Dental	No Cost Sharing; limited coverage	No Cost Sharing; limited coverage	No Cost Sharing; limited coverage
ER	$3.50 copay for non-er visits	$25 copay for non-er visits	$6.00 copay for non-er visits
Eye Care	No Cost Sharing	No Cost Sharing	$3 copay
Glasses	No Cost Sharing	No Cost Sharing	$25 copay
Family Planning	No Cost Sharing	No Cost Sharing	$3 copay for non-prev visit
Hearing Aids	No Cost Sharing	No Cost Sharing	No Cost Sharing
Home Care (inc PDN and PCA)	No Cost Sharing	Not Covered	NCS; Excludes PDN and PCA
Hospice	No Cost Sharing	Not Covered	Not Covered
Hospital Stay	No Cost Sharing	No Cost Sharing	10% copay up to $1K and $10K annual limit
Immunizations	No Cost Sharing	No Cost Sharing	No Cost Sharing
Interpreters (hearing / lang)	No Cost Sharing	No Cost Sharing	No Cost Sharing
Lab, Radiology, and Diagnostics	No Cost Sharing	No Cost Sharing	lab/rad - no copay; diag $3 copay
Medical Equipment and Supplies	No Cost Sharing	No Cost Sharing	No Cost Sharing
Medical Transportation (ER and Spec)	No Cost Sharing	No Cost Sharing; ER only	No Cost Sharing; ER only
Medication Therapy Management	No Cost Sharing	No Cost Sharing	No Cost Sharing
Mental Health inc ARMHS, ACT, IRTS, Crisis Response Services	No Cost Sharing	No Cost Sharing	No Cost Sharing
Outpatient Surgery	No Cost Sharing	No Cost Sharing	No Cost Sharing
Physicians and Clinics	No Cost Sharing	No Cost Sharing	$3 copay
Podiatrist	No Cost Sharing	No Cost Sharing	$3 copay
Prescriptions	$3 copay brand/$1 copay generic	$3 copay brand/$1 copay generic	$3 copay
Physicals / Prev Care	No Cost Sharing	No Cost Sharing	No Cost Sharing
Rehab Therapies	No Cost Sharing	No Cost Sharing	No Cost Sharing
Abortion	Not Covered	Not Covered	Not Covered
Children's Residential MH Treatment (Rule 5)	NA	NA	NA
MH TCM	No Cost Sharing	No Cost Sharing	No Cost Sharing
Common Carrier (CC) Transport and Mileage Reimbursement	No Cost Sharing; CC Only	NCS; CC Only	Not Covered
NH/ICF-MR Facility	Not Covered	Not Covered	Not Covered
School Based Services	NA	NA	NA

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Exhibit C-1: Projected Enrollment

Month	2009 PGAMC Look-alikes	2009 MNCare B/G Look-alikes				Additional	Totals			
		G Rate Cell		B Rate Cell < 75%						
		Enrolled on 3/1	Enrolled after 3/1	Enrolled on 3/1	Enrolled after 3/1		PGAMC	MNCare	Additional	Total
January	-	-	-	-	-	-	-	-	-	-
February	-	-	-	-	-	-	-	-	-	-
March	-	-	-	-	-	-	-	-	-	-
April	-	4,492	1,194	10,481	2,785	688	-	18,951	688	19,639
May	20,250	6,125	2,388	14,292	5,571	2,320	20,250	28,375	2,320	50,945
June	20,250	7,350	3,581	17,150	8,356	4,297	20,250	36,438	4,297	60,985
July	20,250	8,167	4,775	19,056	11,142	7,101	20,250	43,139	7,101	70,490
August	20,250	8,575	5,969	20,008	13,927	7,747	20,250	48,479	7,747	76,476
Sept	20,250	7,350	7,163	17,150	16,713	8,005	20,250	48,375	8,005	76,630
Oct	20,250	6,125	8,356	14,292	19,498	8,263	20,250	48,271	8,263	76,784
Nov	20,250	4,900	9,550	11,433	22,283	8,521	20,250	48,167	8,521	76,938
Dec	20,250	3,675	10,744	8,575	25,069	8,780	20,250	48,063	8,780	77,093

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Exhibit C-2: Projected Enrollment and Relative Morbidity for MNCare Look-alikes

	MNCare G Look-alikes							MNCare B < 75% Look-alikes						
	Enrolled on 3/1			Issued after 3/1		Total		Enrolled on 3/1			Issued after 3/1		Total	
Month	Inforce	Migrated	Remaining	FFS	Mgd Care	Mgd Care Expansion	All	Inforce	Migrated	Remaining	FFS	Mgd Care	Mgd Care Expansion	All
January														
February														
March														
April	13,475	4,492	8,983	398	1,194	5,685	15,067	31,442	10,481	20,961	928	2,785	13,266	35,156
May	12,250	6,125	6,125	796	2,388	8,513	15,433	28,583	14,292	14,292	1,857	5,571	19,863	36,011
June	11,025	7,350	3,675	1,194	3,581	10,931	15,800	25,725	17,150	8,575	2,785	8,356	25,506	36,867
July	9,800	8,167	1,633	1,592	4,775	12,942	16,167	22,867	19,056	3,811	3,714	11,142	30,197	37,722
August	8,575	8,575	-	1,990	5,969	14,544	16,533	20,008	20,008	-	4,642	13,927	33,935	38,578
Sept	7,350	7,350	-	2,388	7,163	14,513	16,900	17,150	17,150	-	5,571	16,713	33,863	39,433
Oct	6,125	6,125	-	2,785	8,356	14,481	17,267	14,292	14,292	-	6,499	19,498	33,790	40,289
Nov	4,900	4,900	-	3,183	9,550	14,450	17,633	11,433	11,433	-	7,428	22,283	33,717	41,144
Dec	3,675	3,675	-	3,581	10,744	14,419	18,000	8,575	8,575	-	8,356	25,069	33,644	42,000
Total	77,175	56,758	20,417	17,906	53,719	110,477	148,800	180,075	132,436	47,639	41,781	125,344	257,780	347,200

	MNCare G Look-alikes							MNCare B < 75% Look-alikes						
	Enrolled on 3/1			Issued after 3/1		Total		Enrolled on 3/1			Issued after 3/1		Total	
Month	Inforce	Migrated	Remaining	FFS	Mgd Care	Mgd Care Expansion	All	Inforce	Migrated	Remaining	FFS	Mgd Care	Mgd Care Expansion	All
January														
February														
March														
April	1.185	2.191	0.682	1.185	1.185	1.980	1.185	0.999	1.847	0.575	0.999	0.999	1.669	0.999
May	1.185	1.776	0.594	1.185	1.185	1.610	1.185	0.999	1.497	0.501	0.999	0.999	1.357	0.999
June	1.185	1.518	0.518	1.185	1.185	1.409	1.185	0.999	1.280	0.437	0.999	0.999	1.188	0.999
July	1.185	1.333	0.445	1.185	1.185	1.278	1.185	0.999	1.124	0.375	0.999	0.999	1.078	0.999
August	1.185	1.185	-	1.185	1.185	1.185	1.185	0.999	0.999	-	0.999	0.999	0.999	0.999
Sept	1.185	1.185	-	1.185	1.185	1.185	1.185	0.999	0.999	-	0.999	0.999	0.999	0.999
Oct	1.185	1.185	-	1.185	1.185	1.185	1.185	0.999	0.999	-	0.999	0.999	0.999	0.999
Nov	1.185	1.185	-	1.185	1.185	1.185	1.185	0.999	0.999	-	0.999	0.999	0.999	0.999
Dec	1.185	1.185	-	1.185	1.185	1.185	1.185	0.999	0.999	-	0.999	0.999	0.999	0.999
Total	1.185	1.393	0.607	1.185	1.185	1.292	1.185	0.999	1.174	0.512	0.999	0.999	1.089	0.999

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Exhibit D - 1: Rates by Rate Cell – MNCare

			Projected Mbr Mths			Rate Cell Factors		Capitation Rates		
Age	Sex	Program	Metro	Non Metro	Statewide	Metro	Non Metro	Metro	Non Metro	Statewide
21 - 49	F	B	39,688	47,963	87,651	1.3559	1.2956	$ 820.57	$ 784.03	$ 800.58
50 +	F	B	25,878	39,917	65,795	1.8013	1.7211	1,090.07	1,041.54	1,060.63
21 - 49	M	B	45,817	46,687	92,504	1.0347	0.9886	626.15	598.27	612.08
50 +	M	B	18,133	26,905	45,038	1.6682	1.5939	1,009.53	964.58	982.67
21 - 49	F	G	11,694	10,701	22,395	1.6617	1.5877	1,005.61	960.84	984.22
50 +	F	G	3,232	2,870	6,102	2.2075	2.1092	1,335.89	1,276.41	1,307.92
21 - 49	M	G	21,986	19,543	41,529	1.2680	1.2115	767.35	733.18	751.27
50 +	M	G	3,828	3,415	7,243	2.0444	1.9533	1,237.18	1,182.09	1,211.21
21 - 49	F	B/G	51,382	58,664	110,045	1.4255	1.3489	862.68	816.28	837.95
50 +	F	B/G	29,110	42,787	71,897	1.8464	1.7471	1,117.37	1,057.29	1,081.61
21 - 49	M	B/G	67,803	66,230	134,034	1.1103	1.0544	671.93	638.08	655.20
50 +	M	B/G	21,961	30,320	52,281	1.7337	1.6344	1,049.21	989.07	1,014.33
All			170,257	198,000	368,257	1.4117	1.3801	854.32	835.21	844.05

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Exhibit D-2: Rates by Rate Cell – PGAMC

Development of Metro and Non Metro Area Factors

			2009 Member Months												
Age	Sex	Program	Metro	Non Metro	Statewide	Carver	Core Metro	Greater Metro	Hennepin	NE	NW	Olmsted	Ramsey	SE	SW
All Ages	F	GA	34,009	16,880	50,889	212	4,326	601	21,307	4,078	5,293	1,075	8,164	3,173	2,660
All Ages	M	GA	60,200	28,407	88,607	268	4,746	776	42,555	7,633	10,004	1,583	12,631	4,292	4,119
All Ages	F	GAMC	19,738	10,737	30,475	148	2,451	402	14,036	2,026	3,865	519	3,103	2,235	1,690
All Ages	M	GAMC	45,908	19,270	65,178	163	4,182	589	33,665	4,473	6,810	1,082	7,898	3,319	2,997
Total			159,855	75,294	235,149	791	15,705	2,368	111,563	18,210	25,972	4,259	31,796	13,019	11,466
Metro Indicator			1.0000	-		1.0000	1.0000	-	1.0000	-	-	-	1.0000	-	-
Area Factor			0.9522	1.0964	0.9984	1.1204	1.3096	1.3096	0.8676	1.0511	1.1295	1.0491	1.0684	1.0491	1.1204

Morbidity Factor

			Morbidity Factor		
Age	Sex	Program	Metro	Non-Metro	Statewide
21 - 49	F	GA/MC	1.4025	1.4025	1.4025
50 +	F	GA/MC	1.5959	1.5959	1.5959
21 - 49	M	GA/MC	1.1221	1.1221	1.1221
50 +	M	GA/MC	1.6121	1.6121	1.6121

Projected 2011 Enrollment

			Projected 2011 Enrollment		
Age	Sex	Program	Metro	Non-Metro	Statewide
21 - 49	F	GA/MC	27,282.47	13,683.36	40,965.83
50 +	F	GA/MC	9,955.55	4,673.35	14,628.90
21 - 49	M	GA/MC	57,926.08	26,908.92	84,834.99
50 +	M	GA/MC	14,963.98	6,606.29	21,570.27
Total			110,128	51,872	162,000

Capitation Rate by Rate Cell

			Rates		
Age	Sex	Program	Metro	Non-Metro	Statewide
21 - 49	F	GA/MC	$ 1,486.53	$ 1,711.64	$ 1,561.72
50 +	F	GA/MC	1,691.51	1,947.67	1,773.34
21 - 49	M	GA/MC	1,189.33	1,369.43	1,246.45
50 +	M	GA/MC	1,708.68	1,967.44	1,787.93
Total			$ 1,378.92	$ 1,587.96	$ 1,445.85

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit D - 3: Rates by Rate Cell – Additional

Age	Sex	Projected Mbr Mths			Capitation Rates		
		Metro	Non Metro	Statewide	Metro	Non Metro	Statewide
21 - 49	F	7,775	8,877	16,651	$ 791.37	$ 748.80	$ 768.68
50 +	F	4,405	6,474	10,879	1,025.00	969.89	992.20
21 - 49	M	10,260	10,021	20,281	616.39	585.33	601.04
50 +	M	3,323	4,588	7,911	962.48	907.31	930.48
All		25,762	29,960	55,722	783.70	766.17	774.27

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Exhibit D-4: Rates by Rate Cell -- Total

Age	Sex	Enrollment			Rates		
		Metro	Non-Metro	Statewide	Metro	Non-Metro	Statewide
MNCare							
21 - 49	F	51,381.67	58,663.67	110,045.34	$ 862.68	$ 816.28	$ 837.95
50 +	F	29,110.30	42,786.99	71,897.29	1,117.37	1,057.29	1,081.61
21 - 49	M	67,803.49	66,230.04	134,033.53	671.93	638.08	655.20
50 +	M	21,961.05	30,319.74	52,280.79	1,049.21	989.07	1,014.33
Total		170,256.51	198,000.44	368,256.94	854.32	835.21	844.05
PGAMC							
21 - 49	F	27,282.47	13,683.36	40,965.83	$ 1,486.53	$ 1,711.64	$ 1,561.72
50 +	F	9,955.55	4,673.35	14,628.90	1,691.51	1,947.67	1,773.34
21 - 49	M	57,926.08	26,908.92	84,834.99	1,189.33	1,369.43	1,246.45
50 +	M	14,963.98	6,606.29	21,570.27	1,708.68	1,967.44	1,787.93
Total		110,128.09	51,871.91	162,000.00	1,378.92	1,587.96	1,445.85
Additional							
21 - 49	F	7,774.71	8,876.57	16,651.27	$ 791.37	$ 748.80	$ 768.68
50 +	F	4,404.76	6,474.22	10,878.98	1,025.00	969.89	992.20
21 - 49	M	10,259.54	10,021.45	20,280.99	616.39	585.33	601.04
50 +	M	3,322.99	4,587.77	7,910.75	962.48	907.31	930.48
Total		25,761.99	29,960.01	55,722.00	783.70	766.17	774.27
Total							
21 - 49	F	86,438.85	81,223.59	167,662.45	$ 1,053.17	$ 959.75	$ 1,007.91
50 +	F	43,470.62	53,934.55	97,405.17	1,239.50	1,123.95	1,175.52
21 - 49	M	135,989.10	103,160.41	239,149.51	888.13	823.72	860.35
50 +	M	40,248.02	41,513.80	81,761.81	1,287.24	1,135.73	1,210.31
Total		306,146.59	279,832.36	585,978.94	1,037.09	967.36	1,003.79

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Exhibit E: Appendix II-E Tables

Appendix II-E: MA Adults without Children Rates
For Metro
April 1, 2011 - December 31, 2011

Age	Sex	Rate before Withhold	Performance Withhold	Plan Rate before Ratable Reduction	Plan Rate after Ratable Reduction
21 - 49	F	$ 1,079.95	$ 102.60	$ 977.36	$ 953.12
50 +	F	1,271.02	120.75	1,150.27	1,121.75
21 - 49	M	910.72	86.52	824.20	803.76
50 +	M	1,319.97	125.40	1,194.58	1,164.95

Appendix II-E: MA Adults without Children Rates
For Non Metro
April 1, 2011 - December 31, 2011

Age	Sex	Rate before Withhold	Performance Withhold	Plan Rate before Ratable Reduction	Plan Rate after Ratable Reduction
21 - 49	F	$ 984.15	$ 93.49	$ 890.66	$ 868.57
50 +	F	1,152.53	109.49	1,043.04	1,017.17
21 - 49	M	844.67	80.24	764.43	745.47
50 +	M	1,164.61	110.64	1,053.98	1,027.84

Appendix II-E: MA Adults without Children Rates
For Non Metro, County Based Plans
April 1, 2011 - December 31, 2011

Age	Sex	Rate before Withhold	Performance Withhold	Plan Rate before Ratable Reduction	Plan Rate after Ratable Reduction
21 - 49	F	$ 974.31	$ 92.56	$ 881.75	$ 859.88
50 +	F	1,141.01	108.40	1,032.61	1,007.00
21 - 49	M	836.23	79.44	756.78	738.02
50 +	M	1,152.97	109.53	1,043.44	1,017.56

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Appendix O
Rate Setting Report
PMAP and MinnesotaCare - September 2011 Capitation Adjustment

Milliman

8500 Normandale Lake Blvd.
Suite 1850
Minneapolis, MN 55437
USA

Tel +1 952 897 5300
Fax +1 952 897 5301

milliman.com

December 17, 2010

Mr. R. Jason Wiley
Managed Care Rate Setter
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55101-2208

Re: Capitation Rate Adjustments for 2011 – PMAP and MNCare

Dear Jason:

This letter contains rate adjustments to be applied to fourth quarter 2010 rates for PMAP Families and Children and MNCare rate cells. Capitation payment rates in 2011 will be derived by applying adjustment factors to the rates in effect as of the fourth quarter of 2010. Adjustments will be made for (1) cost and utilization trend (2) changes to the State's surplus target and (3) policy decisions and legislated changes to benefits and reimbursement levels. This letter contains my analysis of the impact of these factors on 2011 capitation rates for the PMAP and MNCare Families and Children rate cells and the MNCare Adults without Children rate cells.

The letter is divided into several sections, including:

- An introduction;
- Trend and Surplus Adjustments for PMAP and MNCare Families and Children;
- Trend Adjustment for MNCare Adults without Children; and
- Adjustments for policy decisions and legislated 2011 benefit and reimbursement changes.

The purpose of this analysis is to assist the Minnesota Department of Human Services (DHS) with setting payment rates for contracting health plans for these programs. The results may not be appropriate for other purposes.

The results contained in this letter are intended only for use by DHS and CMS, the federal agency that must approve the capitation rates used for the PMAP and MNCare programs. This analysis should be considered preliminary until the resulting capitation rates are approved by DHS and CMS. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

This letter should be reviewed only in its entirety. It assumes the reader is familiar with Minnesota's Medicaid programs and managed care rating principles.

The results in this letter are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon specific assumptions and methods nor upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

Introduction

The structure, assumptions, and data used in the development of the rates are summarized below:

I. The base utilization and cost data used to determine the rate levels is actual experience for calendar year 2009 for the populations enrolled in PMAP and MNCare Families and Children managed care programs in Minnesota.

   This analysis includes data from most of the continuing plans and reflects the experience of 88.6% of 2009 enrollment for PMAP Families and Children, 88.1% of 2009 enrollment for MNCare Families and Children, and 83.7% of 2009 enrollment for MNCare Adults without Children.

II. Health status risk adjustment is used to adjust certain payment rates. Risk assessment is performed using diagnosis codes and the Johns Hopkins Adjusted Clinical Groups (ACG) risk adjuster. Currently, 50% of the rates for the PMAP and MNCare "unlimited" rate cells is based on health status risk adjustment and 50% is based on a traditional demographic rate structure. Beginning in 2011, 75% of the rates for these rate cells will be based on risk adjustment and 25% will be based on the demographic rate structure. An appropriate revenue neutrality adjustment will be applied.

III. Demographic rates vary by eligibility category, age and gender, and geographic location. For PMAP, the current eligibility categories include Families with Children and Pregnant Women. For MNCare, the current eligibility categories include Pregnant Women, Children, and Parents with incomes up to 275% of the Federal Poverty Guideline (FPG) and Non-Parents up to 250% of the FPG.

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

IV. Rate relationships by demographic rate cell were developed in 2009 and are based on actual claim experience from 2007-2008 for the PMAP and MNCare populations enrolled in managed care programs in Minnesota.

V. Adjustments are made for trends in utilization and cost per service, on a combined basis. The trends are based on historical claim trends from 2006 to 2009 for public program populations enrolled in managed care programs in Minnesota and on benchmark utilization and provider payment rates for public programs including the Medicare fee-for-service program.

VI. Administrative costs were projected by trending forward 2009 administrative costs. I used a trend rate of 2.0% for this purpose. I am applying a reduction to administrative cost equal to 1% of revenue to offset the value of assumed investment income earnings.

As directed by DHS, I combined the administrative costs of PMAP, MNCare, MSC+, and MSHO for the purpose of testing projected administrative expenses in 2011 against Minnesota's statutory limit of 8.2% of revenue. This testing requires estimates of cost and revenue levels in 2011. If treated individually, I estimate that not all programs would be projected to achieve an administrative cost level as low as 8.2% of revenue.

VII. The load for the 2011 contribution to surplus for the PMAP and MNCare Families and Children rate cells in this analysis is 1.18%, before investment income. For this analysis, I have assumed that investment income will be 1.0% of revenue based on my review of the investment income and capital gains/losses reported on the plans' financial statements. This adjustment and the adjustment to administrative costs mentioned above offset each other.

Data Reliance

In performing this analysis, I have relied on data and other information provided to me by DHS and the plans with which it contracts. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

For this analysis, I relied on the following data and information:

- Various Enrollment and Capitation reports from DHS that provide detail by rate cell for each health plan and area;
- Copies of the Minnesota State Supplement Report #1, Statement of Revenue, Expenses and Net Income for each health plan as submitted to the State of Minnesota;

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

- Restated net hospital and medical expenses for Medicaid-covered services provided by the health plans, based on more recent experience. I also requested from each health plan a certification by a qualified actuary that the restatement reflects a best estimate;
- Summaries of risk factors from DHS by population and payment quarter;
- Certifications, provided by the health plans, certifying the percentage of expenses that were for non-State Plan services;
- Information from DHS regarding withhold amounts returned to the plans; and
- Miscellaneous data and information provided by DHS and the health plans.

I have performed a limited review of the data used directly in my analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Variability

Differences between estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is almost certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience is different than expected. Accordingly, DHS should continue to carefully monitor actual experience and make adjustments as necessary.

Trend and Surplus Adjustments for PMAP and MNCare Families and Children

The trend and surplus adjustments for PMAP and MNCare Families and Children rate cells are based on the historical financial results for the public program business of participating health plans. The adjustment factors are intended to provide rate levels that result in a targeted contribution to surplus as a percentage of income before investment income for the health plans in aggregate, assuming prudent management. For this analysis, I have included an adjustment of 1.18%. In choosing this adjustment, I considered, among other things, the ability of the plans to absorb recently legislated capitation rate reductions and to achieve performance targets set by the state for which they bear financial risk. I also considered available emerging 2010 experience.

Exhibit A provides summaries of the development of the rate increase for each program. Exhibits B and C describe the development of the claim cost trend figures. Exhibit D describes the impact of benefit changes. Exhibit E describes the calculation of 2010 revenue. Exhibit F describes trends in risk scores. Exhibit G describes the development of the trend in demographic and area factors.

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit H summarizes the development of administrative cost. These exhibits are discussed further below.

Exhibit A (Rate Increase for 2011 Rates)

Exhibits A-1 and A-2 correspond to PMAP and MNCare Families and Children, respectively.

The 2009 claim costs shown in line (a) are developed from actual data received from the plans and enrollment data provided by DHS. They have been adjusted to remove non-State Plan services as provided by the health plans. The plans were asked to provide estimated incurred claims on a "best estimate" basis, meaning the values do not include any margin for adverse deviation.

The annual claim cost trends shown on line (d) are a 50/50 blend of a Benchmark Trend Rate (Exhibit B) and an Experience-based Trend Rate (Exhibit C).

The development of the average 2009 administrative cost per member per month for PMAP in row (f) of Exhibit A-1 is shown in Exhibit H. The per member per month administrative cost for MNCare in Exhibit A-2 was developed using the administrative expenses reported by the plans in their 2009 Minnesota Supplement Report # 1's to the Minnesota Annual Statement, along with membership data provided by DHS. In particular, I divided the 2009 MNCare administrative expenses by total 2009 membership, which resulted in an administrative cost of $31.90 PMPM. (I made an adjustment to one plan's reported administrative cost for expenses they indicated to me were more appropriately considered service cost for the purpose of this analysis.)

The administrative trend is 2.0%. The administrative margin is capped by Minnesota State law at 8.2% of revenue (recognizing that premium tax and certain provider surcharges are exempt from the stated cap of 6.6% of revenue). As requested by DHS, I tested projected 2011 administrative costs against the cap across several programs, including PMAP, MNCare, MSC, and MSHO, but I did not include MNDHO, SNBC, or PGAMC. In aggregate, administrative costs, exclusive of care coordination costs for seniors not enrolled in the Elderly Waiver program, are not expected to exceed 8.2% of revenue in 2011.

Estimated investment income as a percent of revenue and an offset to administrative margin are shown in rows (i) and (j). For this analysis, I have assumed that investment income will be 1.0% of revenue in 2011, which is approximately equal to the average investment income received by the plans in 2008 and 2009. The administrative offset in row (j) is equal to the assumed investment income.

The impact of legislated benefit and reimbursement changes occurring in October 2009 and 2010 is shown in row (m). This adjustment is applied to restate calendar year 2009 cost levels to reflect

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these changes. Additional detail is included in Exhibits D-1 (PMAP) and D-2 (MNCare Families and Children).

The load for the 2011 contribution to surplus in this analysis is 1.18%, before investment income.

The projected 2011 revenue requirement is calculated in row (q) and compared to the average fourth quarter 2010 rate in row (r). Average revenue is calculated using the 2009 membership distribution of the plans whose claim data is included in row (a). The calculation of 2010 revenue is described on Exhibit E. A rate increase is calculated in row (s) as the ratio of the required 2011 revenue to the average fourth quarter 2010 rate.

Finally, an adjustment to the rate increase for risk-adjusted rates is necessary to avoid double-counting trend in claim cost due to changes in risk scores beyond those reflected in the demographic and area factors. The development of this adjustment is described on Exhibit F. The adjustment is shown at the bottom of Exhibits A-1 and A-2.

Exhibit B (Benchmark Trend Rate)

The benchmark trend rates shown in Exhibits A-1 and A-2 are developed by applying benchmark trend rates for various service categories to an assumed distribution of services among those categories as shown in Exhibit B-1 (PMAP) and B-2 (MNCare Families and Children). The distribution was developed in 2007 using actual claim experience provided by three of the largest plans from 2005 and 2006 for the PMAP and MNCare populations enrolled in managed care programs in Minnesota. (I recommend that data be collected from the plans to update these distributions for next year.)

The benchmark trend rates are intended to reflect trend rates I believe are achievable by MCOs that successfully apply aggressive and effective medical management and contracting strategies and tactics.

The trend targets reflect expected changes in CMS' Medicare FFS fee schedules based on currently available information. I selected the benchmark trend for prescription drugs based on Milliman's general knowledge regarding the drug trends recently experienced among a broad range of health plans. I selected the benchmark dental utilization and cost trends based on Milliman's Health Cost Guidelines – Dental and my judgment.

Exhibit C (Experience-Based Trend Rate)

The Experience-Based trend rates shown in Exhibits A-1 and A-2 were developed based on a weighted average of health plan trends over the last three years, backing out trend due to changes

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in demographic and area mix and the impact of benefit changes.

Trends in benefit, reimbursement, and eligibility changes are shown at the top of Exhibits C-1 (PMAP) and C-2 (MNCare Families and Children). Further detail of these trends is provided in Exhibits D-1 and D-2. Below that, the impact of changes in the mix of business by demographic and area is shown. Further detail behind these calculations is provided in Exhibits G-1 and G-2.

Annual trends in claim cost are then shown before and after changes in benefits and mix. I use the three year weighted average of the trends calculated using weights of 1/6, 1/3, and 1/2, for 2006-07, 2007-08, and 2008-09, respectively.

Shown next is the trend across the PMAP and MNCare Families and Children rate cells. Finally, the "50/50 Blended Experience Trends" is a 50/50 weighting of the trend for that population and the overall trend across all families and children rate cells (MNCare and PMAP). This gives partial credibility to each program population's past trend, but also reflects that the trend for a given population is likely to regress to the overall average.

I understand that the state intends to implement a new Medicaid fee-for-service fee schedule in the near future. The change is intended to be revenue neutral with respect to the cost of the state's remaining fee-for-service Medicaid program. I have assumed for this analysis that the change will also be revenue neutral for managed care. The actual impact on managed care costs will depend on the specific changes being implemented (which are not yet available to me) and the extent to which the MCOs' contractual payment rates are linked to the Minnesota FFS fee schedule.

Exhibit D (Impact of Benefit/Eligibility/Reimbursement Changes)

The impact of each benefit, eligibility, and reimbursement change on claim cost is estimated as the claim cost-weighted average of the adjustment factors for each group of rate cells to which the change applies. The claim costs used for weighting purposes are the costs for the base year of the adjustment period. For example, the weights for the 2008-09 adjustments are 2008 claim costs. However, since I do not have 2009 claim costs available by rate cell, I used premium revenue to weight the 2009-2010 Q4 adjustments, instead.

The aggregate impact of changes for each year is estimated as the product of the adjustment factors for each individual change. The adjustment factors were developed in my letters regarding benefit changes for this and prior years.

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Ratable reductions effective for payment rates beginning September 2010 are also included. These adjustments are described in my August 6, 2010 letter regarding Rate Adjustments for the September Amendment. I have considered the MCOs' ability to absorb these reductions in choosing the surplus margin described above.

Exhibit E (Revenue)

Exhibits E-1 (PMAP) and E-2 (MNCare Families and Children) describe the calculation of the average fourth quarter 2010 payment rate used in Exhibit A. Exhibit E-3 describes the calculation of the risk-adjusted component of revenue.

Revenue is calculated using the 2009 membership distribution along with fourth quarter 2010 capitation rates. The 2009 membership distribution is used to be consistent with the projection of 2011 claim cost, which uses 2009 claim cost as a base. The payment rates used exclude MERC and reflect the rate differential for county-based purchasing plans as well as ratable reductions, including those enacted in September 2010.

On Exhibit E-1, for PMAP, the average demographic revenue is weighted 50/50 with the average risk-adjusted revenue. On Exhibit E-2, for MNCare Families and Children, the average revenue for each rate cell is calculated using weights that vary by rate cell. In particular, rates for "F,J A2" rate cells are 100% demographic and rates for all other rate cells are weighted 50/50.

On Exhibit E-3, for PMAP, the average risk-adjusted rate is calculated as the fourth quarter 2010 base rate times the average risk score for the 2009 calendar year assessment period, including adjustments for ratable reductions and withhold. This average risk score includes only those plans whose data is reflected in the average 2009 claim cost shown on Exhibit A-1. Average risk-adjusted rates for MNCare Families and Children are calculated similarly, except there are two base rates.

Exhibit F (Trend in Risk Scores)

As described above, Exhibit A includes an adjustment to the rate increase for risk-adjusted rates due to the trend in risk scores. Exhibit F describes the development of these adjustments.

This year, I considered the trend in risk scores from the 2008 assessment period to the 2009 assessment period. In previous years' analyses, I have considered trends in risk scores over a longer period; however, trends in risk scores were unusually high immediately after the implementation of ACGs version 6.06 which I would not expect to continue.

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The trend in risk scores is calculated separately for PMAP and MNCare unlimited rate cells using average risk scores for the calendar year 2008 and 2009 assessment periods. We excluded two plans from the calculation since they have significant changes in enrollment.

The trends in demographic and area factors are removed from the trends in risk scores. Finally, the weighted average trend in risk scores, net of trend in demographic and area factors, is calculated for each program. The trends for each program are then averaged using member months as weights, producing an average trend of 2.35%.

Exhibit G (Trend in Demographic/Area Factors)

Exhibit G describes the development of the trend in the demographic and area factors shown on Exhibit C. The demographic and area factors are first shown separately and then together for each rate cell/area combination as "rate cell relativities". Enrollment is shown for each year. For each year, the average demographic/area factor is the enrollment-weighted average rate cell relativity.

Exhibit H (Administrative Expense Calculation)

Exhibit H displays the calculation of administrative costs for PMAP Families, Children and Pregnant Women. The 2009 administrative cost was calculated using the premium revenues and administrative expenses from the MCO's 2009 Minnesota Supplement Report #1's.

For PMAP, there are three components used in the calculation of administrative expenses: (1) Minnesota Senior Care Plus (MSC+) Basic Care, (2) Other Medicaid (including MSC+ Elderly Waiver and Nursing Facility Add-On), and (3) PMAP Families, Children and Pregnant Women. I calculated the 2009 revenue for PMAP Families, Children and Pregnant Women by subtracting the MSC+ Basic Care revenue and the MSC+ Elderly Waiver and Nursing Facility Add-On revenue, as provided by DHS, from total PMAP revenue. I assumed that MSC+ has the same administrative expense margin as MSHO (see below). I then subtract the MSC+ administrative expenses from the total PMAP administrative expenses to get PMAP Families, Children and Pregnant Women administrative expenses. Note that an adjustment has been made to the administrative expense of one plan based on information they provided.

For MSHO, there are three components used in the calculation of administrative expenses: (1) MSHO Basic Care, (2) Other Medicaid (including certain Elderly Waiver, Nursing Facility Add-On, and Special Needs Basic Care services) and (3) Medicare. Medicare revenue is calculated as the total 2009 MSHO revenue from the supplemental reports less Basic Care and other Medicaid revenue, as provided by DHS.

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Next, revenue for the Medicaid components is adjusted to account for the 1% premium tax (except on county-based plans). Administrative expenses excluding premium tax are then calculated for each component, using an administrative margin of 6.50% for Medicare and 3.64% for other Medicaid (the average for those programs). The resulting administrative expenses excluding premium tax for those components are then subtracted from the total administrative expenses excluding premium tax to calculate the Basic Care administrative expenses excluding premium tax. I then added the premium tax to get total administrative expenses for MSHO Basic Care. Last, I divide the MSHO Basic Care administrative cost including premium tax by its revenue to calculate an administrative margin. The margin for Basic Care is 6.35%.

Finally, I divide the PMAP Families, Children and Pregnant Women administrative expenses by 2009 member months which results in $38.05 PMPM which can be seen on Exhibit A-1.

Trend Adjustment for MNCare Adults without Children

I understand DHS' intent for the MNCare Adults without Children (the B and G rates cells) is to maintain the surplus margin implicit in current (Fourth Quarter 2010) rate levels. DHS has indicated to me that the newly enacted actuarial soundness standards in Minnesota Statue 256B.69 do not apply to MNCare adults without children. Neither do federal actuarial soundness requirements apply to these rate cells. Therefore, I have calculated a trend adjustment but not a surplus adjustment for this block.

The comments regarding the trend calculations in Exhibits A, B, and C above generally apply to this block, too. However, given the recent history of this block due to the influx of former PGAMC members, we did not blend the trend of this business with the other blocks. Also, the distribution of hospital inpatient cost versus other costs was taken from data provided by the plans in 2008 for an area study. Finally, I used 1% instead of 5.13% for the benchmark inpatient hospital charge trend because the annual benefit is capped at $10,000.

Adjustments for Policy Decisions and Legislated 2011 Benefit and Reimbursement Changes

I developed rate adjustments to account for several benefit and reimbursement changes scheduled to be implemented in 2011.

Varicella Vaccine for Adults

Currently, varicella (chicken pox) vaccine is a managed care covered service for children up to age 18, while adults aged 19 and up are covered on a fee-for-service basis. DHS has decided to begin covering the vaccine for MNCare and MA adults under the managed care program in 2011.

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DHS provided 2009 fee-for-service utilization data for managed care enrollees. I allocated the utilization across the impacted adult populations (including PMAP, MNCare, Seniors, PGAMC, and SNBC). I assumed no change in utilization rates for 2011. Based on a 2009 cost per dose of $83.16 (based on DHS serum and administration costs of $81.66 and $1.50, respectively) trended forward two years at the blended annual trend rates used for rate development, the projected cost of providing these vaccinations is $0.02 PMPM. I divided by projected 2011 claim cost for each program to arrive at the January rate adjustment factors shown in Table 1. (Adjustments for other populations were not significant to four decimal places.)

Table 1: January Adjustment Factors for Varicella

Program	Affected Rate Cells	Adjustment Factor
MNCare	Ages 16-20 (L,K)	1.0001
	Parents (F,J)	1.0001

Increase in Dental Rates

Effective January 1, 2011 for managed care, state operated (SOS) dental clinics are to be paid using a cost-based payment system based on Medicare cost-finding methods and allowable costs. I understand there are currently five such clinics. I used the fiscal note provided by DHS to develop a rate adjustment. The fiscal note estimates a payment increase of $365,190 to state operated clinics in FY2009 dollars. This $365,190 includes adjustments for a 25% service reduction and an increase related to critical access dental eligibility. I trended the FY09 cost to CY11 at an annual rate of 5%, the trend rate assumed for the fiscal note. Across PMAP, MNCare, PGAMC, and Seniors, the projected CY11 cost increase amounts to $0.07 PMPM. I divided by projected 2011 claim cost for each program to arrive at the adjustment factors shown in Table 2.

Table 2: January Adjustment Factors for State Operated Dental Clinics

Program	Affected Rate Cells	Adjustment Factor
PMAP	All	1.0002
MNCare	L,K and F,J	1.0002
	B	1.0001

Ratable Reductions

DHS is applying "ratable reductions" to reduce payments to the MCOs for inpatient services. These reductions were originally effective January 1, 2009 and have changed in magnitude at various times since that date. The amount of these reductions is again scheduled to change on January 1, 2011.

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My rate analysis assumes that the MCOs will be able to absorb the reduction in capitation rates by some combination of decreasing their payments to providers and other means such as reductions in utilization.

A 1.5% ratable reduction implemented in October 2009 for certain PMAP "Basic Care" services is scheduled to sunset on June 30, 2011. October 2009 rates were subject to adjustment factors of 0.9819 for Families and Children and 0.9756 for Pregnant Women rate cells. These rate reductions included the impact of several ratable reductions. Of these reductions, excluding PCA/HH adjustments, 8.82% was for the ratable reduction scheduled to sunset. The adjustment factors to reverse this portion of the reduction taken in October 2009 are shown in Table 3.

Table 3: July Adjustment Factors for Sunset of 1.5% Ratable Reduction

Program	Affected Rate Cells	Adjustment Factor
PMAP	Families and Children	1.0015
	Pregnant Women	1.0021

Health Care Home

Health Care Home payments were required beginning the second half of calendar year 2010. An adjustment was included in 2010 rates to reflect increased cost to the MCOs. For 2011 rates, I developed an adjustment that recognizes more current cost and utilization assumptions provided by DHS. The adjustment factors in this letter are intended to replace the prior factors.

Table 4 shows the projected enrollment distribution by Health Care Home Tier, based on information provided by DHS.

Table 4: Projected Enrollment Distribution

	PMAP			MNCare			
Tier	0-17	18-21	22-64	0-17	18-21	22-64	65+
0	92.6%	78.2%	66.8%	91.4%	78.5%	62.5%	52.4%
1	2.8%	6.8%	7.1%	3.5%	8.9%	10.6%	9.4%
2	3.1%	8.2%	12.3%	3.7%	8.3%	14.7%	15.9%
3	1.2%	4.8%	9.1%	1.1%	3.4%	8.6%	15.3%
4	0.3%	2.0%	4.7%	0.3%	1.0%	3.6%	6.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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Table 5 shows projected average Health Care Home payments PMPM for enrollees projected to receive services, as provided to me by DHS. These averages include a 15% increase for enrollees who have a primary language other than English or a serious and persistent mental illness.

Table 5: Projected Average Health Care Home Payments PMPM

Tier	Payment
0	$0.00
1	$10.47
2	$21.00
3	$42.12
4	$63.27

I calculated the weighted average projected payment PMPM for each population and divided by projected calendar year 2011 claim cost to arrive at the factors shown in Table 6, assuming 1.5 months of payments on average per eligible. The 1.5 months of payments was chosen by DHS. This weighted average, assuming 1.5 months of coverage, varies from $0.24 to $3.72 PMPM, depending on the population. The age ranges in the data provided are different from the rate cell age ranges. I assumed a uniform age distribution within an age group for the purpose of calculating the average projected payment. For pregnant women rate cells I used a member weighted average of the 18-21 and 22-64 age groups.

Table 6: January Adjustment Factors for Health Care Home (To Replace the Factors Applied for 2010 Rates)

Program	Affected Rate Cells	Adjustment Factor
PMAP	Ages 0-20	1.0009
	Ages 21-64	1.0023
	Pregnant Women	1.0008
MNCare	L,K Ages 0-20	1.0014
	L,K Pregnant Women	1.0009
	F,J	1.0029
	B	1.0022

Hospice Care Services

Under a new legislative provision, a recipient of MA age 21 and under who elects to receive hospice care does not waive coverage for services related to the treatment of the condition for which a diagnosis of terminal illness has been made. DHS expects the impact of this provision on plan cost to be insignificant.

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Services Provided in Birth Centers

A legislative provision establishes MA coverage for services provided in a licensed birth center by a licensed health professional if such services would otherwise be covered if provided in a hospital. The legislation also provides that licensed traditional midwives are paid 100% of what a physician would receive for performing the same services and that facility fees are reimbursed at 70% of what a hospital would receive for an uncomplicated vaginal birth.

A fiscal note provided by DHS estimates savings of $44,716 for FY11 and $268,296 for FY12. These figures assume that 0.2% and 1.2% of births will be performed in birth centers, and that 13% of these cases will transfer to a hospital before birth. In the case of a transfer, the professional charge is assumed not to change, but the average facility cost will be paid to the hospital, in addition to a reduced facility cost specified in the bill at 15% of the usual payment to the birth center.

DHS now projects no savings for FY11 and $268,296 for FY12 (July 2011-June 2012). I allocated the $268,296 between PMAP and MNCare based on the distribution of member months to arrive at a FY12 PMPM savings of $1.87. I divided by the CY11 projected claim cost (trended forward 6 months at the blended trend rate used for rate development) to arrive at the July adjustment factors shown in Table 7.

Table 7: July Adjustment Factors for Birth Centers

Program	Affected Rate Cells	Adjustment Factor
PMAP	Pregnant Women	0.9987
MNCare	Pregnant Women	0.9986

MinnesotaCare Inpatient Carve-Out

For admissions occurring on or after July 1, 2011, inpatient hospital services for MNCare Adults without Children will be paid on a fee-for-service basis. Accordingly, the inpatient component of the capitation rate will be carved out for the BB rate cells. I reviewed data regarding inpatient costs for MNCare adults for the years 2005-2007, the most recent years for which data is readily available. According to this data, in 2007 inpatient services account for 15.6% of all services provided for the five largest MCOs on an allowed cost basis.

After applying the benchmark trend rates used in rate development and recognizing the impact of benefit changes, inpatient services are projected to account for 12.61% of services in the second half of 2011. I reviewed available information regarding seasonality patterns and did not find

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evidence of significant seasonal differences in this percentage. The July adjustment factor is shown in Table 8.

Table 8: July Adjustment Factor for MNCare Inpatient Carve-Out

Program	Affected Rate Cells	Adjustment Factor
MNCare	B	0.8739

PCA ADL and Behavior Thresholds

A rate adjustment was made in October 2009 regarding changes to personal care assistant (PCA) benefits. Additional changes related to activities of daily living (ADLs) and behavior thresholds are scheduled to be implemented in July 2011. These changes impact the PMAP program as well as MNCare children rate cells.

DHS estimates that PMAP families and children PCA payments amounted to $4.45 PMPM in 2009. Based on 2007 data, the percentage of member months receiving PCA services does not seem to vary significantly by age. DHS estimates that 13.8% of PCA recipients will no longer be eligible effective July 2011. I assumed that the cost impact for these ineligible recipients will be 6.9%, considering that the newly ineligible recipients may be the less complicated cases, and that there may be substitution of services for these recipients. These assumptions give a projected PMPM savings of $0.31 in 2009. I divided by 2009 claim cost for PMAP (excluding pregnant women) to arrive at the adjustment shown in Table 9. For MNCare, DHS estimates that 2009 PCA payments amounted to $2.53 PMPM. I used a similar method to arrive at a PMPM savings in 2009 of $0.17, and the adjustment factor shown in Table 9.

Table 9: July Adjustment Factors for PCA ADL and Behavior Thresholds

Program	Affected Rate Cells	Adjustment Factor
PMAP	Other than Pregnant Women	0.9991
MNCare	L,K other than Pregnant Women	0.9991

Chiropractic Services

Rate adjustment factors were applied to January 2010 rates for the impact of a MNCare coverage change for chiropractic services scheduled to take effect July 1, 2010. While this coverage change had not yet been approved by CMS, a state plan amendment was approved in September 2010 which enacts coverage for both PMAP and MNCare effective January 1, 2011, for managed care. I used data provided by DHS to estimate the cost of providing an annual evaluation to users of

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chiropractic services. Adjustments for cost estimates developed here are intended to replace those applied for 2010 rates.

DHS provided data regarding the number of enrollees who received chiropractic services in 2009 by age group. I assumed that each enrollee will receive an annual evaluation at an average cost of $24.50, the same cost used in last year's analysis. I verified that this $24.50 is consistent with current reimbursement information provided by DHS for these evaluations. On a per member per month basis the cost of annual evaluations is projected to be $0.07 for ages 0-17 and $0.33 for ages 18-64. I divided by projected 2011 claim cost to arrive at the adjustment factors shown in Table 10.

Table 10: January Adjustment Factors for Chiropractic Services

Program	Affected Rate Cells	Adjustment Factor
PMAP	Ages 0-20	1.0004
	Ages 21-64	1.0007
	Pregnant Women	1.0003
MNCare	Ages 0-20	1.0006
	Ages 21-64	1.0007
	Pregnant Women	1.0003

PPACA Provisions

The recently enacted federal health reform legislation (PPACA) requires drug manufacturers to pay rebates to the State. As this provision is expected to reduce or eliminate rebates paid to the plans, a rate increase is necessary. The plans provided information regarding (A) the ratio of 2009 drug cost after rebates to 2009 net claim cost, (B) the ratio of 2009 rebates to 2009 drug cost before rebates, and (C) the ratio of projected 2011 rebates to 2011 drug cost before rebates. I also considered information regarding the plans' confidence in their estimate of this third item. The adjustment factors shown in Table 11 are developed as follows (referring to the labeled items above):

$$A * (1 - C) / (1 - B) + (1 - A).$$

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Table 11: January Adjustment Factors for Drug Rebates, Applies Only to Rate Cells Impacted by the PPACA Provision

Program	Affected Rate Cells	Adjustment Factor
PMAP and MNCare	Children	1.0034
PMAP and MNCare	Pregnant Women	1.0012
MNCare	Adults w/o Children	1.0079
PMAP and MNCare	Other Adults	1.0056

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Jason, I am available for questions by phone at (952) 820-2481 and by e-mail at leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal & Consulting Actuary

LMW/bc/ral

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Exhibit A-1: Rate Increase for 2011 Rates - PMAP

Development of Rate Increase

(a) 2009 Claim Cost	$	338.29	
(b) Annual Trend Rate - Benchmark		5.34%	Exhibit B
(c) Annual Trend Rate - Experience		5.13%	Exhibit C
(d) Annual Trend Rate - 50/50 Blend		5.24%	= (b + c) / 2
(e) Projected 2011 Claim Cost	$	374.64	= (a) * (1 + d) ^ 2
(f) 2009 Administrative Cost	$	38.05	Exhibit H
(g) Administrative Trend Rate		2.00%	
(h) Projected 2011 Administrative Cost	$	39.59	= (f) * (1 + g) ^ 2
(i) Investment Income as a Percent of Revenue		1.00%	
(j) Admin Offset for Investment Income	$	4.19	= (e + h) * (i) / (1 - p)
(k) Net Provision for Administrative Margin	$	35.40	= (h) - (j)
(l) 2011 Claim and Administrative Cost	$	410.03	= (e) + (k)
(m) Impact of Legislated Changes after 1/1/2009		0.9542	Exhibit D
(n) Projected 2011 Claim and Administrative Cost	$	391.25	= (l) * (m)
(o) Investment Income Margin		1.00%	= (i)
(p) Surplus Margin (w/o Inv Income, incl. Withhold Adj)		1.18%	
(q) Projected 2011 Required Revenue	$	399.97	= (n) / (1 - o - p)
(r) Average 4th Qtr 2010 Payment Rate	$	399.97	Exhibit E
(s) Rate Increase for 2011 Rates		0.00%	= (q) / (r) - 1
Trend in Risk Scores Net of Trend in D/A Factors		2.35%	
Adjustment to Rate Increase for Risk-Adjusted Rates		-2.35%	

Notes: (1) For these purposes, "projected claim costs" do not reflect expected actual cost levels. We apply an estimated claim cost trend that is independent of changes in demographic and area factors.
(2) 2010 Revenue is calculated using the 2009 membership distribution, to be consistent with the claim cost projection.
(3) All figures in dollars are per member per month.

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Exhibit A-2: Rate Increase for 2011 Rates - MNCare Families and Children

Development of Rate Increase

(a) 2009 Claim Cost	$	272.45	
(b) Annual Trend Rate - Benchmark		5.90%	Exhibit B
(c) Annual Trend Rate - Experience		5.48%	Exhibit C
(d) Annual Trend Rate - 50/50 Blend		5.69%	= (b + c) / 2
(e) Projected 2011 Claim Cost	$	304.35	= (a) * (1 + d) ^ 2
(f) 2009 Administrative Cost	$	31.90	
(g) Administrative Trend Rate		2.00%	
(h) Projected 2011 Administrative Cost	$	33.19	= (f) * (1 + g) ^ 2
(i) Investment Income as a Percent of Revenue		1.00%	
(j) Admin Offset for Investment Income	$	3.42	= (e + h) * (i) / (1 - p)
(k) Net Provision for Administrative Margin	$	29.77	= (h) - (j)
(l) 2011 Claim and Administrative Cost	$	334.12	= (e) + (k)
(m) Impact of Legislated Changes after 1/1/2009		0.9594	Exhibit D
(n) Projected 2011 Claim and Administrative Cost	$	320.57	= (l) * (m)
(o) Investment Income Margin		1.00%	= (i)
(p) Surplus Margin (w/o Inv Income, incl. Withhold Adj)		1.18%	
(q) Projected 2011 Required Revenue	$	327.71	= (n) / (1 - o - p)
(r) Average 4th Qtr 2010 Payment Rate	$	324.02	Exhibit E
(s) Rate Increase for 2011 Rates		1.14%	= (q) / (r) - 1
Trend in Risk Scores Net of Trend in D/A Factors		2.35%	
Adjustment to Rate Increase for Risk-Adjusted Rates		-2.35%	

Notes: (1) For these purposes, "projected claim costs" do not reflect expected actual cost levels. We apply an estimated claim cost trend that is independent of changes in demographic and area factors.
(2) 2010 Revenue is calculated using the 2009 membership distribution, to be consistent with the claim cost projection.
(3) All figures in dollars are per member per month.

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Exhibit A-3: MNCare Adults without Children

Development of Claim Cost Trend

(a) Annual Trend Rate - Benchmark	5.70%	Exhibit B
(b) Annual Trend Rate - Experience	9.41%	Exhibit C
(c) Annual Trend Rate - 50/50 Blend	7.55%	= (a + b) / 2
(d) 2009 Administrative Margin as a Percent of Revenue	7.69%	
(e) Administrative Trend Rate	2.00%	
(f) Admin-Adjusted Annual Trend Rate	7.13%	= (1 - d) * (1 + c) + (d) * (1 + e) -1

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Exhibit B-1: Benchmark Trend Rate - PMAP

Benefit	Distribution	Utilization	Trend Rate Charge	Total Cost
Hospital Inpatient	33.19%	-1.00%	5.13%	4.08%
Hospital Outpatient	17.41%	3.50%	3.88%	7.52%
Physician and Other	34.45%	3.00%	1.76%	4.81%
Drugs	10.93%			7.50%
Dental	4.02%	0.50%	4.50%	5.02%
Composite Trend Rate	100.00%			5.34%

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Exhibit B-2: Benchmark Trend Rate - MNCare Families and Children

Benefit	Distribution	Trend Rate Utilization	Trend Rate Charge	Total Cost
Hospital Inpatient	18.66%	-1.00%	5.13%	4.08%
Hospital Outpatient	23.24%	3.50%	3.88%	7.52%
Physician and Other	32.37%	3.00%	1.76%	4.81%
Drugs	21.93%			7.50%
Dental	3.80%	0.50%	4.50%	5.02%
Composite Trend Rate	100.00%			5.90%

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Exhibit B-3: Benchmark Trend Rate - MNCare Adults without Children

Benefit	Distribution	Utilization	Trend Rate Charge	Total Cost
Hospital Inpatient	12.78%	-1.00%	1.00%	-0.01%
Hospital Outpatient	26.27%	3.50%	3.88%	7.52%
Physician and Other	28.36%	3.00%	1.76%	4.81%
Drugs	29.24%			7.50%
Dental	3.34%	0.50%	4.50%	5.02%
Composite Trend Rate	100.00%			5.70%

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Exhibit C-1: Experience-Based Trend Rate - PMAP

Benefit/Reim/Eligibility Changes	2007	2008	2009
Claim Cost Impact of Benefit/Eligibility Changes (compared to the prior year)	1.0028	1.0041	0.9942

Demog/Area Factors	2006	2007	2008	2009
Avg Demog/Area Factor	0.996	1.002	0.997	0.983
Trend in D/A Factors		0.6%	-0.5%	-1.4%
Weighted Avg Trend in D/A Factors				-0.7%

Claim Costs	2006	2007	2008	2009
Member Months	2,682,686	2,725,087	2,909,508	3,236,126
Claim Cost PMPM	$ 290.03	$ 314.43	$ 332.57	$ 338.29
Claim Cost Trend		8.4%	5.8%	1.7%
Net of Ben/Elig Changes		8.1%	5.3%	2.3%
Also Net of Trend in D/A Ftrs		7.4%	5.8%	3.8%
Weighted Avg Experience Trend				5.1%

Claim Costs (All Programs)*	2007	2008	2009
2-Year Rolling Avg Claim Cost (000s)	$ 817,450	$ 912,221	$ 1,031,171
% of Total for All Programs (Weights)	80.5%	82.8%	84.7%
Weighted Avg Trend (All Programs)	9.0%	4.9%	4.1%
All Program Weighted Avg Experience Trend			5.2%

Experience-Based Trend	
50/50 Blended Experience Trend	5.1%

Notes: All trends are annual, over the prior year.
The weights are 1/6, 1/3, and 1/2, with increasing weight on more recent years.
* Includes PMAP and MNCare Families and Children

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Exhibit C-2: Experience-Based Trend Rate - MNCare Families and Children

Benefit/Eligibility Changes	2007	2008	2009
Claim Cost Impact of Benefit/Eligibility Changes (compared to the prior year)	1.0053	1.0065	0.9943

Demog/Area Factors	2006	2007	2008	2009
Avg Demog/Area Factor	0.742	0.741	0.742	0.749
Trend in D/A Factors		-0.2%	0.1%	1.0%
Weighted Avg Trend in D/A Factors				0.5%

Claim Costs	2006	2007	2008	2009
Member Months	925,328	772,029	719,829	697,287
Claim Cost PMPM	$ 218.21	$ 252.77	$ 255.57	$ 272.45
Claim Cost Trend		15.8%	1.1%	6.6%
Net of Ben/Elig Changes		15.2%	0.5%	7.2%
Also Net of Trend in D/A Ftrs		15.4%	0.4%	6.1%
Weighted Avg Experience Trend				5.8%

Claim Costs (All Programs)*	2007	2008	2009
2-Year Rolling Avg Claim Cost (000s)	$ 198,529	$ 189,554	$ 186,971
% of Total for All Programs (Weights)	19.5%	17.2%	15.3%
Weighted Avg Trend (All Programs)	9.0%	4.9%	4.1%
All Program Weighted Avg Experience Trend			5.2%

Experience-Based Trend	
50/50 Blended Experience Trend	5.5%

Notes: All trends are annual, over the prior year.
The weights are 1/6, 1/3, and 1/2, with increasing weight on more recent years.
* Includes PMAP and MNCare Families and Children

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit C-3: Experience-Based Trend Rate - MNCare Adults without Children

Benefit/Eligibility Changes	2007	2008	2009
Claim Cost Impact of Benefit/Eligibility Changes (compared to the prior year)	1.0045	1.0411	0.9993

Demog/Area Factors	2006	2007	2008	2009
Avg Demog/Area Factor	1.391	1.429	1.414	1.398
Trend in D/A Factors		2.7%	-1.1%	-1.2%
Weighted Avg Trend in D/A Factors				-0.5%

Claim Costs	2006	2007	2008	2009
Member Months	285,102	376,698	421,647	505,152
Claim Cost PMPM	$ 364.81	$ 425.09	$ 509.34	$ 521.32
Claim Cost Trend		16.5%	19.8%	2.4%
Net of Ben/Elig Changes		16.0%	15.1%	2.4%
Also Net of Trend in D/A Ftrs		12.9%	16.3%	3.6%
Weighted Avg Experience Trend				9.4%

Notes: All trends are annual, over the prior year.
The weights are 1/6, 1/3, and 1/2, with increasing weight on more recent years.

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Exhibit D-1: Impact of Benefit/Eligibility/Reimbursement Changes - PMAP (Under 65)

Change	Type	Assumed Effective Date	Rate Impact on Subpop.	Subpopulation Affected (Rate Cells)	% of Claims Affected	Net Impact	2006-07 Impact	2007-08 Impact	2008-09 Impact	2009-2010 Q4 Adjustment
Infant Circumcision	Benefit	1/1/07	0.9989	Males, Ages 0-1	10.10%	0.9999	0.9999	1.0001	1.0000	1.0000
		1/1/08	1.0011	Males, Ages 0-1	11.26%	1.0001				
Critical Access MH Rates	Reimb.	7/1/07 *	1.0006	All Except Ages 0-2	77.54%	1.0005	1.0005	1.0006	1.0000	1.0000
		1/1/08	1.0001	All	100.00%	1.0001				
Gardasil Vaccine	Benefit	1/1/07	1.0039	Females, Ages 2-15	10.07%	1.0009	1.0009	0.9993	1.0000	1.0000
			1.0052	Females, Ages 16-20	5.11%					
			1.0011	Females, Ages 21-49	25.15%					
		1/1/08	0.9984	Females, Ages 2-15	10.00%	0.9993				
			0.9948	Females, Ages 16-20	4.85%					
			0.9989	Females, Ages 21-49	24.37%					
		1/1/10	1.0001	Males, Ages 2-15, 21-49	21.81%	1.0000				
			1.0006	Males, Ages 16-20	3.75%					
Model Benefit Set for MH Svcs	Benefit	1/1/07	1.0040	Females, Ages 16+	31.96%	1.0015	1.0015	1.0031	1.0000	1.0000
			1.0016	Males, Ages 16+	8.81%					
			1.0005	Pregnant Women	14.97%					
		1/1/08	1.0064	Females, Ages 16+	30.93%	1.0031				
			1.0105	Males, Ages 16+	8.69%					
			1.0014	Pregnant Women	14.92%					
Shingles Vaccine	Benefit	1/1/08	1.0010	Ages 50-64	2.75%	1.0000	1.0000	1.0000	1.0000	1.0000
Family Planning Rates	Reimb.	1/1/08	1.0005	Female, Ages 16-49	29.22%	1.0001	1.0000	1.0001	1.0000	1.0000
Halfway House/Extended Care	Benefit	7/1/08 *	1.0011	Ages 2+	76.39%	1.0008	1.0000	1.0008	1.0008	1.0000
MH Targeted Case Management	Benefit	7/1/09 *	1.0062	Females, Ages 2+	41.82%	1.0056	1.0000	1.0000	1.0056	1.0056
			1.0137	Males, Ages 2+	21.05%					
			1.0005	Pregnant Women	15.25%					
Rule 5 Treatment Services	Benefit	1/1/09	1.0054	Ages 2-20	29.77%	1.0016	1.0000	1.0000	1.0016	1.0000
MH Outpatient Services	Benefit	1/1/09	1.0001	All	100.00%	1.0001	1.0000	1.0000	1.0001	1.0000
Removal of Rm & Brd Costs from FS Resid CD	Benefit	1/1/09	0.9992	All	100.00%	0.9992	1.0000	1.0000	0.9992	1.0000
Income Based Copay Limits	Benefit	1/1/09	1.0001	Adults, Ages 21+	33.09%	1.0000	1.0000	1.0000	1.0000	1.0000
Inpatient Ratable Reduction	Reimb.	1/1/09	0.9917	All	100.00%	1.0000	1.0000	1.0000	0.9917	1.0000
October 2009 Rate Amendment	Reimb.	10/1/09	0.9819	Non-Pregnant	84.75%	0.9809	1.0000	1.0000	0.9952	0.9857
			0.9756	Pregnant Women	15.25%					
Reversal of Inpatient Ratable Reduction	Reimb.	1/1/10	1.0084	All	100.00%	1.0084	1.0000	1.0000	1.0000	1.0084
Inpatient Ratable Reduction	Reimb.	1/1/10	0.9943	All	100.00%	0.9943	1.0000	1.0000	1.0000	0.9943
Changes in Dental Benefit	Benefit	1/1/10	0.9961	Ages 2-20	41.94%	0.9929	1.0000	1.0000	1.0000	0.9929
			0.9802	Ages 21-64	27.84%					
Post-Partum Depression Screen	Benefit	1/1/10	1.0000	Pregnant Women	10.07%	1.0000	1.0000	1.0000	1.0000	1.0000
Health Care Home	Benefit	7/1/10	1.0002	Ages 0-20, Pregnant Women	72.16%	1.0003	1.0000	1.0000	1.0000	1.0003
			1.0005	Ages 21-64	27.84%					
Ratable Reduction for Non-Admin Services	Reimb.	9/1/10	0.9724	All	100.00%	0.9724	1.0000	1.0000	1.0000	0.9724
Reversal of Inpatient Ratable Reduction	Reimb.	9/1/10	1.0058	All	100.00%	1.0058	1.0000	1.0000	1.0000	1.0058
Inpatient Ratable Reduction	Reimb.	9/1/10	0.9941	All	100.00%	0.9941	1.0000	1.0000	1.0000	0.9941
Ratable Reduction for Physician & Professional Services	Reimb.	10/1/10	0.9956	All	100.00%	0.9941	1.0000	1.0000	1.0000	0.9941
Rate Increase for Certain Basic Services	Reimb.	10/1/10	1.0002	All	100.00%	1.0003	1.0000	1.0000	1.0000	1.0003
Total Impact:	Benefit and Eligibility Changes						1.0028	1.0041	0.9942	0.9542

* Adjustment factors for effective dates of July 1 are applied for two successive years (to reflect year-long coverage in the second year).

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Exhibit D-2: Impact of Benefit/Eligibility/Reimbursement Changes - MNCare Families and Children

Change	Type	Assumed Effective Date		Rate Impact on Subpop.	Subpopulation Affected (Rate Cells)	% of Claims Affected	Net Impact	2006-07 Impact	2007-08 Impact	2008-09 Impact	2009-2010 Q4 Adjustment
Infant Circumcision	Benefit	1/1/07		0.9984	Males, Ages 0-1	3.07%	1.0000	1.0000	1.0001	1.0000	1.0000
		1/1/08		1.0016	Males, Ages 0-1	3.37%	1.0001				
Remove Restorative Dental Copay	Benefit	7/1/07	*	1.0060	F,J (M) Females 21-49	24.34%	1.0027	1.0027	1.0027	1.0000	1.0000
				1.0064	F,J (M) Females 50-64	4.42%					
				1.0044	F,J (M) Females 65+	0.00%					
				1.0068	F,J (M) Males 21-49	10.58%					
				1.0069	F,J (M) Males 50-64	3.84%					
				1.0047	F,J (M) Males 65+	0.02%					
Critical Access MH Rates	Reimb.	7/1/07	*	1.0013	All Except Ages 0-2	93.22%	1.0012	1.0012	1.0013	1.0000	1.0000
		1/1/08		1.0001	All	100.00%	1.0001				
Gardasil Vaccine	Benefit	1/1/07		1.0067	L,K Females 2-15	9.65%	1.0013	1.0013	0.9991	1.0000	1.0001
				1.0073	L,K Females 16-20	7.43%					
				1.0004	F,J (A) Females 21-49	6.43%					
				1.0005	F,J (M) Females 21-49	24.34%					
		1/1/08		0.9973	L,K Females 2-15	9.24%	0.9991				
				0.9928	L,K Females 16-20	6.63%					
				0.9996	F,J (A) Females 21-49	6.19%					
				0.9995	F,J (M) Females 21-49	24.93%					
		1/1/10		1.0002	Males, Ages 2-15	11.31%	1.0001				
				1.0006	Males, Ages 16-20	5.33%					
				1.0001	Males, F,J 21-49	12.98%					
Model Benefit Set for MH Svcs	Benefit	1/1/07		1.0002	L,K Ages 16-20, PW	18.12%	1.0000	1.0000	1.0012	1.0000	1.0000
		1/1/08		1.0011	L,K Ages 16-20, PW	17.34%	1.0012				
				1.0019	All Other Adults	55.10%					
Shingles Vaccine	Benefit	1/1/08		1.0029	Ages 50-64	11.11%	1.0003	1.0000	1.0003	1.0000	1.0000
				1.0113	Ages 65+	0.10%					
Family Planning Rates	Reimb.	1/1/08		1.0003	Female, Ages 16-49	37.75%	1.0001	1.0000	1.0001	1.0000	1.0000
Halfway House/Extended Care	Benefit	7/1/08	*	1.0017	Ages 2+	92.62%	1.0016	1.0000	1.0016	1.0016	1.0000
MH Targeted Case Management	Benefit	7/1/09	*	1.0049	Ages 2-20	33.08%	1.0040	1.0000	1.0000	1.0040	1.0040
				1.0038	Ages 21+	56.45%					
				1.0049	Pregnant Women	4.81%					
Rule 5 Treatment Services	Benefit	1/1/09		1.0012	Ages 2-20	33.08%	1.0004	1.0000	1.0000	1.0004	1.0000
Removal of Rm & Brd Costs from FS Resid CD	Benefit	1/1/09		0.9990	All Ages	100.00%	0.9990	1.0000	1.0000	0.9990	1.0000
Inpatient Ratable Reduction	Reimb.	1/1/09		0.9920	K,L and F,J M2	88.46%	0.9928	1.0000	1.0000	0.9928	1.0000
				0.9986	F,J A2	11.54%					
October 2009 Rate Amendment	Reimb.	10/1/09		0.9857	L,K Ages 0-20	38.73%	0.9861	1.0000	1.0000	0.9965	0.9896
				0.9864	F,J Ages 21+	56.45%					
				0.9861	Pregnant Women	4.81%					
Reversal of Inpatient Ratable Reduction	Reimb.	1/1/10		1.0081	K,L and F,J M2	94.10%	1.0077	1.0000	1.0000	1.0000	1.0077
				1.0014	F,J A2	5.90%					
Inpatient Ratable Reduction	Reimb.	1/1/10		0.9945	K,L and F,J M2	94.10%	0.9948	1.0000	1.0000	1.0000	0.9948
				0.9990	F,J A2	5.90%					
Changes in Dental Benefit	Benefit	1/1/10		0.9960	L,K Ages 2-20	33.25%	0.9969	1.0000	1.0000	1.0000	0.9969
				0.9977	Ages 21-49	42.80%					
				0.9941	F,J Ages 50+	13.40%					
Expansion of Chiropractic Services	Benefit	7/1/10		1.0005	L,K Ages 0-20, F,J and PW	100.00%	1.0005	1.0000	1.0000	1.0000	1.0005
Post-Partum Depression Screen	Benefit	1/1/10		1.0000	PW	4.74%	1.0000	1.0000	1.0000	1.0000	1.0000
Health Care Home	Benefit	7/1/10		1.0003	L,K Ages 0-20	39.05%	1.0005	1.0000	1.0000	1.0000	1.0005
				1.0007	F,J (A2, M2)	56.20%					
				1.0002	PW	4.74%					
Ratable Reduction for Non-Admin Services	Reimb.	9/1/10		0.9719	All	100.00%	0.9719	1.0000	1.0000	1.0000	0.9719
Reversal of Inpatient Ratable Reduction	Reimb.	9/1/10		1.0055	K,L and F,J M2	94.10%	1.0052	1.0000	1.0000	1.0000	1.0052
				1.0010	F,J A2	5.90%					
Inpatient Ratable Reduction	Reimb.	9/1/10		0.9944	K,L and F,J M2	94.10%	0.9946	1.0000	1.0000	1.0000	0.9946
				0.9990	F,J A2	5.90%					
Ratable Reduction for Physician & Professional Services	Reimb.	10/1/10		0.9950	All	100.00%	0.9933	1.0000	1.0000	1.0000	0.9933
Total Impact:	Benefit and Eligibility Changes							1.0053	1.0065	0.9943	0.9594

* Adjustment factors for effective dates of July 1 are applied for two successive years (to reflect year-long coverage in the second year).

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Exhibit D-3: Impact of Benefit/Eligibility/Reimbursement Changes - MNCare Adults without Children

Change	Type	Assumed Effective Date		Rate Impact on Subpop.	Subpopulation Affected (Rate Cells)	% of Claims Affected	Net Impact	2006-07 Impact	2007-08 Impact	2008-09 Impact
Removal of Limited Benefit Set	Benefit	1/1/08		1.0949	B (M3)	33.96%	1.0322	1.0000	1.0322	1.0000
Remove Restorative Dental Copay	Benefit	7/1/07	*	1.0054	B (M1) Females 21-49	14.14%	1.0026	1.0026	1.0026	1.0000
				1.0057	B (M1) Females 50-64	11.72%				
				1.0039	B (M1) Females 65+	0.21%				
				1.0063	B (M1) Males 21-49	11.12%				
				1.0062	B (M1) Males 50-64	7.67%				
				1.0042	B (M1) Males 65+	0.15%				
Critical Access MH Rates	Reimb.	7/1/07	*	1.0013	All	100.00%	1.0013	1.0013	1.0014	1.0000
		1/1/08		1.0001	All	100.00%	1.0001			
Gardasil Vaccine	Benefit	1/1/07		1.0017	B (M1,M2) Females 21-49	14.14%	1.0006	1.0006	0.9996	1.0000
				1.0024	B (M3) Females 21-49	14.82%				
		1/1/08		0.9983	B (M1,M2) Females 21-49	10.67%	0.9996			
				0.9976	B (M3) Females 21-49	9.29%				
Model Benefit Set for MH Svcs	Benefit	1/1/08		1.0019	All	100.00%	1.0019	1.0000	1.0019	1.0000
Shingles Vaccine	Benefit	1/1/08		1.0029	Ages 50-64	41.31%	1.0012	1.0000	1.0012	1.0000
				1.0113	Ages 65+	0.38%				
Family Planning Rates	Reimb.	1/1/08		1.0003	Female, Ages 21-49	30.39%	1.0001	1.0000	1.0001	1.0000
Halfway House/Extended Care	Benefit	7/1/08	*	1.0017	All	100.00%	1.0017	1.0000	1.0017	1.0017
MH Targeted Case Management	Benefit	7/1/09	*	1.0038	All	100.00%	1.0038	1.0000	1.0000	1.0038
Removal of Rm & Brd Costs from FS Resid CD	Benefit	1/1/09		0.9990	All	100.00%	0.9990	1.0000	1.0000	0.9990
Inpatient Ratable Reduction	Reimb.	1/1/09		0.9986	All	100.00%	0.9986	1.0000	1.0000	0.9986
October 2009 Rate Amendment	Reimb.	10/1/09		0.9851	All	100.00%	0.9851	1.0000	1.0000	0.9963
Total Impact:	Benefit and Eligibility Changes							1.0045	1.0411	0.9993

* Adjustment factors for effective dates of July 1 are applied for two successive years (to reflect year-long coverage in the second year).

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Exhibit E-1: Revenue - PMAP (Under 65)

2009 Enrollment

Rate Cell			Hennepin	Carver	Core Metro	Greater Metro	NE	NW	Olmsted	Ramsey	SE	SW	Total
Families with Children	0-1	Female	31,698	810	18,943	3,621	4,856	22,271	3,397	16,256	16,767	14,765	133,384
Families with Children	1-2	Female	21,629	563	12,812	2,625	3,634	17,244	2,704	11,645	12,727	10,198	95,781
Families with Children	2-15	Female	181,605	4,859	103,866	20,479	30,808	134,526	21,919	103,736	91,506	76,924	770,228
Families with Children	16-20	Female	44,291	890	22,064	3,817	7,753	31,551	4,540	28,724	19,026	17,402	180,058
Families with Children	21-49	Female	109,771	3,581	77,203	16,401	25,763	113,262	15,278	66,738	70,005	56,201	554,203
Families with Children	50+	Female	6,439	198	2,832	508	771	3,515	815	3,446	2,306	1,810	22,640
Families with Children	0-1	Male	31,146	814	20,172	3,647	4,556	23,584	3,898	16,418	17,155	14,779	136,169
Families with Children	1-2	Male	22,197	557	13,549	2,660	3,605	18,496	2,971	11,844	13,001	10,565	99,445
Families with Children	2-15	Male	180,606	4,885	105,376	19,907	30,993	139,788	21,270	105,307	96,353	79,013	783,498
Families with Children	16-20	Male	36,992	932	18,136	3,507	6,730	25,495	3,759	25,936	16,427	13,621	151,535
Families with Children	21-50	Male	27,464	980	22,398	5,454	8,474	42,500	4,478	22,052	20,169	17,321	171,290
Families with Children	50+	Male	3,471	122	2,138	319	577	3,018	840	2,632	1,890	1,314	16,321
Pregnant Women	All Ages	Female	28,971	746	17,337	3,521	4,144	21,746	3,337	11,641	15,936	14,195	121,574
Total			726,280	19,937	436,826	86,466	132,664	596,996	89,206	426,375	393,268	328,108	3,236,126

2010 Demographic Rates

Rate Cell			Hennepin	Carver	Core Metro	Greater Metro	NE	NW	Olmsted	Ramsey	SE	SW	Average
Families with Children	0-1	Female	$ 763.88	$ 741.99	$ 843.28	$ 843.30	$ 755.67	$ 771.93	$ 600.88	$ 699.31	$ 664.19	$ 747.23	$ 751.83
Families with Children	1-2	Female	245.28	238.28	270.81	270.81	242.67	247.87	192.95	224.56	213.30	239.98	240.91
Families with Children	2-15	Female	181.21	176.02	200.05	200.05	179.28	183.09	142.55	165.89	157.54	177.27	178.10
Families with Children	16-20	Female	363.87	353.45	401.75	401.72	360.00	367.66	286.23	333.12	316.41	355.96	357.12
Families with Children	21-49	Female	607.28	589.95	670.49	670.48	600.86	613.69	477.72	555.97	527.97	594.07	597.75
Families with Children	50+	Female	983.50	955.31	1,085.83	1,085.80	973.06	993.29	773.66	900.42	855.08	962.53	964.56
Families with Children	0-1	Male	937.50	910.62	1,035.03	1,035.05	927.51	947.15	737.48	858.28	815.17	917.17	922.84
Families with Children	1-2	Male	289.32	281.04	319.41	319.41	286.25	292.31	227.58	264.88	251.52	283.05	284.26
Families with Children	2-15	Male	215.18	209.02	237.57	237.58	212.89	217.42	169.27	197.01	187.07	210.51	211.42
Families with Children	16-20	Male	271.01	263.23	299.17	299.19	268.10	273.76	213.17	248.10	235.64	265.12	265.60
Families with Children	21-50	Male	441.14	428.52	487.03	487.04	436.46	445.70	347.03	403.87	383.61	431.50	434.42
Families with Children	50+	Male	877.40	852.30	968.62	968.63	868.07	886.78	690.16	803.23	763.11	858.65	856.01
Pregnant Women	All Ages	Female	1,558.56	1,513.98	1,720.69	1,720.60	1,541.91	1,575.03	1,226.01	1,426.86	1,354.82	1,524.30	1,536.03
Average			$ 408.05	$ 402.48	$ 463.35	$ 466.88	$ 402.11	$ 421.58	$ 326.14	$ 358.86	$ 363.97	$ 412.88	$ 405.70

Demographic Rate $ 405.70
Risk-Adjusted Rate $ 394.24

Weight on Demographic Revenue 50%
Weight on Risk-Adjusted Revenue 50%

2010 Revenue $ 399.97

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Exhibit E-2: Revenue - MNCare Families and Children

2009 Enrollment Rate Cell				Metro	Non-Metro	Weight on Demographic Rate Metro	Weight on Demographic Rate Non-Metro	2010 Demographic Rates (after rateable reductions) (after county-based adj) Metro	2010 Demographic Rates Non-Metro	Weight on Risk-Adjusted Rate Metro	Weight on Risk-Adjusted Rate Non-Metro	2010 Risk-Adjusted Rates (after rateable reductions) Metro	2010 Risk-Adjusted Rates Non-Metro	2010 Blended Rates Metro	2010 Blended Rates Non-Metro
	0-1	Female	(L,K)	2,334	3,740	50%	50%	$ 582.27	555.75	50%	50%	$ 268.10	$ 268.10	$ 425.18	$ 411.92
	1-2	Female	(L,K)	2,708	3,373	50%	50%	172.12	164.26	50%	50%	268.10	268.10	220.11	216.18
	2-15	Female	(L,K)	50,041	83,036	50%	50%	164.33	156.82	50%	50%	268.10	268.10	216.21	212.46
	16-20	Female	(L,K)	19,329	32,817	50%	50%	303.39	289.52	50%	50%	268.10	268.10	285.74	278.81
	0-1	Male	(L,K)	2,833	4,317	50%	50%	745.84	711.77	50%	50%	268.10	268.10	506.97	489.93
	1-2	Male	(L,K)	2,621	4,178	50%	50%	262.78	250.82	50%	50%	268.10	268.10	265.44	259.46
	2-15	Male	(L,K)	52,628	85,230	50%	50%	182.24	173.93	50%	50%	268.10	268.10	225.17	221.01
	16-20	Male	(L,K)	18,994	32,627	50%	50%	241.58	230.57	50%	50%	268.10	268.10	254.84	249.33
Pregnant Women			(I,K)	2,684	4,581	50%	50%	1,403.76	1,339.54	50%	50%	268.10	268.10	835.93	803.82
Parent >215%	21-49	Female	(F,J)	4,689	7,692	100%	100%	459.83	438.75	0%	0%			459.83	438.75
Parent <215%	21-49	Female	(F,J)	52,247	85,887	50%	50%	480.00	457.98	50%	50%	403.22	403.22	441.61	430.60
Parent >215%	50+	Female	(F,J)	887	1,694	100%	100%	610.10	582.27	0%	0%			610.10	582.27
Parent <215%	50+	Female	(F,J)	8,411	12,796	50%	50%	636.86	607.71	50%	50%	403.22	403.22	520.04	505.46
Parent >215%	21-49	Male	(F,J)	1,870	4,223	100%	100%	353.09	336.86	0%	0%			353.09	336.86
Parent <215%	21-49	Male	(F,J)	28,284	57,703	50%	50%	368.61	351.66	50%	50%	403.22	403.22	385.91	377.44
Parent >215%	50+	Male	(F,J)	656	1,452	100%	100%	566.22	540.42	0%	0%			566.22	540.42
Parent <215%	50+	Male	(F,J)	7,914	12,811	50%	50%	591.09	564.11	50%	50%	403.22	403.22	497.15	483.66
Total Enrollment					697,287										

2010 Revenue - MNCare Families and Children $ 324.02

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Exhibit E-3: Risk Adjusted Revenue

PMAP

Base Rate	Average Risk Score	Rateable Reductions	Withhold	Adjusted Rate
$ 304.90	1.1999	0.9752	1.1050	$ 394.24

MNCare Families and Children

Eligibility Type	Base Rate	Membership Distribution	Average Risk Score	Rateable Reductions	Withhold	Adjusted Rate
K,L and I,K	$ 183.77	33.9%	1.3999	0.990	1.0526	$ 268.10
F,J (M2,M4)	276.39	22.1%	1.3999	0.990	1.0526	403.22

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Exhibit F: Trend in Risk Scores

Risk Scores for Calendar Year Assessment Period

Population	2008	2009
FC & PW	1.2038	1.2146
MNCare ULH	1.3670	1.4383

Trends in Risk Scores

Population	2009
FC & PW	0.90%
MNCare ULH	5.22%
Weighted Average	1.74%

Trends in Demographic and Area Factors

Population	2009
FC & PW	-1.49%
MNCare ULH	3.10%
Weighted Average	-0.59%

Trends in Risk Scores Net of Trends in Demographic and Area Factors

Population	2009
FC & PW	2.42%
MNCare ULH	2.05%
Combined Programs	2.35%
Selected Trend	2.35%

Notes: All trends are annual, over the prior year.

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Exhibit G-1: Trend in Demographic/Area Factors - PMAP

	2006	2007	2008	2009
Average Demographic/Area Factor	0.996	1.002	0.997	0.983
Trend in Demographic/Area Factors		0.6%	-0.5%	-1.4%

Demographic Factors

Families and Children		
Female	0-1	1.817
	1-2	0.584
	2-15	0.430
	16-20	0.864
	21-49	1.464
	50+	2.371
Male	0-1	2.230
	1-2	0.688
	2-15	0.507
	16-20	0.638
	21-50	1.055
	50+	2.099
Pregnant Women		
All Ages		3.730

Area Factors

Hennepin	1.019
Carver	0.990
Core Metro	1.125
Greater Metro	1.125
NE	1.008
NW	1.024
Olmsted	0.793
Ramsey	0.933
SE	0.880
SW	0.990

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Exhibit G-1: Trend in Demographic/Area Factors - PMAP

Rate Cell Relativities

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest
Families with Children											
Female	0-1	1.851	1.798	2.044	2.044	1.832	1.860	1.442	1.695	1.599	1.798
	1-2	0.595	0.578	0.656	0.656	0.588	0.597	0.463	0.544	0.513	0.578
	2-15	0.438	0.426	0.484	0.484	0.433	0.440	0.341	0.401	0.378	0.426
	16-20	0.880	0.855	0.971	0.971	0.871	0.884	0.685	0.806	0.760	0.855
	21-49	1.492	1.449	1.647	1.647	1.476	1.499	1.162	1.366	1.288	1.449
	50+	2.416	2.347	2.667	2.667	2.390	2.427	1.881	2.212	2.087	2.347
Male	0-1	2.272	2.207	2.509	2.509	2.248	2.283	1.770	2.080	1.963	2.207
	1-2	0.701	0.681	0.774	0.774	0.694	0.705	0.546	0.642	0.606	0.681
	2-15	0.516	0.502	0.570	0.570	0.511	0.519	0.402	0.473	0.446	0.502
	16-20	0.650	0.631	0.718	0.718	0.643	0.653	0.506	0.595	0.561	0.631
	21-50	1.075	1.045	1.187	1.187	1.064	1.080	0.837	0.985	0.929	1.045
	50+	2.139	2.078	2.361	2.361	2.116	2.149	1.666	1.958	1.847	2.078
Pregnant Women											
Female	All Ages	3.800	3.691	4.195	4.195	3.760	3.818	2.959	3.479	3.282	3.691

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Exhibit G-1: Trend in Demographic/Area Factors - PMAP

2006 Enrollment

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest
Families with Children											
Female	0-1	28,569	848	16,506	2,814	4,734	17,259	3,970	14,123	15,882	12,939
	1-2	18,242	450	9,915	1,970	3,212	12,222	2,603	9,908	10,852	8,540
	2-15	154,359	3,394	79,464	14,597	28,692	99,515	19,581	96,783	79,334	66,352
	16-20	38,437	573	17,425	2,668	7,407	23,384	4,715	24,840	17,205	13,901
	21-49	96,112	2,218	61,985	12,006	23,399	78,569	13,970	60,883	57,621	44,978
	50+	5,569	73	1,972	327	569	2,286	780	3,358	1,688	1,445
Male	0-1	30,523	728	16,647	3,110	4,646	17,766	3,999	14,978	16,599	14,351
	1-2	19,684	419	11,024	1,993	3,568	13,099	2,617	10,061	10,889	9,024
	2-15	151,669	3,279	82,110	14,726	28,603	101,125	19,442	97,775	82,055	65,674
	16-20	32,313	475	14,267	2,214	6,007	17,959	3,517	22,300	13,175	10,593
	21-50	22,197	563	15,343	2,831	6,957	25,944	4,158	18,873	16,005	13,033
	50+	3,072	33	1,453	175	375	1,452	601	2,339	1,236	1,088
Pregnant Women											
Female	All Ages	28,251	790	15,258	3,209	4,007	17,033	3,638	10,536	16,090	13,151

2007 Enrollment

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest
Families with Children											
Female	0-1	31,495	785	17,725	3,444	4,388	18,097	4,047	14,570	16,855	13,597
	1-2	19,189	417	10,520	2,121	3,538	11,922	2,456	10,095	11,105	8,571
	2-15	156,389	3,713	80,850	16,055	27,950	101,086	19,899	95,112	78,846	67,045
	16-20	38,462	587	17,108	3,059	6,951	23,371	4,472	24,796	16,923	14,026
	21-49	96,144	2,570	62,380	12,894	23,268	80,495	13,955	59,479	59,628	46,250
	50+	5,740	88	2,002	424	745	2,369	813	3,087	1,895	1,587
Male	0-1	32,578	810	17,930	3,428	4,321	19,706	4,085	15,290	17,413	14,774
	1-2	20,081	383	10,706	2,321	3,442	12,854	2,661	10,580	11,588	9,594
	2-15	154,212	3,538	83,408	15,465	28,279	102,398	19,812	95,706	82,623	67,396
	16-20	32,692	616	14,578	2,545	5,697	18,766	3,630	22,453	13,298	11,027
	21-50	22,628	706	15,946	3,562	6,359	27,483	4,152	18,585	16,406	12,974
	50+	3,058	31	1,429	239	455	1,685	686	2,203	1,408	1,094
Pregnant Women											
Female	All Ages	29,881	644	15,225	3,397	3,605	17,802	3,783	10,260	16,064	13,203

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Exhibit G-1: Trend in Demographic/Area Factors - PMAP

2008 Enrollment

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest
Families with Children											
Female	0-1	31,734	665	18,111	3,409	4,576	20,563	3,710	15,156	17,671	14,248
	1-2	21,019	476	11,989	2,451	3,472	15,080	2,550	10,621	11,638	9,187
	2-15	163,605	3,956	88,954	17,270	28,245	117,486	20,172	96,472	81,883	69,149
	16-20	40,851	674	18,315	3,373	7,251	27,360	4,422	25,646	17,621	15,120
	21-49	100,892	2,850	66,822	14,376	23,750	96,646	14,193	60,656	62,716	49,193
	50+	5,987	144	2,169	435	866	2,959	794	3,108	1,950	1,565
Male	0-1	32,108	753	18,697	3,879	4,284	22,433	4,307	15,256	17,176	14,553
	1-2	21,609	453	12,167	2,399	3,530	16,160	2,685	11,395	12,377	10,159
	2-15	163,618	3,596	89,915	16,672	28,905	120,334	20,292	97,432	87,036	70,655
	16-20	33,022	738	15,560	2,911	5,827	22,218	3,559	23,442	13,818	11,845
	21-50	23,748	784	17,882	4,171	7,030	34,233	4,104	19,544	16,524	14,111
	50+	3,275	83	1,615	238	548	2,360	722	2,312	1,516	1,181
Pregnant Women											
Female	All Ages	28,311	714	16,614	3,594	4,018	19,934	3,290	11,497	16,238	13,425

2009 Enrollment

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest
Families with Children											
Female	0-1	31,698	810	18,943	3,621	4,856	22,271	3,397	16,256	16,767	14,765
	1-2	21,629	563	12,812	2,625	3,634	17,244	2,704	11,645	12,727	10,198
	2-15	181,605	4,859	103,866	20,479	30,808	134,526	21,919	103,736	91,506	76,924
	16-20	44,291	890	22,064	3,817	7,753	31,551	4,540	28,724	19,026	17,402
	21-49	109,771	3,581	77,203	16,401	25,763	113,262	15,278	66,738	70,005	56,201
	50+	6,439	198	2,832	508	771	3,515	815	3,446	2,306	1,810
Male	0-1	31,146	814	20,172	3,647	4,556	23,584	3,898	16,418	17,155	14,779
	1-2	22,197	557	13,549	2,660	3,605	18,496	2,971	11,844	13,001	10,565
	2-15	180,606	4,885	105,376	19,907	30,993	139,788	21,270	105,307	96,353	79,013
	16-20	36,992	932	18,136	3,507	6,730	25,495	3,759	25,936	16,427	13,621
	21-50	27,464	980	22,398	5,454	8,474	42,500	4,478	22,052	20,169	17,321
	50+	3,471	122	2,138	319	577	3,018	840	2,632	1,890	1,314
Pregnant Women											
Female	All Ages	28,971	746	17,337	3,521	4,144	21,746	3,337	11,641	15,936	14,195

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Exhibit G-2: Trend in Demographic/Area Factors - MNCare

MNCare Families and Children	2006	2007	2008	2009
Average Demographic/Area Factor	0.742	0.741	0.742	0.749
Trend in Demographic/Area Factors		-0.2%	0.1%	1.0%

MNCare Adults without Children	2006	2007	2008	2009
Average Demographic/Area Factor	1.391	1.429	1.414	1.398
Trend in Demographic/Area Factors		2.7%	-1.1%	-1.2%

Demographic Factors

Female		0 - 1	(L,K)	1.310
		1 - 2	(L,K)	0.391
		2 - 15	(L,K)	0.372
		16 - 20	(L,K)	0.687
Male		0 - 1	(L,K)	1.693
		1 - 2	(L,K)	0.596
		2 - 15	(L,K)	0.412
		16 - 20	(L,K)	0.546
Female Pregnant Women			(I,K)	3.165
Female	Parent >215%	21 - 49	(F,J)	1.041
	Parent <215%	21 - 49	(F,J)	1.087
	(M1,M2)	21 - 49	(B)	1.321
	TM (MC)	21 - 49	(G)	1.619
	(M3)	21 - 49	(B)	1.321
	Parent >215%	50 - 64	(F,J)	1.382
	Parent <215%	50 - 64	(F,J)	1.444
	(M1,M2)	50 - 64	(B)	1.755
	TM (MC)	50 - 64	(G)	2.151
	(M3)	50 - 64	(B)	1.755
	Parent >215%	65+	(F,J)	1.382
	Parent <215%	65+	(F,J)	1.444
	(M1,M2)	65+	(B)	1.755
	TM (MC)	65+	(G)	2.151
	(M3)	65+	(B)	1.755
Male	Parent >215%	21 - 49	(F,J)	0.794
	Parent <215%	21 - 49	(F,J)	0.829
	(M1,M2)	21 - 49	(B)	1.008
	TM (MC)	21 - 49	(G)	1.236
	(M3)	21 - 49	(B)	1.008
	Parent >215%	50 - 64	(F,J)	1.280
	Parent <215%	50 - 64	(F,J)	1.337
	(M1,M2)	50 - 64	(B)	1.626
	TM (MC)	50 - 64	(G)	1.992
	(M3)	50 - 64	(B)	1.626
	Parent >215%	65+	(F,J)	1.280
	Parent <215%	65+	(F,J)	1.337
	(M1,M2)	65+	(B)	1.626
	TM (MC)	65+	(G)	1.992
	(M3)	65+	(B)	1.626

Area Factors

Metro	1.026
Non-Metro	0.981

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Exhibit G-2: Trend in Demographic/Area Factors - MNCare

Rate Cell Relativities

				Metro	Non-Metro
Female		0 - 1	(L,K)	1.344	1.284
		1 - 2	(L,K)	0.401	0.383
		2 - 15	(L,K)	0.382	0.365
		16 - 20	(L,K)	0.705	0.674
Male		0 - 1	(L,K)	1.737	1.660
		1 - 2	(L,K)	0.611	0.584
		2 - 15	(L,K)	0.423	0.404
		16 - 20	(L,K)	0.561	0.536
Female Pregnant Women			(I,K)	3.248	3.104
Female	Parent >215%	21 - 49	(F,J)	1.068	1.020
	Parent <215%	21 - 49	(F,J)	1.116	1.066
	(M1,M2)	21 - 49	(B)	1.356	1.296
	TM (MC)	21 - 49	(G)	1.662	1.588
	(M3)	21 - 49	(B)	1.356	1.296
	Parent >215%	50 - 64	(F,J)	1.419	1.355
	Parent <215%	50 - 64	(F,J)	1.482	1.416
	(M1,M2)	50 - 64	(B)	1.801	1.721
	TM (MC)	50 - 64	(G)	2.207	2.109
	(M3)	50 - 64	(B)	1.801	1.721
	Parent >215%	65+	(F,J)	1.419	1.355
	Parent <215%	65+	(F,J)	1.482	1.416
	(M1,M2)	65+	(B)	1.801	1.721
	TM (MC)	65+	(G)	2.207	2.109
	(M3)	65+	(B)	1.801	1.721
Male	Parent >215%	21 - 49	(F,J)	0.815	0.779
	Parent <215%	21 - 49	(F,J)	0.851	0.813
	(M1,M2)	21 - 49	(B)	1.035	0.989
	TM (MC)	21 - 49	(G)	1.268	1.212
	(M3)	21 - 49	(B)	1.035	0.989
	Parent >215%	50 - 64	(F,J)	1.314	1.255
	Parent <215%	50 - 64	(F,J)	1.372	1.311
	(M1,M2)	50 - 64	(B)	1.668	1.594
	TM (MC)	50 - 64	(G)	2.044	1.953
	(M3)	50 - 64	(B)	1.668	1.594
	Parent >215%	65+	(F,J)	1.314	1.255
	Parent <215%	65+	(F,J)	1.372	1.311
	(M1,M2)	65+	(B)	1.668	1.594
	TM (MC)	65+	(G)	2.044	1.953
	(M3)	65+	(B)	1.668	1.594

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Exhibit G-2: Trend in Demographic/Area Factors - MNCare

2006 Enrollment

				Metro	Non-Metro
Female		0 - 1	(L,K)	4,265	6,276
		1 - 2	(L,K)	4,252	6,238
		2 - 15	(L,K)	66,872	113,834
		16 - 20	(L,K)	23,226	44,700
Male		0 - 1	(L,K)	4,824	6,779
		1 - 2	(L,K)	4,313	6,351
		2 - 15	(L,K)	68,191	118,305
		16 - 20	(L,K)	22,944	43,480
Female Pregnant Women			(I,K)	4,804	7,133
Female	Parent >215%	21 - 49	(F,J)	13,806	29,142
	Parent <215%	21 - 49	(F,J)	56,651	99,261
	(M1,M2)	21 - 49	(B)	17,586	22,507
	TM (MC)	21 - 49	(G)	1,287	1,873
	(M3)	21 - 49	(B)	19,628	32,214
	Parent >215%	50 - 64	(F,J)	1,798	3,758
	Parent <215%	50 - 64	(F,J)	6,752	11,032
	(M1,M2)	50 - 64	(B)	8,200	13,393
	TM (MC)	50 - 64	(G)	365	623
	(M3)	50 - 64	(B)	13,711	32,768
	Parent >215%	65+	(F,J)	14	2
	Parent <215%	65+	(F,J)	21	2
	(M1,M2)	65+	(B)	240	133
	TM (MC)	65+	(G)	0	0
	(M3)	65+	(B)	121	166
Male	Parent >215%	21 - 49	(F,J)	6,899	18,541
	Parent <215%	21 - 49	(F,J)	31,047	65,153
	(M1,M2)	21 - 49	(B)	18,845	20,943
	TM (MC)	21 - 49	(G)	1,881	2,381
	(M3)	21 - 49	(B)	13,745	21,023
	Parent >215%	50 - 64	(F,J)	1,412	4,230
	Parent <215%	50 - 64	(F,J)	6,805	12,160
	(M1,M2)	50 - 64	(B)	5,744	9,921
	TM (MC)	50 - 64	(G)	439	601
	(M3)	50 - 64	(B)	7,415	16,781
	Parent >215%	65+	(F,J)	11	0
	Parent <215%	65+	(F,J)	30	14
	(M1,M2)	65+	(B)	193	64
	TM (MC)	65+	(G)	0	0
	(M3)	65+	(B)	183	128

2007 Enrollment

				Metro	Non-Metro
Female		0 - 1	(L,K)	3,706	5,618
		1 - 2	(L,K)	3,402	4,832
		2 - 15	(L,K)	55,788	95,649
		16 - 20	(L,K)	19,931	36,757
Male		0 - 1	(L,K)	4,151	5,947
		1 - 2	(L,K)	3,863	5,348
		2 - 15	(L,K)	57,007	99,537
		16 - 20	(L,K)	19,374	36,498
Female Pregnant Women			(I,K)	3,535	5,439
Female	Parent >215%	21 - 49	(F,J)	11,396	23,220
	Parent <215%	21 - 49	(F,J)	46,605	81,833
	(M1,M2)	21 - 49	(B)	17,001	23,319
	TM (MC)	21 - 49	(G)	16,399	17,162
	(M3)	21 - 49	(B)	16,269	29,412
	Parent >215%	50 - 64	(F,J)	1,690	3,432
	Parent <215%	50 - 64	(F,J)	6,236	10,371
	(M1,M2)	50 - 64	(B)	8,553	15,533
	TM (MC)	50 - 64	(G)	4,895	5,529
	(M3)	50 - 64	(B)	12,965	31,446
	Parent >215%	65+	(F,J)	1	6
	Parent <215%	65+	(F,J)	10	11
	(M1,M2)	65+	(B)	261	118
	TM (MC)	65+	(G)	2	0
	(M3)	65+	(B)	99	153
Male	Parent >215%	21 - 49	(F,J)	5,096	14,248
	Parent <215%	21 - 49	(F,J)	25,291	54,240
	(M1,M2)	21 - 49	(B)	19,267	23,753
	TM (MC)	21 - 49	(G)	25,300	25,615
	(M3)	21 - 49	(B)	11,534	19,020
	Parent >215%	50 - 64	(F,J)	1,451	3,257
	Parent <215%	50 - 64	(F,J)	6,083	11,098
	(M1,M2)	50 - 64	(B)	6,406	11,962
	TM (MC)	50 - 64	(G)	5,307	5,485
	(M3)	50 - 64	(B)	7,068	16,342
	Parent >215%	65+	(F,J)	10	11
	Parent <215%	65+	(F,J)	45	6
	(M1,M2)	65+	(B)	222	56
	TM (MC)	65+	(G)	0	0
	(M3)	65+	(B)	144	101

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Exhibit G-2: Trend in Demographic/Area Factors - MNCare

2008 Enrollment

				Metro	Non-Metro
Female		0 - 1	(L,K)	3,289	3,969
		1 - 2	(L,K)	3,018	4,525
		2 - 15	(L,K)	51,903	87,752
		16 - 20	(L,K)	19,081	34,280
Male		0 - 1	(L,K)	3,111	4,872
		1 - 2	(L,K)	3,320	4,720
		2 - 15	(L,K)	54,149	90,891
		16 - 20	(L,K)	19,008	34,387
Female Pregnant Women			(I,K)	3,122	5,021
Female	Parent >215%	21 - 49	(F,J)	10,790	21,943
	Parent <215%	21 - 49	(F,J)	44,321	75,316
	(M1,M2)	21 - 49	(B)	38,637	61,193
	TM (MC)	21 - 49	(G)	15,643	15,237
	(M3)	21 - 49	(B)	0	0
	Parent >215%	50 - 64	(F,J)	1,759	3,631
	Parent <215%	50 - 64	(F,J)	6,480	10,297
	(M1,M2)	50 - 64	(B)	25,745	53,086
	TM (MC)	50 - 64	(G)	4,969	4,205
	(M3)	50 - 64	(B)	0	0
	Parent >215%	65+	(F,J)	0	0
	Parent <215%	65+	(F,J)	7	16
	(M1,M2)	65+	(B)	265	265
	TM (MC)	65+	(G)	3	0
	(M3)	65+	(B)	0	0
Male	Parent >215%	21 - 49	(F,J)	4,750	13,175
	Parent <215%	21 - 49	(F,J)	24,023	50,897
	(M1,M2)	21 - 49	(B)	39,756	54,138
	TM (MC)	21 - 49	(G)	24,460	23,361
	(M3)	21 - 49	(B)	0	0
	Parent >215%	50 - 64	(F,J)	1,421	3,462
	Parent <215%	50 - 64	(F,J)	6,296	10,785
	(M1,M2)	50 - 64	(B)	16,938	33,898
	TM (MC)	50 - 64	(G)	4,979	4,464
	(M3)	50 - 64	(B)	0	0
	Parent >215%	65+	(F,J)	0	5
	Parent <215%	65+	(F,J)	31	6
	(M1,M2)	65+	(B)	267	122
	TM (MC)	65+	(G)	9	7
	(M3)	65+	(B)	0	0

2009 Enrollment

				Metro	Non-Metro
Female		0 - 1	(L,K)	2,334	3,740
		1 - 2	(L,K)	2,708	3,373
		2 - 15	(L,K)	50,041	83,036
		16 - 20	(L,K)	19,329	32,817
Male		0 - 1	(L,K)	2,833	4,317
		1 - 2	(L,K)	2,621	4,178
		2 - 15	(L,K)	52,628	85,230
		16 - 20	(L,K)	18,994	32,627
Female Pregnant Women			(I,K)	2,684	4,581
Female	Parent >215%	21 - 49	(F,J)	4,689	7,692
	Parent <215%	21 - 49	(F,J)	52,247	85,887
	(M1,M2)	21 - 49	(B)	49,491	71,751
	TM (MC)	21 - 49	(G)	14,761	14,946
	(M3)	21 - 49	(B)	0	0
	Parent >215%	50 - 64	(F,J)	887	1,694
	Parent <215%	50 - 64	(F,J)	8,411	12,796
	(M1,M2)	50 - 64	(B)	33,462	61,222
	TM (MC)	50 - 64	(G)	4,217	4,096
	(M3)	50 - 64	(B)	0	0
	Parent >215%	65+	(F,J)	0	0
	Parent <215%	65+	(F,J)	0	0
	(M1,M2)	65+	(B)	0	0
	TM (MC)	65+	(G)	0	0
	(M3)	65+	(B)	0	0
Male	Parent >215%	21 - 49	(F,J)	1,870	4,223
	Parent <215%	21 - 49	(F,J)	28,284	57,703
	(M1,M2)	21 - 49	(B)	55,857	68,507
	TM (MC)	21 - 49	(G)	27,101	26,841
	(M3)	21 - 49	(B)	0	0
	Parent >215%	50 - 64	(F,J)	656	1,452
	Parent <215%	50 - 64	(F,J)	7,914	12,811
	(M1,M2)	50 - 64	(B)	22,821	40,697
	TM (MC)	50 - 64	(G)	4,693	4,689
	(M3)	50 - 64	(B)	0	0
	Parent >215%	65+	(F,J)	0	0
	Parent <215%	65+	(F,J)	0	0
	(M1,M2)	65+	(B)	0	0
	TM (MC)	65+	(G)	0	0
	(M3)	65+	(B)	0	0

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Exhibit H : Administrative Expense Calculation

Step 1: Allocate PMAP Admin

	MSC+			
	Basic Care	Other Medicaid	PMAP < 65	Total
Revenue	$ 96,264,578	$ 67,278,462	$1,531,173,960	$1,694,717,000 *
Administrative Margin	6.35%	3.07%	9.23%	
Administration	$ 6,115,678	$ 2,067,840	$141,377,520	$149,561,038 **
Member Months	136,025		3,715,270	
Admin PMPM	$ 44.96		$ 38.05	

*From 2009 MCO Minnesota Supplement Report #1

**From 2009 MCO Minnesota Supplement Report #1 with an adjustment for one plan

Step 2: Allocate MSHO Admin

	Basic Care	Other Medicaid	Medicare	Total
Revenue	$ 272,926,843	$ 262,258,603	$585,043,554	$1,120,229,000 *
Premium Tax (1% of Medicaid Revenue)***	$2,504,001	$2,289,708		$4,793,709
Revenue Exc. Premium Tax	$ 270,422,842	$259,968,894	$585,043,554	$1,115,435,291
Premium Tax	$2,504,001	$2,289,708		$4,793,709
Admin. Expenses Excl. Premium Tax	$14,835,012	$7,261,854	$38,027,831	$60,124,697
Administrative Expenses	$17,339,013	$9,551,563	$38,027,831	$64,918,407 **
Administrative Margin	6.35%	3.64%	6.50%	5.80%
Member Months	443,504			
Admin PMPM	$39.10			

*From 2009 MCO Minnesota Supplement Report #1

**From 2009 MCO Minnesota Supplement Report #1 with an adjustment for one plan

***Does not apply to County-Based plans

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Appendix P
Rate Setting Report
PMAP and MinnesotaCare - September 2011 Capitation Rate Adjustment
Preferred Integrated Networks (PINs)

Milliman

8500 Normandale Lake Blvd.
Suite 1850
Minneapolis, MN 55437
USA

Tel +1 952 897 5300
Fax +1 952 897 5301

milliman.com

August 18, 2011

Mr. R. Jason Wiley
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55101-2208

Re: September 2011 Rate Adjustments – Kids PINs

Dear Jason:

Recently, the State of Minnesota legislated a 2.82% reduction to capitation rates paid to managed care organizations to provide medical assistance for families and children (PMAP). The reduction is to be effective September 1, 2011.

You requested that I revise the capitation rates provided in my letter dated December 6, 2011 to reflect this change. Exhibit A to this letter contains the revised rates. Because my earlier letter contains important information regarding the development of the 2011 rates, this letter should be considered a follow up to that one and should not be distributed separately from it.

I also considered the continued actuarial soundness of these rates. In particular, I considered that the original rates included a margin of 1.18%. I also considered that subsequent analysis indicates that recent trend rates have been lower than assumed in the original analysis. Finally, I considered that the legislature has also made changes to the eligibility criteria for PCA services to include recipients who have a dependency in one activity of daily living or Level I behavior, which will increase costs, but for which no rate adjustment is planned. After considering all of these changes together, I anticipate that the average rate paid in 2011 will continue to be actuarially sound even with the 2.82% reduction.

In performing this analysis, I have relied on data and other information provided to me by DHS and the MCOs regarding the legislated changes and 2010 experience. I also continue to rely on data and other information provided to me by DHS, as described in my December 6, 2010 letter. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

I have performed a limited review of the data used directly in my analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the

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data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Differences between estimates and actual amounts depend on the extent to which experience conforms to the assumptions made for this analysis. It is almost certain that actual experience does not conform exactly to the assumptions used in this analysis.

❖❖❖

Jason, I am available for questions by phone at (952) 820-2481 and by e-mail at leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal & Consulting Actuary

LMW/mtf

This material assumes that the reader is familiar with MN Medicaid programs, their eligibility rules, rating approaches and other factors. The material was prepared solely to provide assistance to DHS to set capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Milliman

Mr. Jason Wiley
August 18, 2011

Exhibit A: PINs PMPM Plan Payment Calculation for Rates Effective September 1, 2011 through December 31, 2011

Area and Age Group	Base Rate (a)	Ratable Reductions (b)	Adjusted Base Rate (c)=(a)-(b)	Medical Education Carve Out (d)	2011 Rates Excl. Med. Educ. and RR (e)=(c)-(d)	TCM Component (f)	TCM Withhold (g)=(f)*.095	Base Rate less TCM Add-On (h)=(e)-(f)	Base Rate Withhold (i)=(h)*.095	Withhold (j)=(g)+(i)	2011 Rates Excl. Withhold (k)=(h)-(j)+(d)	2011 Rates less MERC less Withhold (l)=(k)-(d)
Dakota County												
1-5	$4,577.33	$1.17	$4,576.16	$91.52	$4,484.64	$576.66	$54.78	$3,907.98	$371.26	$426.04	$3,573.46	$3,481.94
6-12	$2,933.31	$0.69	$2,932.63	$58.65	$2,873.97	$576.66	$54.78	$2,297.31	$218.24	$273.03	$2,082.94	$2,024.29
13-17	$2,506.64	$0.56	$2,506.08	$50.12	$2,455.95	$576.66	$54.78	$1,879.29	$178.53	$233.32	$1,696.10	$1,645.98

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Appendix Q
Rate Setting Report
MSHO and MSC+ - Capitation Rate Adjustment

Milliman

8500 Normandale Lake Blvd.
Suite 1850
Minneapolis, MN 55437
USA

Tel +1 952 897 5300
Fax +1 952 897 5301

milliman.com

December 17, 2010

Ms. Pam Parker
Manager, Special Needs Purchasing
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55101-2208

Re: 2011 Capitation Payment Rate Adjustments – Seniors Acute Care Services

Dear Pam:

This letter contains rate adjustments to be applied to fourth quarter 2010 rates for senior acute care services. "Seniors" includes both the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs. Capitation payment rates in 2011 will be derived by applying adjustment factors to the rates in effect as of the fourth quarter of 2010. New adjustments will be made for (1) cost and utilization trend, (2) changes to the State's surplus target, and (3) policy decisions and legislated changes to benefits and reimbursement levels. In addition, an adjustment will be applied to complete the phase-in of rate cell relativity changes that were developed in 2009.

The letter is divided into several sections, including:

- An introduction;
- Trend and Surplus Adjustments; and
- Adjustments for policy decisions and legislated 2011 benefit and reimbursement changes.

The purpose of this analysis is to assist the Minnesota Department of Human Services (DHS) with setting payment rates for contracting health plans for these programs. The results may not be appropriate for other purposes. These results are intended only for use by DHS and CMS, the federal agency that must approve these capitation rates. This analysis should be considered preliminary until the resulting capitation rates are approved by DHS and CMS. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This letter should be reviewed only in its entirety. It assumes the reader is familiar with Minnesota's Medicaid programs and managed care rating principles.

The results in this letter are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon specific assumptions and methods nor upon these results

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without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

Introduction

The structure, assumptions, and data used in the development of the rates are summarized below:

I. The base utilization and cost data used to determine the rate levels is actual experience for Medicaid-covered services for calendar year 2009 for the MSHO and MSC+ populations enrolled in managed care programs in Minnesota. This analysis reflects the experience of 90.0% of 2009 combined MSHO and MSC+ enrollment, excluding FirstPlan which discontinued participation this year.

II. Demographic rates vary by eligibility category, age and gender, and geographic location. Current eligibility categories include aged institutionalized and aged non-institutionalized.

III. Rate relationships by demographic rate cell were developed in 2009 and are based on actual claim experience from 2007-2008 for the aged populations enrolled in managed care programs in Minnesota. The factors developed in 2009 were partially phased in during 2010. Phase-in will be completed this year.

IV. Adjustments are made for trends in utilization and cost per service, on a combined basis. The trends are based on historical claim trends from 2006 to 2009 for public program populations enrolled in managed care programs in Minnesota and on benchmark utilization and provider payment rates for public programs including the Medicare fee-for-service program.

V. Administrative costs were projected by trending forward 2009 administrative costs. I used a trend rate of 2.0% for this purpose. (For MSHO, administrative expenses are allocated to Medicaid according to revenue and recognize that MSHO Medicare premiums are not subject to the state premium tax.) I am applying a reduction to administrative cost equal to 1% of revenue to offset the value of assumed investment income earnings.

As directed by DHS, I combined the administrative costs of PMAP, MNCare, MSC+, and MSHO, exclusive of care coordination costs for seniors not enrolled in the Elderly Waiver

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program, for the purpose of testing projected administrative expenses in 2011 against Minnesota's statutory limit of 8.2% of revenue. This testing requires estimates of cost and revenue levels in 2011. If treated individually, not all programs would be projected to achieve an administrative cost level as low as 8.2% of revenue.

VI. The load for the 2011 contribution to surplus in this analysis is 1.0%, before investment income. For this analysis, I have assumed that investment income will be 1.0% of revenue based on my review of the investment income and capital gains/losses reported on the plans' financial statements. This adjustment and the adjustment to administrative costs mentioned above offset each other.

Data Reliance

In performing this analysis, I have relied on data and other information provided to me by DHS and the plans with which it contracts, including:

- Various Enrollment and Capitation reports from DHS that provide detail by rate cell for each health plan and area;
- Copies of the Minnesota State Supplement Report #1, Statement of Revenue, Expenses and Net Income for each health plan, as submitted to the State of Minnesota;
- Restated net hospital and medical expenses for Medicaid-covered services provided by the health plans, based on more recent run-out, along with an actuarial certification that the values were prepared on a "best-estimate" basis.;
- Certifications, provided by the health plans, certifying the percentage of expenses that were for non-State Plan services; and
- Miscellaneous data and information provided by DHS and the health plans.

I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

I have performed a limited review of the data used directly in my analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Variability

Differences between estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is almost certain that actual experience will

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not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience is different than expected. Accordingly, DHS should continue to carefully monitor actual experience and make adjustments as necessary.

Trend & Surplus Adjustments

The trend and surplus adjustments I have developed are based on the historical financial results of the health plans that participate in the MSHO and MSC+ programs, supplemented by other data and information. The trends and rate adjustments are intended to provide rate levels that result in a targeted contribution to surplus as a percentage of income before investment income for the health plans in aggregate, assuming prudent management. For this analysis, we have included a surplus adjustment of 1.0%. In choosing this adjustment I considered, among other things, the ability of the plans to absorb recently legislated capitation rate reductions and to achieve performance targets set by the state for which they bear financial risk. This figure takes into account that we have explicitly recognized the value of investment income.

Exhibit A provides a summary of the development of the rate increase (8.29%). Exhibits B and C describe the development of the claim cost trend figures. Exhibit D describes the impact of benefit changes. Exhibit E describes the calculation of 2010 revenue. Exhibit F describes the development of the trend in demographic and area factors. Exhibit G shows the development of estimated administrative costs. The exhibits are discussed below.

Exhibit A (Rate Increase for 2011 Rates)

The 2009 Medicaid-covered MSHO and MSC claim cost in line (a) was developed from claim data provided by the plans and enrollment data provided by DHS. They have been adjusted to remove non-State Plan services as provided by the health plans. The plans were asked to provide estimated incurred claims on a "best estimate" basis, meaning the values do not include any margin for adverse deviation.

The annual claim cost trend rate on line (d) is a 50/50 blend of a Benchmark Trend Rate (Exhibit B) and an Experience-based Trend Rate (Exhibit C).

The development of the average 2009 administrative cost per member per month in row (f) is shown in Exhibit G.

The administrative trend is 2.0%.

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The impact of legislated benefit and reimbursement changes occurring in 2009 and 2010 is shown in row (m). This adjustment is applied to restate calendar year 2009 cost levels to reflect these changes. Additional detail is included in Exhibit D.

The load for the 2011 contribution to surplus in this analysis is 1.0% before investment income.

The projected 2011 revenue requirement is calculated in row (q) and compared to the average fourth quarter 2010 rate in row (r). Average revenue is calculated using the 2009 membership distribution of the plans whose claim data is included in row (a). The calculation of 2010 revenue is described on Exhibit E. A rate increase is calculated in row (s) as the ratio of the 2011 required revenue to the average fourth quarter 2010 rate minus one.

Exhibit B (Benchmark Trend Rate)

The benchmark trend rate shown in Exhibit A is developed by applying benchmark trend rates for various service categories to plan data as shown in Exhibit B. The claim costs shown by benefit category were developed using the data provided by the plans.

The benchmark trend rates are intended to reflect trend rates I believe are achievable by MCOs that successfully apply aggressive and effective medical management and contracting strategies and tactics.

The benchmark trend rates for Medicare cost-sharing are based on Milliman research regarding trends in Medicare cost-sharing for 2009 and projected trends for 2011, including the effect of published increases in the Part A and Part B deductibles. The Part A cost-sharing trend of 2.91% is based on the increase in the deductible for 2011. Part B cost-sharing is primarily hospital outpatient and physician cost-sharing. The Part B cost-sharing trend of 6.25% considers benchmark trend rates of 7.52% for hospital outpatient services and 4.81% for physician services.

The trend rate for Non-Medicare-covered drugs is based primarily on Milliman estimates of generic drug trends, as most non-Medicare-covered drugs are generics.

Exhibit C (Experience-Based Trend Rate)

The Experience-Based trend rate shown in Exhibit A is developed based on a weighted average of health plan trends over the last three years, backing out trend due to changes in demographic and area mix and the impact of benefit changes.

The average claim costs and demographic and area factors shown for 2006-2007, 2007-2008, and 2008-2009 were developed using the plan data described above. The impact of benefit changes is

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described in Exhibit D. The development of the trend in demographic and area factors is described in Exhibit F.

I understand that the state intends to implement a new Medicaid fee-for-service fee schedule in the near future. The change is intended to be revenue neutral with respect to the cost of the state's remaining fee-for-service Medicaid program. I have assumed for this analysis that the change will also be revenue neutral for managed care. The actual impact on managed care costs will depend on the specific changes being implemented (which are not yet available to me) and the extent to which the MCOs' contractual payment rates are linked to the Minnesota FFS fee schedule.

Exhibit D (Impact of Benefit and Reimbursement Changes)

The aggregate impact of benefit changes on claim cost in each year is calculated as the revenue weighted average of the adjustment factors for each group of rate cells (e.g., institutionalized and non-institutionalized by gender). The adjustment factors were developed in my letters regarding benefit changes for this and prior years.

Ratable reductions effective for payment rates beginning September 2010 are also included. These adjustments are described in my August 6, 2010 letter regarding Rate Adjustments for the September Amendment. I have considered the MCOs' ability to absorb these reductions in choosing the surplus margin described above.

Exhibit E (2010 Revenue)

The 2010 revenue shown on Exhibit A is calculated as the weighted average capitation rate among enrollees whose data is reflected in the average 2009 claim cost in Exhibit A. The calculation of 2010 revenue is shown on Exhibit E.

The fourth quarter 2010 capitation rates used for this calculation have been adjusted to reflect that the MCOs receive the MERC amount for MSHO enrollees (except Non-MC MSHO enrollees). I understand that the MERC amount received by the plans for these dual-eligible MSHO enrollees is subject to ratable reductions, whereas MERC carve-outs are not subject to ratable reductions.

Exhibit F (Trend in Demographic/Area Factors)

Exhibit F describes the development of the trend in demographic and area factors shown on Exhibit C. The demographic and area factors are first shown separately and then together for each rate cell/area combination as "rate cell relativities". Enrollment is shown for each year. For each year, the average demographic/area factor is the enrollment-weighted average rate cell relativity.

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Exhibit G (Administrative Expense Calculation)

Exhibit G displays the administrative costs calculation. The 2009 administrative cost was calculated using the premium revenues and administrative expenses from the MCO's 2009 Minnesota Supplement Reports, as well as 2009 care coordination expenses for non-EW enrollees.

Administrative costs are estimated separately for MSHO and MSC+ and then averaged together. For MSHO, there are three components used in the calculation of administrative expenses: (1) MSHO Basic Care, (2) Other Medicaid (including certain Elderly Waiver, Nursing Facility Add-On, and Special Needs Basic Care services) and (3) Medicare. Medicare revenue is calculated as the total 2009 MSHO revenue from the supplemental reports less Basic Care and other Medicaid revenue, as provided by DHS.

Next, revenue for the Medicaid components is adjusted to account for the 1% premium tax (except on county-based plans). Administrative expenses excluding premium tax are then calculated for each component, using an administrative margin of 6.50% for Medicare and 3.64% for other Medicaid (the average for those programs). The resulting administrative expenses excluding premium tax for those components are then subtracted from the total administrative expenses excluding premium tax to calculate the Basic Care administrative expenses excluding premium tax. I then added the premium tax to get total administrative expenses for MSHO Basic Care. Last, I divide the MSHO Basic Care administrative expenses including premium tax by the 2009 MSHO member months which results in $39.10 PMPM.

To calculate administrative costs for MSC+, I multiplied 2009 MSC+ Basic Care revenue by the administrative margin (administrated expenses/revenue) calculated for MSHO Basic Care. I divided the resulting administrative costs by the 2009 member months which results in $44.96 PMPM.

Finally, I combined MSHO Basic Care and MSC+ Basic Care administrative expenses using their 2009 member months as weights. I then added estimated expenditures for care coordination which were included as claim cost in the 2009 Minnesota Supplement Report#1, but not in the source data used for this analysis. This results in $60.02 PMPM which is seen on Exhibit A.

Policy Decisions and Legislated 2011 Benefit and Reimbursement Changes

I developed rate adjustments to account for several benefit and reimbursement changes scheduled to be implemented in 2011, as described below.

Varicella Vaccine for Adults
Currently, varicella (chicken pox) vaccine is a managed care covered service for children up to age 18, while adults aged 19 and up are covered on a fee-for-service basis. DHS has decided to begin

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covering the vaccine for adults under the managed care program in 2011.

DHS provided 2009 fee-for-service utilization data for managed care enrollees. I allocated the utilization across the impacted adult populations (including PMAP, MNCare, Seniors, PGAMC, and SNBC). I assumed no change in utilization rates for 2011. Based on a 2009 cost per dose of $83.16 (based on DHS serum and administration costs of $81.66 and $1.50, respectively) trended forward two years at the blended annual trend rates used for rate development, the projected cost of providing these vaccinations is $0.02 PMPM. I divided by projected 2011 claim cost to arrive at a January rate adjustment factor that is not significant to four decimal places.

Increase in Dental Rates

Effective January 1, 2011 for managed care, state operated (SOS) dental clinics are to be paid using a cost-based payment system based on Medicare cost-finding methods and allowable costs. I understand there are currently five such clinics. I used the fiscal note provided by DHS to develop a rate adjustment.

The fiscal note estimates a payment increase of $365,190 to state operated clinics in FY2009 dollars. This $365,190 includes adjustments for a 25% service reduction and an increase related to critical access dental eligibility. I trended the FY09 cost to CY11 at an annual rate of 5%, the trend rate assumed for the fiscal note. Across PMAP, MNCare, PGAMC, and Seniors, the projected CY11 cost increase amounts to $0.07 PMPM. I divided by projected 2011 claim cost to arrive at the adjustment factor shown in Table 1.

Table 1: Adjustment Factor for State Operated Dental Clinics

Program	Affected Rate Cells	Adjustment Factor
Seniors	All	1.0001

Ratable Reductions

DHS is applying "ratable reductions" to reduce payments to the MCOs for inpatient services. These reductions were originally effective January 1, 2009 and have changed in magnitude at various times since that date. The amount of these reductions is again scheduled to change on January 1, 2011. My rate analysis assumes that the MCOs will be able to absorb the reduction in capitation rates by some combination of decreasing their payments to providers and other means such as reductions in utilization. For seniors, this adjustment does not apply to dual eligibles, since Medicaid's liability is limited to Medicare cost sharing.

A 1.5% ratable reduction implemented in October 2009 for certain "Basic Care" services is scheduled to sunset on June 30, 2011. October 2009 rates were subject to adjustment factors of

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0.9976 for duals and 0.9875 for non-duals rate cells (excluding PCA/HH reductions applied to non-institutionalized rate cells). These rate reductions included the impact of several ratable reductions. Of these reductions (excluding PCA/HH adjustments) approximately 10-20% was for the ratable reductions scheduled to sunset. I recalculated the adjustment factors assuming the 1.5% ratable reduction was not included. I compared these recalculated factors to the factors that were actually applied in October 2009 to develop the adjustment factors shown in Table 2, taking into account that the rate increase applies for the second half of the year.

Table 2: Adjustment Factors for July Sunset of 1.5% Ratable Reduction

Program	Affected Rate Cells	Adjustment Factor
Seniors	Institutionalized Duals	1.0003
	Institutionalized Non-Duals	1.0007
	Non-Institutionalized Duals	1.0003
	Non-Institutionalized Non-Duals	1.0007

Health Care Home

Health Care Home payments were required beginning the second half of calendar year 2010. An adjustment was included in 2010 rates to reflect increased cost to the MCOs. For 2011 rates, I developed an adjustment that recognizes more current cost and utilization assumptions provided by DHS. The adjustment factors in this letter are intended to replace the prior factors.

Table 3 shows the projected enrollment distribution by Health Care Home Tier, based on information provided by DHS.

Table 3: Projected Enrollment Distribution

Tier	Enrollment Distribution
0	20.6%
1	8.9%
2	24.1%
3	26.4%
4	20.0%
Total	100.0%

Table 4 shows projected average Health Care Home payments PMPM for enrollees projected to receive services, as provided to me by DHS. These averages include a 15% add-on for enrollees who have a primary language other than English or a serious and persistent mental illness.

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Payments for Tier 3 and 4 MSHO dual eligibles are projected at 50% of the rate for other seniors due to the involvement of Medicare's care coordination function.

Table 4: Projected Average Health Care Home Payments PMPM

Tier	MSHO Duals	All Other Seniors
0	$0.00	$0.00
1	$10.47	$10.47
2	$21.00	$21.00
3	$21.06	$42.12
4	$31.64	$63.27

I calculated the weighted average projected payment PMPM for each population and divided by projected calendar year 2011 claim cost to arrive at the factors shown in Table 5, assuming 1.5 months of payments on average per eligible. The 1.5 months of payments was chosen by DHS. This weighted average, assuming 1.5 months of coverage, is $3.72 PMPM for MSHO duals and $2.23 PMPM for all other seniors.

Table 5: Adjustment Factors for Health Care Home (To Replace the Factors Applied for 2010 Rates)

Program	Affected Rate Cells	Adjustment Factor
Seniors	Institutionalized Duals	1.0077
	Non-Institutionalized Duals	1.0037
	Institutionalized Non-Duals	1.0022
	Non-Institutionalized Non-Duals	1.0018

PCA Trend Adjustment

Information provided by the MCOs indicates that PCA trends have been running higher than the average for all covered services. Our benchmark trend rate for PCA services is also higher than the average benchmark trend rate for all services. Additional information regarding the distribution of PCA services among enrollees in non-institutionalized rate cells ("community enrollees") indicates that PCA accounts for a much greater portion of plan cost in Metro rate cells, compared to all other rate cells. I developed an adjustment to Basic Care rates to recognize the relatively high PCA trend rates and the disproportionate impact on Metro rate cells.

To develop this adjustment, I began with the projected 2011 claim cost used for rate development and backed out administrative, investment income, and surplus margins. I applied two years of

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negative trend and the average rate cell factors to arrive at an estimate of 2009 claim cost (at the 2011 benefit level) for (1) institutionalized, (2) community Metro, and (3) community non-Metro rate cells. I next assumed that in 2009 PCA services accounted for 50% of Metro claim cost and 15% of non-Metro claim cost. These figures are consistent with data provided by the MCOs.

Using these 2009 estimates, I then separately projected 2011 claim cost for each population, assuming a 12% annual PCA trend rate from 2009 to 2011. The 12% figure was selected by taking into consideration recent trends in PCA cost using recent data (through 2009) provided by the MCOs as well as our benchmark trend rates. The implied annual trend rate on all other services is 4.01%. (The annual trend rate for all services is unchanged by this adjustment.) I then compared these revised projections to the baseline projection, which used 6.51% on all services, to develop the adjustment factors shown in Table 6.

Table 6: PCA Trend Adjustment Factors

Program	Affected Rate Cells	Adjustment Factor
Seniors	Institutionalized	0.9535
	Community Metro	1.0296
	Community Non-Metro	0.9763

I also reviewed the adjustment applied in October 2009 and revised in January 2010 for the 275 hour limit and activities of daily living (ADL) changes to determine the impact of recognizing regional variations in PCA usage. As of January 2010, a reduction of 2.03% was applied to the community rate cells. This 2.03% implicitly assumed a uniform distribution of PCA services among these rate cells. The adjustments shown in Table 7 recognize the variation in PCA usage. These adjustments are revenue neutral to DHS with respect to the projected 2011 distribution of PCA cost. (Based on the analysis and assumptions described above, PCA is projected to account for 54% of claim cost in the Metro rate cells, and 17% of claim cost in the non-Metro rate cells.)

Table 7: Adjustment to October 2009/January 2010 Rate Reduction

Program	Affected Rate Cells	Adjustment Factor
Seniors	Community Metro	0.9925
	Community Non-Metro	1.0118

Taken together, the factors in Table 6 and Table 7 increase community Metro rates by about 2.2%, and decrease the community non-Metro rates by about 1.2%. The corresponding reduction in institutionalized rates is about 4.6%, as shown in Table 6.

PCA ADL and Behavior Thresholds

As described above, rate adjustments were made in October 2009 and January 2010 regarding

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changes to PCA benefits. Additional changes related to ADLs and behavior thresholds are scheduled to be implemented in July 2011. DHS projects that the impact of these changes will reduce PCA claim cost by 4.175% on average for calendar year 2011, compared to cost levels before any of the recent ADL and behavior threshold changes. A rate reduction of 3.95% on PCA cost is already in effect. The additional rate reduction amounts to 0.23%. I used the PCA claim cost projections described in the section above, 54% for Metro and 17% for non-Metro, to develop the factors shown in Table 8.

Table 8: PCA ADL and Behavior Threshold Adjustment Factors

Program	Affected Rate Cells	Adjustment Factor
Seniors	Community Metro	0.9987
	Community Non-Metro	0.9996

Summary of PCA Adjustments

While I understand the adjustment factors in Tables 6-8 above will be applied separately in calculating 2011 rates, I understand you would like to see the combined impact for informational purposes. Table 9 provides a summary of the combined impact by rate cell category.

Table 9: Summary of PCA Adjustments

Program	Affected Rate Cells	Trend Adjustment (a)	Prior Rate Reduction Adjustment (b)	ADL and Behavior Adjustment (c)	Product of PCA Adjustments = (a) x (b) x (c)
Seniors	Institutionalized	0.9535	N/A	N/A	0.9535
	Community Metro	1.0296	0.9925	0.9987	1.0205
	Community Non-Metro	0.9763	1.0118	0.9996	0.9874

Chiropractic Services

A state plan amendment was approved in September 2010 which enacts coverage for an annual evaluation to users of chiropractic services, effective January 1, 2011 for managed care. I used data provided by DHS to develop an estimate of the cost of providing these evaluations.

DHS provided data regarding the number of enrollees who received chiropractic services in 2009 by institutionalized status. I assumed that each enrollee who receives chiropractic services will receive an annual evaluation at an average cost of $24.50, the same cost used in last year's analysis for similar coverage for the MNCare program. I verified that this $24.50 is consistent with current reimbursement information provided by DHS for these evaluations. On a per member per month

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basis the cost of annual evaluations is projected to be $0.02 for institutionalized enrollees and $0.15 for non-institutionalized enrollees. I divided by projected 2011 claim cost to arrive at the adjustment factors shown in Table 10.

Table 10: Adjustment Factors for Chiropractic Services

Program	Affected Rate Cells	Adjustment Factor
Seniors	Institutionalized	1.0001
	Non-Institutionalized	1.0002

PPACA Provisions

The recently enacted federal health reform legislation (PPACA) requires drug manufacturers to pay rebates to the State. As this provision is expected to reduce or eliminate rebates paid to the plans, a rate increase is necessary. We asked the plans to provide information regarding (A) the ratio of 2009 drug cost after rebates to 2009 net claim cost, (B) the ratio of 2009 rebates to 2009 drug cost before rebates, and (C) the ratio of projected 2011 rebates to 2011 drug cost before rebates. I also considered information regarding the plans' confidence in their estimate of this third item. The adjustment factors shown in Table 11 are developed as follows (referring to the labeled items above):

$$A * (1 - C) / (1 - B) + (1 - A).$$

Table 11: Adjustment Factors for Drug Rebates, Applies Only to Rate Cells Impacted by the PPACA Provision

Program	Affected Rate Cells	Adjustment Factor
Seniors	Duals	1.0003
	Non-Duals	1.0144

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Pam, I am available for questions by phone at (952) 820-2481 and by e-mail at leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal & Consulting Actuary

LMW/bc/ral

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Exhibit A: Rate Increase for 2011 Rates - Seniors

(a) 2009 Medicaid-Covered MSHO & MSC+ Claim Cost	$	579.34	
(b) Annual Trend Rate - Benchmark		5.96%	Exhibit B
(c) Annual Trend Rate - Experience		7.07%	Exhibit C
(d) Annual Trend Rate - 50/50 Blend		6.51%	= (b + c) / 2
(e) Projected 2011 Claim Cost	$	657.25	= (a) * (1 + d) ^ 2
(f) 2009 Administrative and Non-EW Care Coordination Cost	$	60.02	Exhibit G
(g) Administrative Trend Rate		2.00%	
(h) Projected 2011 Administrative Cost	$	62.45	= (f) * (1 + g) ^ 2
(i) Investment Income as a Percent of Revenue		1.00%	
(j) Admin Offset for Investment Income	$	7.27	= (e + h) * (i) / (1 - p)
(k) Net Provision for Administrative Margin	$	55.18	= (h) - (j)
(l) 2011 Claim and Administrative Cost	$	712.43	= (e) + (k)
(m) Impact of Legislated Changes after 1/1/2009		0.9532	Exhibit D
(n) Projected 2011 Claim and Administrative Cost	$	679.09	= (l) * (m)
(o) Investment Income Margin		1.00%	= (i)
(p) Surplus Margin (w/o Inv Income, incl. Withhold Adj)		1.00%	
(q) Projected 2011 Required Revenue	$	692.94	= (n) / (1 - o - p)
(r) Average 4th Qtr 2010 Payment Rate	$	639.92	Exhibit E
(s) Rate Increase for 2011 Rates		8.29%	= (q) / (r) - 1

Notes: (1) For these purposes, "projected claim costs" do not reflect expected actual cost levels. We apply an estimated claim cost trend that is independent of changes in demographic and area factors.
(2) 2010 Revenue is calculated using the 2009 membership distribution, to be consistent with the claim cost projection.
(3) All figures in dollars are per member per month.

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Exhibit B: Benchmark Trend Rate

Item	2009 Claim Cost	Benchmark Annual Trend Rate	2011 Claim Cost
Drug Costs			
Medicare cost sharing	$ -	0.00%	$ -
Non-Medicare-covered drugs	18.11	6.61%	20.58
Part C Cost Sharing			
Medicare Part A cost sharing	35.40	2.91%	37.49
Medicare Part B cost sharing	130.61	6.25%	147.44
Other Medicaid-Covered Costs			
Hospital Inpatient	10.53	4.08%	11.41
Hospital Outpatient	7.80	7.52%	9.01
Physician	14.12	4.81%	15.52
Dental	15.63	5.02%	17.24
Home Health	69.01	6.59%	78.42
Personal Care Assistants	206.68	6.59%	234.84
NF Relocation TCM and MH TCM	1.05	4.08%	1.14
All other Non-Medicare services	70.40	4.81%	77.34
Total Medicaid-Covered Costs			
Subtotal	579.34		650.41
Reinsurance recoveries	-		-
Grand Total	**$ 579.34**	**5.96%**	**$ 650.41**

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Exhibit C: Experience-Based Trend Rate

2006-2007 Trend	2006	2007
Average Demog/Area Factor	0.9449	0.9690
Trend in Demog/Area Factors		2.55%

	2006	2007
Incurred Claim Cost PMPM	$ 445.86	$ 485.28
Claim Cost Trend		8.84%
Net of Benefit/Elig Changes (Exh D)		8.66%
Also Net of Trend in D/A Factors		5.96%

2007-2008 Trend	2007	2008
Average Demog/Area Factor	0.9690	0.9852
Trend in Demog/Area Factors		1.67%

	2007	2008
Incurred Claim Cost PMPM	$ 485.28	$ 541.43
Claim Cost Trend		11.57%
Net of Benefit/Elig Changes (Exh D)		10.42%
Also Net of Trend in D/A Factors		8.61%

2008-2009 Trend	2008	2009
Average Demog/Area Factor	0.9852	0.9936
Trend in Demog/Area Factors		0.85%

	2008	2009
Incurred Claim Cost PMPM	$ 541.43	$ 579.34
Claim Cost Trend		7.00%
Net of Benefit/Elig Changes (Exh D)		7.31%
Also Net of Trend in D/A Factors		6.41%

Blended Trend	7.07%

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Exhibit D: Impact of Benefit and Reimbursement Changes

Change	Type	Assumed Effective Date	Rate Impact on Subpop.	Subpopulation Affected (Rate Cells)	% of Claims Affected	Net Impact	2006-07 Impact	2007-08 Impact	2008-09 Impact	2009-2010 Q4 Adjustment
Rate Increase for Critical Access Mental Health Providers	Reimb.	1/1/07	1.0004	All	100.00%	1.0004	1.0004	1.0000	1.0000	1.0000
Adult Mental Health Rehab Services (ARMHS & Crisis)	Benefit	1/1/07	1.0001	Inst.	18.79%	1.0012	1.0012	1.0000	1.0000	1.0000
			1.0015	Non-Inst.	81.21%					
Model Benefit Set for Mental Health Services	Benefit	1/1/08	1.0008	Inst.	17.15%	1.0027	1.0000	1.0027	1.0000	1.0000
			1.0032	Non-Inst. Female	57.62%					
			1.0030	Non-Inst. Male	25.23%					
Shingles Vaccine	Benefit	1/1/08	1.0440	Non-Medicare	14.18%	1.0062	1.0000	1.0062	1.0000	1.0000
Fee Increase for Selected Critical Access Providers	Reimb.	1/1/08	1.0001	All	100.00%	1.0001	1.0000	1.0001	1.0000	1.0000
Halfway House and Extended Care Services	Benefit	1/1/08	1.0011	Non-Inst.	82.85%	1.0009	1.0000	1.0009	1.0000	1.0000
Rate Increase for Critical Access Mental Health Providers	Reimb.	1/1/08	1.0004	All	100.00%	1.0004	1.0000	1.0004	1.0000	1.0000
Ratable Reduction for Fee-For-Service Hospitals	Reimb.	1/1/09	0.9917	Non-Medicare	14.89%	0.9988	1.0000	1.0000	0.9988	1.0000
Offset of Model Benefit Set for Mental Health Services	Benefit	1/1/09	1.0001	Non-Inst.	83.78%	1.0001	1.0000	1.0000	1.0001	1.0000
Mental Health Targeted Case Management	Benefit	7/1/09	1.0009	Inst.	16.22%	1.0029	1.0000	1.0000	1.0029	1.0000
			1.0032	Non-Inst. Female	57.57%					
			1.0037	Non-Inst. Male	26.20%					
Halfway House and Extended Care Services	Benefit	1/1/09	1.0011	Non-Inst.	83.78%	1.0009	1.0000	1.0000	1.0009	1.0000
Removal of Room and Board Costs From FS Resid CD	Reimb.	1/1/09	0.9992	All	100.00%	0.9992	1.0000	1.0000	0.9992	1.0000
Income Based Copay Limits	Reimb.	1/1/09	1.0001	All	100.00%	1.0001	1.0000	1.0000	1.0001	1.0000
October 2009 Legislative and Unallotment Changes	Reimb	10/1/09	0.9976	Inst. Medicare	15.59%	0.9805	1.0000	1.0000	0.9951	0.9853
			0.9875	Inst. Non-Medicare	0.63%					
			0.9789	Non-Inst. Medicare	69.52%					
			0.9689	Non-Inst. Non-Medicare	14.26%					
Reversal on 2009 Ratable Reduction for Fee-For-Service Hospitals	Reimb	1/1/10	1.0084	Non-Medicare	14.45%	1.0012	1.0000	1.0000	1.0000	1.0012
Ratable Reduction for Fee-For-Service Hospitals	Reimb	1/1/10	0.9943	Non-Medicare	14.45%	0.9992	1.0000	1.0000	1.0000	0.9992
Mental Health Targeted Case Management	Benefit	1/1/10	1.0009	Inst.	15.79%	1.0030	1.0000	1.0000	1.0000	1.0030
			1.0032	Non-Inst. Female	57.51%					
			1.0037	Non-Inst. Male	26.70%					
Dental Benefit	Benefit	1/1/10	0.9956	All	100.00%	0.9956	1.0000	1.0000	1.0000	0.9956
PCA Coverage and Limits	Benefit	1/1/10	0.9862	Non-Inst.	84.21%	0.9884	1.0000	1.0000	1.0000	0.9884
Health Care Home	Benefit	1/1/10	1.0008	All	100.00%	1.0008	1.0000	1.0000	1.0000	1.0008
Ratable Reduction for Non-Admin Services	Reimb	9/1/10	0.9905	Inst. Medicare	15.39%	0.9807	1.0000	1.0000	1.0000	0.9807
			0.9804	Non-Inst. Medicare	70.16%					
			0.9719	Non-Medicare	14.45%					
Reversal of Inpatient Ratable Reduction	Reimb	9/1/10	1.0058	Non-Medicare	14.45%	1.0008	1.0000	1.0000	1.0000	1.0008
Inpatient Ratable Reduction	Reimb	9/1/10	0.9941	Non-Medicare	14.45%	0.9991	1.0000	1.0000	1.0000	0.9991
Ratable Reduction for Physician & Professional Services	Reimb	10/1/10	0.9996	Inst. Medicare	15.39%	0.9982	1.0000	1.0000	1.0000	0.9982
			0.9991	Non-Inst. Medicare	70.16%					
			0.9956	Non-Medicare	14.45%					
Rate Increase for Certain Basic Care Services	Reimb	10/1/10	1.0011	Inst. Non-Medicare	0.40%	1.0000	1.0000	1.0000	1.0000	1.0000
			1.0001	Non-Inst. Non-Medicare	14.05%					
Total Impact:	Benefit and Eligibility Changes						1.0016	1.0104	0.9971	0.9532

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Exhibit E: 2010 Revenue

Rate Cell			Hennepin	Ramsey	Greater Metro	Core Metro	North East	North Central	Carver	South West	Olmsted	South East	Total
2009 Enrollment by Rate Cell													
65 - 74	F	Instit	3,012	884	359	815	457	2,281	102	1,411	298	1,735	11,354
75 - 84	F	Instit	5,233	2,177	833	2,576	1,453	6,882	229	4,791	562	5,166	29,902
85 +	F	Instit	9,262	4,334	2,062	5,054	3,956	18,295	734	14,606	1,442	14,475	74,220
All Ages - Non MC	F	Instit	172	36	34	20	27	60	2	33	-	34	418
65 - 74	M	Instit	2,389	719	267	695	316	1,872	79	1,168	182	1,401	9,088
75 - 84	M	Instit	2,276	749	401	903	545	3,469	135	2,499	240	2,494	13,711
85 +	M	Instit	1,709	634	437	952	739	4,250	115	3,303	292	3,413	15,844
All Ages - Non MC	M	Instit	122	17	12	15	12	26	-	25	-	26	255
65 - 74	F	Non-Inst	21,542	10,527	2,098	11,250	4,084	17,701	623	8,467	2,441	10,634	89,367
75 +	F	Non-Inst	24,715	12,066	4,175	14,951	6,488	34,011	1,364	18,268	4,136	22,463	142,637
All Ages - Non MC	F	Non-Inst	7,107	2,638	203	1,001	56	388	92	505	567	325	12,882
65 - 74	M	Non-Inst	12,672	5,711	1,084	4,692	2,415	11,259	184	5,199	1,611	6,023	50,850
75 +	M	Non-Inst	10,745	4,278	1,062	3,810	1,684	10,028	289	5,770	1,636	6,602	45,904
All Ages - Non MC	M	Non-Inst	5,989	2,042	51	674	40	203	45	471	402	302	10,219
Total			106,945	46,812	13,078	47,408	22,272	110,725	3,993	66,516	13,809	75,093	506,651
September 2010 Rates (Including MERC amount add-on received by MCOs for some MSHO enrollees)													
65 - 74	F	Instit	$ 607.60	$ 684.16	$ 532.32	$ 533.02	$ 347.64	$ 433.22	$ 429.40	$ 431.73	$ 403.01	$ 401.82	$ 500.06
75 - 84	F	Instit	447.76	501.42	390.18	391.35	255.81	318.49	317.46	318.13	295.96	295.57	355.21
85 +	F	Instit	327.30	364.96	284.76	285.54	186.89	232.71	231.92	232.33	216.05	215.67	251.11
All Ages - Non MC	F	Instit	2,164.27	2,540.42	1,955.56	1,955.62	1,267.95	1,581.16	1,569.53	1,572.06	1,474.81	1,466.76	1,921.78
65 - 74	M	Instit	596.74	678.01	527.33	527.66	344.54	430.52	426.77	429.06	400.31	398.48	495.31
75 - 84	M	Instit	501.29	561.94	438.05	438.69	286.46	357.24	356.53	356.38	331.52	331.45	391.94
85 +	M	Instit	424.26	474.67	369.31	370.57	242.77	302.25	300.69	301.77	279.57	280.08	320.18
All Ages - Non MC	M	Instit	2,163.91	2,540.65	1,955.29	1,955.34	1,268.12	1,577.27	1,569.57	1,564.01	1,474.76	1,466.56	1,935.05
65 - 74	F	Non-Inst	776.74	875.10	681.88	683.45	447.77	556.39	554.53	557.12	518.37	517.27	655.39
75 +	F	Non-Inst	893.52	1,007.60	784.08	785.05	513.45	639.13	637.74	638.99	595.34	594.14	719.82
All Ages - Non MC	F	Non-Inst	1,995.14	2,321.18	1,807.61	1,807.78	1,184.66	1,476.45	1,466.69	1,475.89	1,373.82	1,367.87	1,957.94
65 - 74	M	Non-Inst	725.71	818.31	638.00	639.57	419.90	521.22	519.88	521.99	485.94	484.60	608.76
75 +	M	Non-Inst	932.54	1,054.56	819.65	821.35	535.98	667.38	667.73	667.47	622.00	620.92	768.73
All Ages - Non MC	M	Non-Inst	2,020.97	2,345.28	1,832.76	1,832.39	1,205.05	1,499.94	1,491.34	1,501.14	1,395.61	1,390.77	1,989.34
Total			$ 892.49	$ 984.56	$ 642.13	$ 689.14	$ 402.07	$ 505.10	$ 529.01	$ 487.31	$ 557.62	$ 459.49	$ 639.92

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Exhibit F: Trend in Demographic/Area Factors - Seniors

2006-2007 Trend	2006	2007
Average Demographic/Area Factor	0.9449	0.9690
Trend in Demographic/Area Factors		2.55%

2007-2008 Trend	2007	2008
Average Demographic/Area Factor	0.9690	0.9852
Trend in Demographic/Area Factors		1.67%

2008-2009 Trend	2008	2009
Average Demographic/Area Factor	0.9852	0.9936
Trend in Demographic/Area Factors		0.85%

Demographic Factors

Institutionalized		
Female	65-74	0.729
	75-84	0.550
	85+	0.409
	Non-MC	2.473
Male	65-74	0.727
	75-84	0.619
	85+	0.529
	Non-MC	2.473
Non-Institutionalized		
Female	65-74	1.020
	75+	1.147
	Non-MC	2.707
Male	65-74	0.964
	75+	1.182
	Non-MC	2.844

Area Factors

Hennepin	1.157
Carver	0.897
Core Metro	1.060
Greater Metro	1.060
Northeast	0.725
Northwest	0.887
Olmsted	0.822
Ramsey	1.295
Southeast	0.822
Southwest	0.897

Rate Cell Relativities

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest
Institutionalized											
Female	65-74	0.844	0.654	0.773	0.773	0.529	0.647	0.599	0.944	0.599	0.654
	75-84	0.637	0.493	0.583	0.583	0.399	0.488	0.452	0.712	0.452	0.493
	85+	0.473	0.367	0.433	0.433	0.296	0.363	0.336	0.529	0.336	0.367
	Non-MC	2.862	2.217	2.621	2.621	1.793	2.194	2.032	3.202	2.032	2.217
Male	65-74	0.842	0.652	0.771	0.771	0.527	0.645	0.598	0.942	0.598	0.652
	75-84	0.716	0.555	0.656	0.656	0.449	0.549	0.509	0.801	0.509	0.555
	85+	0.612	0.475	0.561	0.561	0.384	0.470	0.435	0.685	0.435	0.475
	Non-MC	2.862	2.217	2.621	2.621	1.793	2.194	2.032	3.202	2.032	2.217
Non-Institutionalized											
Female	65-74	1.180	0.914	1.080	1.080	0.739	0.905	0.838	1.320	0.838	0.914
	75+	1.327	1.029	1.216	1.216	0.832	1.018	0.942	1.485	0.942	1.029
	Non-MC	3.132	2.427	2.869	2.869	1.962	2.402	2.224	3.505	2.224	2.427
Male	65-74	1.116	0.865	1.022	1.022	0.699	0.856	0.792	1.249	0.792	0.865
	75+	1.368	1.060	1.253	1.253	0.857	1.049	0.971	1.530	0.971	1.060
	Non-MC	3.290	2.550	3.013	3.013	2.061	2.523	2.336	3.681	2.336	2.550

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Exhibit F Continued: Trend in Demographic/Area Factors - Seniors

2006 Enrollment

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest	Total
Institutionalized												
Female	65-74	3,056	133	757	375	518	2,282	227	885	1,849	1,377	11,459
	75-84	6,278	245	2,416	886	2,178	7,248	609	2,609	6,356	5,089	33,914
	85+	10,545	606	5,412	2,479	4,810	19,026	1,543	4,909	15,141	15,399	79,870
	Non-MC	213	-	33	19	23	52	8	24	65	8	445
Male	65-74	2,212	68	581	182	508	1,723	234	666	1,371	1,213	8,758
	75-84	2,585	58	1,041	387	828	3,485	232	937	2,855	2,864	15,272
	85+	1,628	116	883	335	1,019	4,364	209	806	3,756	3,559	16,675
	Non-MC	171	-	6	10	9	35	8	40	39	23	341
Non-Institutionalized												
Female	65-74	18,041	402	8,808	1,567	3,676	13,215	2,047	9,142	9,371	8,489	74,758
	75+	20,022	791	10,511	3,539	5,124	25,463	3,403	10,605	20,334	17,636	117,428
	Non-MC	6,061	51	1,159	97	75	358	439	1,808	571	296	10,915
Male	65-74	10,673	104	3,629	731	2,138	7,832	1,238	4,750	5,413	4,379	40,887
	75+	7,592	242	2,844	681	1,069	7,458	1,212	3,466	5,985	5,264	35,813
	Non-MC	4,171	27	633	58	27	238	395	1,515	243	369	7,676
Total Enrollment		93,248	2,843	38,713	11,346	22,002	92,779	11,804	42,162	73,349	65,965	454,211

2007 Enrollment

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest	Total
Institutionalized												
Female	65-74	3,029	105	883	429	401	2,144	252	964	1,911	1,365	11,483
	75-84	5,852	251	2,537	952	1,853	6,955	591	2,438	6,050	4,812	32,291
	85+	10,184	707	5,443	2,263	4,748	18,543	1,576	4,922	15,083	15,276	78,745
	Non-MC	229	-	10	14	35	50	6	35	50	15	444
Male	65-74	2,150	97	553	237	439	1,614	234	625	1,466	1,184	8,599
	75-84	2,323	51	963	402	723	3,484	220	921	2,849	2,622	14,558
	85+	1,600	112	865	332	894	4,217	253	733	3,800	3,498	16,304
	Non-MC	139	-	21	-	12	40	-	28	31	36	307
Non-Institutionalized												
Female	65-74	19,338	433	9,883	1,716	3,860	14,544	2,340	9,700	9,743	8,570	80,127
	75+	22,967	1,129	12,928	3,955	6,730	29,540	3,905	11,365	22,483	18,444	133,446
	Non-MC	6,727	40	1,161	140	68	363	502	2,101	419	342	11,863
Male	65-74	11,275	160	4,007	811	2,207	8,708	1,404	5,106	5,663	4,744	44,085
	75+	8,867	259	3,509	822	1,460	8,604	1,488	3,716	6,683	5,546	40,954
	Non-MC	5,396	22	700	70	42	230	394	1,698	212	400	9,164
Total Enrollment		100,076	3,366	43,463	12,143	23,472	99,036	13,165	44,352	76,443	66,854	482,370

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Exhibit F Continued: Trend in Demographic/Area Factors - Seniors

2008 Enrollment

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest	Total
Institutionalized												
Female	65-74	2,882	84	766	339	409	2,058	267	969	1,644	1,418	10,836
	75-84	5,519	206	2,654	875	1,674	6,807	525	2,199	5,667	4,862	30,988
	85+	9,902	618	5,115	2,189	4,279	18,347	1,467	4,624	14,800	14,947	76,288
	Non-MC	206	144	5	9	27	78	-	28	44	23	564
Male	65-74	2,136	50	618	298	382	1,673	196	641	1,421	1,261	8,676
	75-84	2,210	101	983	400	638	3,419	237	881	2,564	2,525	13,958
	85+	1,635	84	904	341	794	4,160	284	685	3,568	3,300	15,755
	Non-MC	136	47	15	10	10	21	-	17	32	32	320
Non-Institutionalized												
Female	65-74	20,052	548	10,506	1,886	4,014	16,717	2,352	9,990	10,210	8,556	84,831
	75+	23,786	1,295	13,870	4,069	6,295	32,666	3,978	11,741	22,604	18,533	138,837
	Non-MC	7,313	58	1,017	175	55	399	488	2,306	387	391	12,589
Male	65-74	11,578	183	4,198	942	2,279	10,496	1,547	5,433	5,942	4,946	47,544
	75+	9,782	292	3,828	945	1,413	9,625	1,649	3,903	6,745	5,565	43,747
	Non-MC	6,060	17	635	39	40	225	384	1,901	232	423	9,956
Total Enrollment		103,197	3,727	45,114	12,517	22,309	106,691	13,374	45,318	75,860	66,782	494,889

2009 Enrollment

Rate Cell		Hennepin	Carver	Core Metro	Greater Metro	Northeast	Northwest	Olmsted	Ramsey	Southeast	Southwest	Total
Institutionalized												
Female	65-74	3,012	102	815	359	457	2,281	298	884	1,735	1,411	11,354
	75-84	5,233	229	2,576	833	1,453	6,882	562	2,177	5,166	4,791	29,902
	85+	9,262	734	5,054	2,062	3,956	18,295	1,442	4,334	14,475	14,606	74,220
	Non-MC	172	2	20	34	27	60	-	36	34	33	418
Male	65-74	2,389	79	695	267	316	1,872	182	719	1,401	1,168	9,088
	75-84	2,276	135	903	401	545	3,469	240	749	2,494	2,499	13,711
	85+	1,709	115	952	437	739	4,250	292	634	3,413	3,303	15,844
	Non-MC	122	-	15	12	12	26	-	17	26	25	255
Non-Institutionalized												
Female	65-74	21,542	623	11,250	2,098	4,084	17,701	2,441	10,527	10,634	8,467	89,367
	75+	24,715	1,364	14,951	4,175	6,488	34,011	4,136	12,066	22,463	18,268	142,637
	Non-MC	7,107	92	1,001	203	56	388	567	2,638	325	505	12,882
Male	65-74	12,672	184	4,692	1,084	2,415	11,259	1,611	5,711	6,023	5,199	50,850
	75+	10,745	289	3,810	1,062	1,684	10,028	1,636	4,278	6,602	5,770	45,904
	Non-MC	5,989	45	674	51	40	203	402	2,042	302	471	10,219
Total Enrollment		106,945	3,993	47,408	13,078	22,272	110,725	13,809	46,812	75,093	66,516	506,651

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Exhibit G : Administrative Expense Calculation

Step 1: Allocate MSHO Admin

	Basic Care	Other Medicaid	Medicare	Total
Revenue	$ 272,926,843	$ 262,258,603	$ 585,043,554	$ 1,120,229,000 *
Premium Tax (1% of Medicaid Revenue)***	$ 2,504,001	$ 2,289,708		$ 4,793,709
Revenue Exc. Premium Tax	$ 270,422,842	$ 259,968,894	$ 585,043,554	$ 1,115,435,291
Premium Tax	$ 2,504,001	$ 2,289,708	$ -	$ 4,793,709
Admin. Expenses Excl. Premium Tax	$ 14,835,012	$ 7,261,854	$ 38,027,831	$ 60,124,697
Administrative Expenses	$ 17,339,013	$ 9,551,563	$ 38,027,831	$ 64,918,407 **
Administrative Margin	6.35%	3.64%	6.50%	5.80%
Member Months	443,504			
Admin PMPM	$ 39.10			

*From 2009 MCO Minnesota Supplement Report #1

**From 2009 MCO Minnesota Supplement Report #1 with an adjustment for one plan

***Does not apply to County-Based plans

Step 2: Allocate PMAP Admin

	MSC+			
	Basic Care	EW and NF Add-On	PMAP < 65	Total
Revenue	$ 96,264,578	$ 67,278,462	$ 1,531,173,960	$ 1,694,717,000 *
Administrative Margin	6.35%	3.07%	9.23%	
Administration	$ 6,115,678	$ 2,067,840	$ 141,377,520	$ 149,561,038 **
Member Months	136,025		3,715,270	
Admin PMPM	$ 44.96		$ 38.05	

*From 2009 MCO Minnesota Supplement Report #1

**From 2009 MCO Minnesota Supplement Report #1 with an adjustment for one plan

Step 3: Develop Seniors Admin

	MSHO	MSC+	Care Coordination*	Total
Member Months	443,504	136,025	579,529	579,529
Admin PMPM	$ 39.10	$ 44.96	$ 19.55	$ 60.02

*Represents Care Coordination Costs not reported on the 2009 MCO Minnesota Supplement Report #1

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Appendix R
Rate Setting Report
MSHO and MSC+ - Add On Capitation Rate Adjustment

15800 Bluemound Road
Suite 400
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3684

milliman.com

Eric P. Goetsch, FSA, MAAA
Principal and Consulting Actuary

eric.goetsch@milliman.com

November 29, 2010

Ms. Pam Parker
Director, Special Needs Purchasing
Minnesota Department of Human Services
540 Cedar Street
Elmer L. Anderson Human Services Building
St. Paul, MN 55155-3854

RE: Rate Development for CY 2011 EW and NF Add-on for MSHO and MSC+

Dear Pam:

The attached report describes the development of the County Based Purchasing (CBP) and non-CBP Elderly Waiver (EW) and Nursing Facility (NF) Add-on rates for the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs for the calendar year (CY) 2011 contract period.

Please let us know if you have any questions.

Sincerely,

Eric Goetsch

Eric Goetsch, FSA, MAAA
Principal and Consulting Actuary

EPG/zh

Attachment

This material assumes that the reader is familiar with Minnesota's Medicaid long term care and acute care programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the Minnesota Department of Human Services in setting rates for the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Calendar Year 2011 Rate Development for the Elderly Waiver and Nursing Facility Add-Ons for MSHO and MSC+

Prepared for:
Minnesota Department of Human Services

Prepared by:
Milliman, Inc.

Eric P. Goetsch, FSA, MAAA
Principal and Consulting Actuary

15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3684

milliman.com

November 29, 2010

This material assumes that the reader is familiar with Minnesota's Medicaid long term care and acute care programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the Minnesota Department of Human Services in setting rates for the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

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Appendix A – CY 2009 Aggregate Health Plan EW Experience PMPM by Category of Service

This material assumes that the reader is familiar with Minnesota's Medicaid long term care and acute care programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the Minnesota Department of Human Services in setting rates for the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

I. INTRODUCTION

This report documents the development of the County Based Purchasing (CBP) and non-CBP Elderly Waiver (EW) and Nursing Facility (NF) Add-on rates for the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs for the calendar year (CY) 2011 contract period. The report assumes the reader is familiar with the basic aspects of the MSHO and MSC+ programs, the population groups covered under the programs, the Minnesota Medicaid program, and managed care rating principles.

This report contains:

- A description of the information used to develop the CY 2011 EW base rates and risk factors, which will be used to determine the 2011 EW Add-on capitation payments. The EW Add-on rates were rebased for 2011 using 2009 health plan experience and now include a risk adjustment component to more appropriately allocate revenue for the EW population.

- A description of the information used to develop the CY 2011 NF rating components, which were used to determine the 2011 NF Add-on capitation payments. The NF Add-on rates were rebased for 2011 using both recent managed care and FFS experience.

The structure of this report is intended to provide transparency of all the components of both the CY 2011 EW and NF Add-on rate developments.

Overall, the CY 2011 EW Add-On rates provide an estimated aggregate decrease of 0.65% from CY 2010 EW Add-On rates on a per member per month (PMPM) basis. Due to the introduction of risk adjustment, the increase or decrease in rates PMPM from CY 2010 to CY 2011 will vary by plan.

The CY 2011 NF Add-On rates provide an estimated aggregate increase of approximately 5.2% from average CY 2010 NF Add-On rates on a PMPM basis. Due to rebasing of the area, age, and gender factors, the increase or decrease in rates PMPM from CY 2010 to CY 2011 will vary by plan.

CAVEATS AND LIMITATIONS

This report is intended for use by the Minnesota Department of Human Services (DHS) and participating health plans as they negotiate a contract to provide EW and NF services to the MSHO and MSC+ population in CY 2011. The information contained in this report may not be suitable for other purposes or audiences. Our understanding is DHS intends to distribute this report to the health plans participating in the MSHO and MSC+ programs, as well as to CMS to document the rate development.

The results presented in this letter are estimates only based on historical health plan experience. Actual CY 2011 experience will vary from these estimates.

We relied on data and information supplied to us by the health plans and DHS. While we did review the information for reasonableness, we did not audit or attempt any independent verification of such data. If this data is incomplete or inaccurate, then our conclusions will be incomplete or inaccurate.

This report was prepared specifically for DHS and the development of CY 2011 EW and NF Add-on rates for the MSHO and MSC+ programs and may not be appropriate for other purposes. This report should only be viewed in its entirety. Milliman does not intend to benefit any third party and assumes no duty or liability to other parties who receive this work.

This report is a summary of the CY 2011 EW and NF Add-on rate development and does not address all of the issues detailed in the CMS checklist. This report also does not contain an actuarial certification for the premium rates. This information will be provided in a separate report at a later date.

This material assumes that the reader is familiar with Minnesota's Medicaid long term care and acute care programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the Minnesota Department of Human Services in setting rates for the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

II. DEVELOPMENT OF CY 2011 ELDERY WAIVER ADD-ON RATES

CALENDAR YEAR 2009 HEALTH PLAN EXPERIENCE

The CY 2011 EW Add-on rates are based on aggregate CY 2009 health plan experience; both for EW and care coordination / case management (CC / CM) services. The rate development uses the experience provided by the health plans for EW eligibles enrolled in the MSHO and MSC+ programs for their State Plan services. Table 1a contains the statewide aggregate 2009 PMPM health plan experience for these two main service subgroups, excluding the costs for EW services provided to new EW eligibles in the first month prior to their being in Rate Cell B. Appendix A contains the category-of-service detail underlying the EW services.

Table 1a
Calendar Year 2011 MSHO and MSC+ Rate Development
Elderly Waiver and Care Coordination / Case Management Services
Calendar Year 2009 Aggregate Health Plan Experience PMPM
Excluding EW Services Cost for New EW Eligibles
in First Month Prior to Rate Cell B

Component	PMPM
Elderly Waiver Services	$971.23
Care Coordination / Case Management Services	$113.05
Total	**$1,084.28**

Based on a DHS analysis of first-time EW eligibles in July through December 2008, there was an average of 159 new EW eligibles each month during this time period. Based on an analysis performed by Milliman with data from DHS, there was an average of 10.5 EW days in the month prior to being in Rate Cell B. Since 2009 EW cost data was only provided for months in which individuals were in Rate Cell B, we estimate 658.7 member months of cost data were not included [658.7 = 159 x 12 x 10.5 / (365/12)]. Since there were 217,988 EW member months reported, we estimate we are missing 0.30% of the costs (0.30% = 658.7 / 217,988). As a result, we increased the 2009 EW services base cost by 0.30%.

Table 1b contains the statewide aggregate 2009 PMPM health plan experience for the two main service subgroups, including the estimated costs for EW services provided to new EW eligibles in the first month prior to their being in Rate Cell B.

Table 1b
Calendar Year 2011 MSHO and MSC+ Rate Development
Elderly Waiver and Care Coordination / Case Management Services
Calendar Year 2009 Aggregate Health Plan Experience PMPM
Including Estimated EW Services Cost for New EW Eligibles
in First Month Prior to Rate Cell B

Component	PMPM
Elderly Waiver Services	$974.14
Care Coordination / Case Management Services	$113.05
Total	**$1,087.19**

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DEVELOPMENT OF CALENDAR YEAR 2011 EW ADD-ON BASE RATES

The following adjustments were made to the aggregate CY 2009 EW health plan experience to develop to CY 2011 EW Add-on base rates.

Trend

An annual trend of 6.0% was used to project the CY 2009 EW plan experience to the CY 2011 rating period. Additional "trend" is applied in the form of the risk factor change that will occur as the mix of age, ADL, and risk factors changes over time. We estimate this risk-factor related trend to be approximately 1.7% per year. The EW fee-for-service (FFS) trends were 8.0% per year from 2007 to 2009 and are projected to be 8.1% per year from 2009 to 2011. Using managed care trends (approximately 7.7% per year) that are slightly lower than FFS trends for EW services seems reasonable since plans should be managing costs more efficiently for these services versus when they are provided on a FFS basis.

Adjustment for EW Cost Limits

The CY 2009 health plan experience includes the impact of new legislation effective October 1, 2009 which affected monthly service cost limits for EW clients, including a new case mix category with low dependencies in activities of daily living. DHS estimated that the changes in service cost limits would reduce EW costs by 0.41%, which resulted in a corresponding reduction to the EW rates for 4Q 2009.

These service cost limits will be in place for all of CY 2011; therefore, we need to annualize the impact of the service cost limits inherent in the last three months of the CY 2009 health plan experience. As a result, we adjusted the CY 2009 experience by removing the implicit three month impact and applying an adjustment to reflect the impact for the entire year. This results in an adjustment factor of 0.9969, which was calculated as follows:

$$0.9969 = \frac{1 - 0.0041}{1 - (0.0041 / 4)} \quad \begin{array}{l}\text{(Adjustment to apply impact of limit for entire year)} \\ \text{(Adjustment to remove impact of limit for 3 months)}\end{array}$$

Adjustment for Service Rate Limits for 24-Hour Customized Living Services

The CY 2009 health plan experience includes the impact of new legislation effective October 1, 2009 which capped service rate limits for 24-hour customized living services at the 95th percentile of 24-hour rates in effect on March 31, 2009 for each case mix resident class. DHS was authorized to establish an alternative payment system by applying a single hourly rate for direct services provided in certain housing with services establishments. DHS estimated that these service rate limits would reduce EW costs by 0.90%, which resulted in a corresponding reduction to the EW rates for 4Q 2009.

These service rate limits will be in place for all of CY 2011; therefore, we need to annualize the impact of the service rate limits inherent in the last three months of the CY 2009 health plan experience. As a result, we adjusted the CY 2009 experience by removing the implicit three month impact and applying an adjustment to reflect the impact for the entire year. This results in an adjustment factor of 0.9969, which was calculated as follows:

$$0.9932 = \frac{1 - 0.0090}{1 - (0.0090 / 4)} \quad \begin{array}{l}\text{(Adjustment to apply impact of limit for entire year)} \\ \text{(Adjustment to remove impact of limit for 3 months)}\end{array}$$

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Adjustment for Reduction Related to the Removal of COLA

The legislation effective October 1, 2009 included the removal of a COLA which required a 2.58% reduction in EW rates for 4Q 2009 as is assumed to have been passed on to providers in the form of reduced reimbursement levels for 4Q 2009.

This reduction was a permanent reduction in EW rates; therefore, we need to annualize the impact of the reimbursement reduction inherent in the last three months of the CY 2009 health plan experience. As a result, we adjusted the CY 2009 experience by removing the implicit three month impact and applying an adjustment to reflect the impact for the entire year. This results in an adjustment factor of 0.9805, which was calculated as follows:

$$0.9805 = \frac{1 - 0.0258}{1 - (0.02580 / 4)} \quad \begin{array}{l}\text{(Adjustment to apply impact limit for entire year)} \\ \text{(Adjustment to remove impact of limit for 3 months)}\end{array}$$

Adjustment for Non-Administrative Managed Care Rateable Reduction

The legislation effective September 1, 2010 included ratable reduction language stating that the initial 2010 EW rates for non-administrative services were to be reduced by 3%. This rateable reduction continues to apply in CY 2011 and therefore needs to be reflected in the CY 2011 EW rates. Administrative services represent 2.5% of the CY 2011 rates (as described below). As a result, an adjustment factor of 0.9708 was applied for this reduction to reflect 97.5% of the 3% reduction (0.9708 = 1 – (0.03 x 0.975)).

Adjustment for Customized Living Rate Reduction

The legislation effective January 1, 2011 includes a temporary managed care rate reduction equal to 10% of the customized living component of the EW rates. Effective July 1, 2011, the temporary 10% rate reduction expires and is replaced by a permanent 5% reduction. So as to avoid multiple sets of base rates in CY 2011, we assumed a 7.5% reduction for all of CY 2011.

Based on CY 2009 health plan experience, customized living services represented 68.41% of the total non-CC/CM EW costs. Therefore, an adjustment factor of 0.9487 was applied for this reduction (0.9487 = 1 – (0.075 x 0.6841)).

Adjustment for Administration Requirements

EW Add-on rates for prior years were developed from fee-for-service data and implicitly assumed administrative costs could be funded from cost savings resulting from utilization reductions from fee-for-service to managed care levels. However, since we are using health plan experience to develop the 2011 EW Add-on rates, an explicit administrative load is required. Therefore, the CY 2011 EW Add-on rates were increased to include a 2.5% administrative cost load to recognize additional administrative costs for services beyond CC/CM services. As a result, an adjustment factor of 1.0256 was applied (1.0256 = 1 / 0.975).

The administrative cost load of 2.5% of revenue reflects that the EW base rates already include a component for CC/CM services and that an explicit administrative load is already included in the basic care rates for EW individuals.

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Legislated Premium Tax

The non-CBP MSHO and MSC+ CY 2011 EW Add-on rates were increased to include a provision for the legislated premium tax of 1%, resulting in an adjustment factor of 1.0101 being applied to the rates (1.0101 = 1 / 0.99). The CBP 2011 EW Add-on rates do not include the premium tax adjustment.

Calendar Year 2011 Base Rates

Table 2 contains the development of the MSHO / MSC+ EW base rates for CY 2011.

Table 2
Calendar Year 2011 MSHO and MSC+ Rate Development
Elderly Waiver and Care Coordination / Case Management Services
Calendar Year 2011 Base Rates

Component / Adjustment	Elderly Waiver Services	Care Coordination / Case Management
Aggregate CY 2009 EW Health Plan Experience PMPM	**$974.14**	**$113.05**
Trend	1.1236	1.1236
Adjustment for EW Cost Limits	0.9969	0.9969
Adjustment for Service Rate Limits For 24-Hour Customized Living Services	0.9932	0.9932
Adjustment for Reduction Related to the Removal of COLA	0.9805	0.9805
Adjustment for Non-Administrative Managed Care Rateable Reduction	0.9708	0.9708
Adjustment for Customized Living Rate Reduction	0.9487	N/A
Adjustment for Administration Requirements	1.0256	1.0256
Legislated Premium Tax (not applied to CBP rates)	1.0101	1.0101
CY 2011 Base Rates for non-CBP	**$1,013.84**	**$124.02**
CY 2011 Base Rates for CBP	**$1,003.70**	**$122.78**

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DEVELOPMENT OF CALENDAR YEAR 2011 EW RISK FACTORS

The following risk factors were developed using 2009 EW encounter data provided by DHS and will be applied to the CY 2011 EW Waiver Services base rates to calculate the final CY 2011 EW Add-on rate for each EW eligible. By definition, all of the risk factors composite to 1.000 using the CY 2009 distribution of eligibles by area, ADL, and age. As the area, ADL, and age mix changes over time, the risk factors may not composite to 1.000. For example, using the year-to-date 2010 area, ADL, and age mix across all health plans, the product of the area, ADL, and age risk factors is 1.037 in aggregate for all health plans. This aggregate risk factor change was considered when determining the appropriateness of the trend factors used to develop CY 2011 base rates and will continue to be considered when determining the appropriateness of trends in the future.

Area Factors

We developed area factors by comparing the difference between area-specific costs and total costs. The area-specific costs were calculated for the Metro and non-Metro areas. Table 3 contains the resulting risk factors for each area.

Table 3
CY 2011 MSHO and MSC+ Rate Development
EW Services
Risk Factors for Area

Area	Area Risk Factor
Metro	0.965
Non-Metro	1.022

The overall area risk factors for each plan will be recalculated annually based on the mix of each plan's membership by county at the beginning of the contract year.

Activities of Daily Living (ADL) Factors

We developed ADL factors by comparing the difference between ADL-specific costs and total costs. The ADL-specific costs were calculated for those individuals who require assistance with 0-3, 4-6, and 7-8 ADLs. Table 4 contains the resulting risk factors for each ADL group.

Table 4
CY 2011 MSHO and MSC+ Rate Development
EW Services
Risk Factors for ADLs

ADL Group	ADL Risk Factor
0-3 ADLs	0.678
4-6 ADLs	1.443
7-8 ADLs	2.111

The overall ADL risk factors for each plan will be recalculated annually based on the mix of each plan's membership by ADL group at the beginning of the contract year.

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Age Factors

We developed age factors by comparing the difference between age-specific costs and total costs. The age-specific costs were calculated for those individuals ages 65-74, 75-84, and 85+. Table 5 contains the resulting risk factors for each age group.

Table 5
CY 2011 MSHO and MSC+ Rate Development
EW Services
Risk Factors for Age

Age Group	Age Risk Factor
Ages 65-74	0.735
Ages 75-84	0.936
Ages 85+	1.311

The overall age risk factors for each plan will be recalculated annually based on the mix of each plan's membership by age group at the beginning of the contract year.

Customized Living / Corporate Foster Care Factors

Prior years' EW Add-on rates reflected an average distribution of individuals receiving customized living and corporate foster care services. Beginning in CY 2011, annual plan-specific adjustments will be made to the EW Add-on rates which reflect each plan's percentage of member months in which customized living or corporate foster care services were provided.

The plan-specific customized living / corporate foster care (CL / CFC) risk factors for a given year will reflect the percentages from two years prior. Therefore, the CY 2011 EW Add-on rates will reflect 2009 percentages. For the CY 2012 EW Add-on rates, the plan-specific adjustments will be revised to reflect 2010 percentages. Similar to the other risk factors, the plan-specific CL / CFC risk factors will be calculated at the beginning of the year and will apply for the entire year.

The plan-specific CL / CFC risk factors will be based on a ranking methodology. Table 6 contains the CL / CFC risk factors by ranking. The plan with the highest percentage of total member months in which customized living or corporate foster care services were provided will be ranked #1; the plan with the lowest percentage will be ranked #8.

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Table 6 CY 2011 MSHO and MSC+ Rate Development EW Services Risk Factors for CL / CFC by Ranking	
Customized Living / Corporate Foster Care Ranking	**Unnormalized CL / CFC Risk Factor**
1	1.0525
2	1.0375
3	1.0225
4	1.0075
5	0.9925
6	0.9775
7	0.9625
8	0.9475

If two or more plans have the same percentage of member months in which customized living or corporate foster care services were provided, the rankings will be combined for those plans. For example, if two plans have the same percentage and are ranked #2 and #3, they will both have a risk factor of 1.0300, which is the average of the risk factors for the #2 and #3 rankings. The percentages will be rounded to the nearest 0.5% before ranking the plans.

Once the unnormalized CL / CFC risk factors are assigned to each plan, they will be normalized using health plan membership so the aggregate CL / CFC risk factor is 1.000 at the start of each contract year.

CALENDAR YEAR 2011 FINAL EW ADD-ON RATES

The CY 2011 EW Add-on rates for each health plan will be the sum of the following:

- The EW Services 2011 base rate multiplied by the plan-specific annual risk factors for area, ADL, age, and CL / CFC.
- The EW CC/CM 2011 base rate.

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III. DEVELOPMENT OF CY 2011 NURSING FACILITY ADD-ON RATES

FREQUENCY ASSUMPTION

The frequency of NF admissions in Exhibit 1 is expressed as the expected admissions per eligible, per month and is based on the experience of the MSHO and MSC+ programs. Table 7 contains the annual combined MSHO/MSC+ frequency of admission for 2007 through 2009.

Table 7
CY 2011 MSHO and MSC+ Rate Development
Nursing Facility Services
Annual Frequency Of Admissions By Calendar Year

Calendar Year	Admissions with Some Medicaid Liability
2007	7.4%
2008	7.5%
2009	7.9%

The frequencies of admission were determined based on changes in living arrangement status (from a community living arrangement status to a NF living arrangement status) for each MSHO and MSC+ enrollee. Admissions were counted only for those who were enrolled in MSHO or MSC+ (i.e., not in FFS and not enrolled in MSC) when admitted.

Please note, the admission frequencies in Table 7 reflect those admissions for which there was some Medicaid liability since DHS has no financial responsibility for admissions with only Medicare-covered days. Given the consistency in average days per enrollee from 2007 to 2009 (see Table 9), the starting point for the admission frequency assumption for the 2011 NF Add-on rate development was based on a blend of experience from these three years using the following formula:

$$\begin{aligned} \text{Starting Admission Frequency Assumption} = & \quad (3/6) \times 7.9\% \\ & + \quad (2/6) \times 7.5\% \\ & + \quad (1/6) \times 7.4\% \\ & = \quad 7.683\% \end{aligned}$$

The frequency of admission is based on statewide living arrangement data. An adjustment is made later in the rate setting process to account for the difference in the frequency between Metro and the Non-Metro Counties and between age / gender combinations.

AVERAGE LENGTH-OF-STAY ASSUMPTION

The MSHO and MSC+ NF benefit includes, as a maximum, only the first 180 days per stay. The benefit excludes days that would occur beyond 180 days and days outside of the contract period. All skilled NF days that qualify for Medicare payment count toward the benefit and therefore are included in the 180-day length-of-stay.

This material assumes that the reader is familiar with Minnesota's Medicaid long term care and acute care programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the Minnesota Department of Human Services in setting rates for the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

The average length-of-stay (ALOS) in Exhibit 1 is calculated over a 180-day benefit period and is based on the experience of the MSHO and MSC+ programs. Table 8 contains the annual combined MSHO/MSC+ ALOS for 2007 through 2009. Data through June 2010 was used so as to allow sufficient time to measure the entire potential length of stay of 180 days for 2009 admissions.

Table 8
CY 2011 MSHO and MSC+ Rate Development
Nursing Facility Services
Average Length of Stay By Calendar Year

Calendar Year	All Days	Days with Medicaid Liability
2007	99.6	93.7
2008	99.0	93.1
2009	98.4	89.1

The ALOS was determined based on changes in living arrangement status (from a NF living arrangement status to either a community living arrangement status or until date of death) for each MSHO and MSC+ enrollee.

Please note, the first column of ALOS in Table 8 reflects the ALOS accounting for all days. The second column of ALOS reflects the ALOS accounting for only those days for which there was Medicaid liability. Since DHS has no financial responsibility for Medicare-covered days, the second column of ALOS was used in the NF Add-on rate development. Consistent with the frequency of admission assumption, the starting point for the ALOS for the 2011 NF Add-on rate development was based on a blend of experience from 2007 to 2009 using the following formula:

$$\begin{aligned} \text{Starting ALOS Assumption} = \quad & (3/6) \times 89.1 \\ + \quad & (2/6) \times 93.1 \\ + \quad & (1/6) \times 93.7 \\ = \quad & 91.2 \end{aligned}$$

The ALOS within the contract year depends on the pattern of enrollment by month. The projected CY 2011 ALOS of 70.8 days (from Exhibit 1) within the CY 2011 contract period is based on the most recent enrollment projections.

The ALOS is based on statewide living arrangement data. An adjustment is made later in the rate setting process to account for the difference in the ALOS between Metro and the Non-Metro Counties and between age / gender combinations.

TREND FOR FREQUENCY AND AVERAGE LENGTH-OF-STAY

Table 9 contains the average days per enrollee (which equals the product of admission frequency and ALOS) for the combined MSHO and MSC+ population for CY 2007 through CY 2009. The average days per enrollee have been level for the last three years. As a result, we assumed no utilization trend when projecting CY 2011 admission frequency and ALOS.

This material assumes that the reader is familiar with Minnesota's Medicaid long term care and acute care programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the Minnesota Department of Human Services in setting rates for the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Table 9 CY 2011 MSHO and MSC+ Rate Development Nursing Facility Services Average Days Per Enrollee by Calendar Year	
Calendar Year	**Average Days Per Enrollee**
2007	7.0
2008	7.0
2009	7.0

CHARGE PER DAY ASSUMPTION

The CY 2011 average charge per day of $165.52 was developed using nursing facility MA charge per day information from the Department of Reports and Forecasting at DHS. Table 10 contains the fiscal year projection data that was used to estimate the CY 2011 charge per day.

Table 10 CY 2011 MSHO and MSC+ Rate Development Nursing Facility Services Nursing Facility Charge Per Day Estimates Based on Data from Department of Reports and Forecasting	
Fiscal Year	**Estimated Charge per Day**
2011	$169.66
2012	$171.64

The weighted average of these two fiscal year estimates results in an estimated nursing facility MA charge per day of $170.64 for CY 2011. The legislation effective September 1, 2010 included ratable reduction language stating that the initial 2010 NF rates for non-administrative services were to be reduced by 3%. This rateable reduction continues to apply in CY 2011 and therefore needs to be reflected in the CY 2011 NF rates. As a result, an adjustment factor of 0.97 was applied, resulting in a nursing facility MA charge per day of $165.52 ($165.52 = $170.64 x 0.97), which is used in Exhibits 1 and 2 to develop the 2011 NF add-on rates.

The projected average charge per day is based on statewide experience. An adjustment is made later in the rate setting process to account for the difference in the average charge per day between Metro and the Non-Metro Counties and between age / gender combinations.

180 – DAY NURSING FACILITY ADD-ON RATE CALCULATION

The 180-day NF Add-on rate is calculated by the following formula:

Monthly Rate	=	Adjusted Monthly Frequency of Nursing Facility Admissions
	x	Average Length of Stay within the contract period
	x	Average Charge per Day

This material assumes that the reader is familiar with Minnesota's Medicaid long term care and acute care programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the Minnesota Department of Human Services in setting rates for the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

The calculation of the initial rate as well as subsequent adjustments is outlined in Exhibit 2A for non-CBP and Exhibit 2B for CBP.

Section A of Exhibits 2A and 2B shows the calculation of the initial rate of $75.05 PMPM for CY 2011.

Section B of Exhibits 2A and 2B contains the calculation of the tail rate. The tail rate is equal to the expected nursing facility costs for days in CY 2011 from admissions occurring in CY 2010, divided by projected community eligible months in CY 2011. The tail rate for CY 2011 is $21.95 PMPM.

Section C of Exhibit 2 contains the calculation of the value of the enrollment adjustment based on updated enrollment. There is an enrollment adjustment of $1.31 for CY 2011. The positive enrollment adjustment accounts for plans being underpaid in CY 2010 due to the CY 2010 rates being based on projected CY 2010 enrollment. Actual 2010 enrollment indicates the CY 2010 rates should have been set slightly higher.

Section D of Exhibit 2A contains an initial MSHO / MSC+ base rate for CY 2011 of $98.31 PMPM. The initial base rate was decreased 1.7% for the elimination of disenrollment fees and increased 1.01% for the legislated premium tax of 1% (1.0101 = 1 / 0.99). The final MSHO / MSC+ base rate for CY 2011 is $97.62 PMPM.

Rates for CBP entities are excluded from the 1% premium tax. Section D of Exhibit 2B contains an initial CBP base rate for CY 2011 of $98.31 PMPM. The initial base rate has been decreased by 1.7% for the elimination of disenrollment fees. The final CBP base rate for CY 2011 is $96.64 PMPM.

Section E of Exhibits 2A (MSHO / MSC+ non-CBP) and 2B (MSHO / MSC+ CBP) contains aggregate 180-day NF Add-on rates specific to enrollees eligible for both Medicaid and Medicare versus Medicaid-only enrollees. The adjustment to calculate these rates reflects differences in frequency and ALOS for Medicare versus Non-Medicare enrollees based on statewide experience. The aggregate Medicare and Non-Medicare rates equal the overall 180-day NF Add-on rates times the corresponding Medicare and Non-Medicare adjustment.

Exhibits 3A (MSHO / MSC+ non-CBP) and 3B (MSHO / MSC+ CBP) contain the CY 2010 180-day NF Add-on rates by age, gender and region for enrollees eligible for both Medicaid and Medicare versus Medicaid-only enrollees. The relationships by age, gender and region are based on an equal blend of the current age, gender, and region factors and rebased factors using statewide MSHO and MSC+ CY 2009 NF experience.

This material assumes that the reader is familiar with Minnesota's Medicaid long term care and acute care programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the Minnesota Department of Human Services in setting rates for the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit 1
Minnesota Senior Health Options and Minnesota Senior Care Plus Programs
180 Day Nursing Facility Add-On Rate Calculation for January 2011 Through December 2011
Projected Enrollment after August 2010

	1/09 - 9/09 Contract Period	1/10 - 8/10 Contract Period
	$84.93	$88.99
	$164.84	$166.65
	0.6083%	0.6000%

	10/09 - 12/09 Contract Period	9/10 - 12/10 Contract Period	2011 Contract Period
NF Add-On	$84.42	$86.32	$97.62
Per Diem	$163.85	$161.65	$165.52
Monthly Freq	0.6083%	0.6000%	0.6403%

Year	Month	Monthly Enrollment	Total NF Add-On Paid to Health Plans	Admissions	NF Days for Admissions in Month by Contract Period *			Health Plan Payments to NF for Admissions in Month by Contract Period		
					2009 Contract Period	2010 Contract Period	2011 Contract Period	2009 Contract Period	2010 Contract Period	2011 Contract Period
2009 Contract Period										
2009	January	33,230	$2,822,224	202.1	99.4	0.0		$2,968,983	$0	
	February	33,392	2,835,983	203.1	99.4	0.0		2,983,457	0	
	March	33,485	2,843,881	203.7	99.4	0.0		2,991,766	0	
	April	33,583	2,852,204	204.3	99.4	0.0		3,000,522	0	
	May	33,796	2,870,294	205.6	99.4	0.0		3,019,553	0	
	June	33,842	2,874,201	205.9	99.4	0.0		3,023,663	0	
	July	33,874	2,876,919	206.1	93.0	6.4		2,810,509	218,387	
	August	33,886	2,877,938	206.1	79.6	19.8		2,353,575	681,427	
	September	33,986	2,886,431	206.7	65.0	34.4		1,864,856	1,184,551	
	October	34,083	2,877,287	207.3	49.3	50.1		1,323,783	1,732,260	
	November	34,098	2,878,553	207.4	31.6	67.8		723,273	2,344,387	
	December	34,064	2,875,683	207.2	11.4	88.0		36,535	3,039,790	
Total 2009 Contract Period		405,319	$34,371,598	2,465.7	77.0	22.3		$27,100,473	$9,200,801	
2010 Contract Period										
2010	January	33,943	$3,020,588	203.7		99.4	0.0		$3,024,019	$0
	February	34,132	3,037,407	204.8		99.4	0.0		3,040,857	0
	March	34,319	3,054,048	205.9		99.4	0.0		3,057,517	0
	April	34,491	3,069,354	206.9		99.4	0.0		3,072,841	0
	May	34,615	3,080,389	207.7		99.4	0.0		3,083,888	0
	June	34,696	3,087,597	208.2		99.4	0.0		3,091,104	0
	July	34,806	3,097,386	208.8		93.0	6.4		2,879,583	219,821
	August	34,833	3,099,789	209.0		79.6	19.8		2,412,435	686,190
	September	34,952	3,017,095	209.7		65.0	34.4		1,855,026	1,193,400
	October	35,072	3,027,456	210.4		49.3	50.1		1,325,514	1,746,210
	November	35,193	3,037,869	211.2		31.6	67.8		726,391	2,370,352
	December	35,314	3,048,335	211.9		11.4	88.0		36,855	3,087,123
Total 2010 Contract Period		416,367	$36,677,312	2,498.2		76.9	22.5		$27,606,031	$9,303,096
2011 Contract Period										
2011	January	35,314	$3,447,387	226.1			91.2			$3,413,225
	February	35,314	3,447,387	226.1			91.2			3,413,225
	March	35,314	3,447,387	226.1			91.2			3,413,225
	April	35,314	3,447,387	226.1			91.2			3,413,225
	May	35,314	3,447,387	226.1			91.2			3,413,225
	June	35,314	3,447,387	226.1			91.2			3,413,225
	July	35,314	3,447,387	226.1			85.4			3,194,856
	August	35,314	3,447,387	226.1			73.0			2,732,094
	September	35,314	3,447,387	226.1			59.7			2,232,673
	October	35,314	3,447,387	226.1			45.2			1,691,726
	November	35,314	3,447,387	226.1			29.0			1,084,426
	December	35,314	3,447,387	226.1			10.4			390,633
Total 2011 Contract Period		423,772	$41,368,641	2,713.3			70.8			$31,805,760
Grand Total								$34,744,321	$36,806,832	$41,108,856

* Days that are 100% covered by Medicare are included for 2009 and 2010 only.

Exhibit 2A
Minnesota Senior Health Options and Minnesota Senior Care Plus Programs
180 Day Nursing Facility Add-On Rate Calculation
Contract Period January 2011 to December 2011
Non-County Based Purchasing Rates

Rate Component	1/10 - 8/10	9/10 - 12/10	2011
Section A			
Monthly Claim Frequency	0.006000		0.006403
(x) Medicaid Length of Stay *	66.6		70.8
(x) Charge per Day *	$166.65		$165.52
= Initial Rate (1)	$66.59		$75.05
Section B			
2011 NF $ for 2010 Admits			$9,303,096
(/) 2011 Eligible Months			423,772
= Tail Rate (2)	$22.01		$21.95
Section C			
2010 NF Rates to Health Plans			($36,677,312)
(+) 2009 Enrollment Adjustment in 2010			$424,695
(+) 2010 NF $ for 2009 Admits			$9,200,801
(+) 2010 NF $ for 2010 Admits			$27,606,031
= Enrollment Adjustment Dollars			$554,215
(/) 2011 Eligible Months			423,772
= Enrollment Adjustment Rate (3)	$1.02		$1.31
Section D			
Initial Base Rate = (1)+(2)+(3)	$89.62	$86.93	$98.31
Disenrollment Fee Adjustment	0.9830	0.9830	0.9830
Legislated Premium Tax Adjustment	1.0101	1.0101	1.0101
Final Base Rate	$88.99	$86.32	$97.62
Section E			
(x) Medicare Adjustment	1.000	1.000	1.000
(x) Non Medicare Adjustment	0.669	0.669	0.669
= Aggregate Medicare Rate	$88.99	$86.32	$97.62
= Aggregate Non-Medicare Rate	$59.53	$57.75	$65.31

* The ALOS and charge per day exclude days that are 100% covered by Medicare.

Exhibit 2B
Minnesota Senior Health Options and Minnesota Senior Care Plus Programs
180 Day Nursing Facility Add-On Rate Calculation
Contract Period January 2011 to December 2011
County Based Purchasing Rates

Rate Component	1/10 - 8/10	9/10 - 12/10	2011
Section A			
Monthly Claim Frequency	0.006000		0.006403
(x) Medicaid Length of Stay *	66.6		70.8
(x) Charge per Day *	$166.65		$165.52
= Initial Rate (1)	$66.59		$75.05
Section B			
2011 NF $ for 2010 Admits			$9,303,096
(/) 2011 Eligible Months			423,772
= Tail Rate (2)	$22.01		$21.95
Section C			
2010 NF Rates to Health Plans			($36,677,312)
(+) 2009 Enrollment Adjustment in 2010			$424,695
(+) 2010 NF $ for 2009 Admits			$9,200,801
(+) 2010 NF $ for 2010 Admits			$27,606,031
= Enrollment Adjustment Dollars			$554,215
(/) 2011 Eligible Months			423,772
= Enrollment Adjustment Rate (3)	$1.02		$1.31
Section D			
Initial Base Rate = (1)+(2)+(3)	$89.62	$86.93	$98.31
Disenrollment Fee Adjustment	0.9830	0.9830	0.9830
Final Base Rate	$88.10	$85.45	$96.64
Section E			
(x) Medicare Adjustment	1.000	1.000	1.000
(x) Non Medicare Adjustment	0.669	0.669	0.669
= Aggregate Medicare Rate	$88.10	$85.45	$96.64
= Aggregate Non-Medicare Rate	$58.94	$57.17	$64.65

* The ALOS and charge per day exclude days that are 100% covered by Medicare.

Exhibit 3A

Minnesota Senior Health Options and Minnesota Senior Care Plus Programs
Nursing Facility Add-On Rates (PMPM)
180 Day Benefit Period
Non-County Based Purchasing Rates

January 2011 to December 2011 Contract Period

Medicare Population

Area	Males			Females		
	65-74	75-84	85+	65-74	75-84	85+
Metro	$43.10	$106.46	$217.01	$31.84	$88.21	$163.57
Non Metro	53.44	132.87	275.77	39.33	108.18	203.91

Non-Medicare Population

Area	Males			Females		
	65-74	75-84	85+	65-74	75-84	85+
Metro	$28.83	$71.22	$145.18	$21.30	$59.01	$109.43
Non Metro	35.75	88.89	184.49	26.31	72.37	136.42

Exhibit 3B

Minnesota Senior Health Options and Minnesota Senior Care Plus Programs
Nursing Facility Add-On Rates (PMPM)
180 Day Benefit Period
County Based Purchasing Rates

January 2011 to December 2011 Contract Period

Medicare Population

Area	Males			Females		
	65-74	75-84	85+	65-74	75-84	85+
Non Metro	$52.91	$131.54	$273.01	$38.93	$107.09	$201.87

Non-Medicare Population

Area	Males			Females		
	65-74	75-84	85+	65-74	75-84	85+
Non Metro	$35.40	$88.00	$182.64	$26.05	$71.65	$135.05

Appendix A

Calendar Year 2011 MSHO and MSC+ Rate Development
Elderly Waiver and Care Coordination / Case Management Services
CY 2009 Aggregate Health Plan Experience PMPM by Category of Service

Elderly Waiver Services [1]	**2009 Cost PMPM**
Adult Day Care	$57.02
Adult Day Care Bath	0.17
Adult Day Care FADS License	0.05
Caregiver Training and Education	0.00
CDCS Background checks	0.00
CDCS Consumer Directed Community Supports	2.83
CDCS Mandatory Case Mgt	0.31
Chore Services	1.65
Companion Care, Adult	2.54
Customized Living	89.48
Customized Living 24 Hr	574.97
Env. Mod and Provision (claims only)	0.43
Extended Home Health Aide	1.35
Extended Home Health Aide (eff. March 2009)	2.05
Extended Medical Supplies and Equipment	14.16
Extended Personal Care 1:1	2.39
Extended Shared Personal Care 1:3	0.00
Extended Shared Personal Care 1:2	0.00
Flexible Case Management (claims only)	0.06
Foster Care, Corporate	11.87
Foster Care, family	51.02
Home Delivered Meals	27.59
Homemaker Services	84.99
Homemaker services, Per Diem	2.74
LPN Complex Extended	0.43
LPN Regular Extended 1:1	0.05
LPN Shared Extended 1:2	0.00
Modifications/Adaptations	2.42
Personal Assistance (claims only)	4.95
Residential Care	1.66
Respite not-in-home per diem	0.50
Respite, in home	1.67
Respite, out of home	0.02
RN Complex Extended	0.00
RN Regular Extended 1:1	0.01
RN Regular Extended 1:2	0.00
Self-Directed Support (claims only)	1.28
Transitional Services	0.06
Transportation, Extended	10.85
Transportion, non commercial, mileage	0.26
Treatment and Training (claims only)	0.36
Other [2]	19.03
Total Elderly Waiver Services	$971.23
Care Coordination / Case Management Services [3]	$113.05
Total	$1,084.28

[1] Includes 2009 Elderly Waiver service costs for Blue Plus, First Plan, Health Partners, Medica, Metropolitan Health Plan, PrimeWest Health System, South Country Health Alliance, and UCare Minnesota.

[2] Includes 2009 Elderly Waiver services costs paid by DHS that were submitted with missing/incorrect procedure codes.

[3] Includes 2009 Medicaid care coordination and case management costs for Blue Plus, Medica, Metropolitan Health Plan, PrimeWest Health System, South Country Health Alliance, and UCare Minnesota.

Appendix S
Rate Setting Report
SNBC - Capitation Rate Adjustment

15800 Bluemound Road
Suite 400
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 784 2748

milliman.com

Eric P. Goetsch, FSA
Principal and Consulting Actuary

eric.goetsch@milliman.com

December 6, 2010

Ms. Pam Parker
Director, Special Needs Purchasing
Minnesota Department of Human Services
540 Cedar Street
Elmer L. Anderson Human Services Building
St. Paul, MN 55155-3854

RE: Rate Development for SNBC non-PINs for Calendar Year 2011

Dear Pam:

The attached report describes the development of the rates for the Special Needs BasicCare (SNBC) program for the calendar year 2011 contract period. The rates in this report are for the non-Preferred Integrated Networks (non-PINs).

Sincerely,

Eric Goetsch

Eric Goetsch, FSA, MAAA
Principal and Consulting Actuary

EPG/zh

Attachments

Special Needs BasicCare
Base Rate Development For Calendar Year 2011
Non-PINs

Prepared for:
Minnesota Department of Human Services

Prepared by:
Milliman, Inc.

Eric P. Goetsch, FSA
Principal and Consulting Actuary

Roman G. Kelly
Actuarial Analyst

15800 Bluemound Road
Suite 400
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 784 2748

milliman.com

December 6, 2010

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APPENDICES

Appendix 1: SNBC 2011 Base Rate Tables
Appendix 2: SNBC PMPM Cost Models
Appendix 3: SNBC 2011 NF Add-On Rate Development

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the State of Minnesota in setting rates for capitated programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

I. INTRODUCTION

This report documents the calendar year (CY) 2011 base rate development for the Special Needs BasicCare (SNBC) program. The rates in this report are for the non-Preferred Integrated Networks (non-PINs). The report assumes the reader is familiar with the basic aspects of the SNBC program, the disabled population groups to be covered under the program, the Minnesota Medicaid program, and managed care rating principles.

The layout of this report was structured so as to describe all the information used to develop the CY 2011 base rates from the 2005 base experience while at the same time distinguishing the developmental components for the CY 2009 rate development, October through December 2009 rate adjustment, CY 2010 rate development, September through December 2010 rate adjustment, and the CY 2011 rate development. This approach was taken to allow the user to more easily understand what adjustments were new to the 2011 rate development.

The CY 2011 payments to health plans will be a product of the base rates included in this report and the risk factors developed by both Greg Gifford of the Minnesota Department of Health (acute risk factors) and by Milliman (mental health targeted case management risk factors). Comparisons were done to demonstrate the consistency of the data being used to develop the base rates and the data being used to develop the risk factors.

Overall, the aggregate CY 2011 SNBC base rates reflect an approximately 10.9% increase over the corresponding September through December 2010 SNBC base rates, with approximately 3.8% of this increase resulting from the change in mental health targeted case management (MH-TCM) pricing assumptions described later in this report. Due to risk adjustment and varying population mixes, the increase or decrease in rates PMPM from CY 2010 to CY 2011 will vary by plan.

CAVEATS AND LIMITATIONS

This report is intended for use by the Minnesota Department of Human Services (DHS) and participating health plan(s) as they negotiate a contract to provide most basic State plan services to people with disabilities in CY 2011 (Personal Care Assistant and Private Duty Nursing basic State plan services will remain fee-for-service Medicaid). The information contained in this report may not be suitable for other purposes or audiences. It is our understanding that DHS intends to distribute this report to the health plan(s) participating in SNBC, as well as to CMS to document the rate development.

The results presented in this letter are estimates only based on historical fee-for-service experience. Actual CY 2011 experience will vary from these estimates.

We relied on data and information supplied to us by DHS. We did not audit or attempt any independent verification of such data. If this data is incomplete or inaccurate, then our conclusions will be incomplete or inaccurate.

This report was prepared specifically for DHS and the development of CY 2011 base rates for SNBC and may not be appropriate for other purposes. This report should only be viewed in its entirety. Milliman does not intend to benefit any third party and assumes no duty or liability to other parties who receive this work.

This report is a summary of the base rate development and does not address all of the issues detailed in the CMS checklist. This report also does not contain an actuarial certification for the premium rates. This information will be provided in a separate report at a later date.

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the State of Minnesota in setting rates for capitated programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

II. 2005 BASE EXPERIENCE

Base rates for the SNBC program are based on projections of historical fee-for-service Medicaid data for eligibles with disabilities.

DESCRIPTION OF SNBC RATE CATEGORIES

SNBC has eight base rates for the SNBC population. Base rates are based on combinations of:

- ***Medicare Coverage:*** Medicaid only vs. Medicaid and Medicare (dual eligible). Dual eligible enrollees must be enrolled in both Parts A and B of Medicare.

- ***Institutional Status:*** Population categories of Institutionalized (NF / ICF) vs. Community (all other population categories).

- ***County of Residence:*** Metro counties (includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Sherburne, Washington, and Wright Counties) vs. non-metro counties.

BASE RATE CALCULATION METHODOLOGY

The base rate development is based on CY 2005 fee-for-service data, provided by DHS, for eligibles with disabilities. We relied on this data as given, but did perform reasonableness tests where possible. Comparisons were done to demonstrate the consistency of the data used to develop the base rates and the data used to develop the risk factors.

The fee-for-service data was analyzed to calculate aggregate per member per month (PMPM) amounts for acute care services and prescription drugs that are not covered by Medicare.

Nursing facility institutional costs are accounted for in the nursing facility add-on rate, which is only applicable to the community population. Nursing facility costs for persons who resided in a nursing facility prior to enrollment in SNBC will be paid on a fee-for-service basis. Additionally, nursing facility costs after the health plan's 100-day nursing facility liability period will be paid on a fee-for-service basis.

The CY 2011 base rates in Appendix 1 are net of third party collections since third party revenues were removed from the 2005 fee-for-service cost experience.

The 2005 aggregate fee-for-service combined cost experience for acute services for combinations of population groups are shown in Table 1 along with the associated eligible months of exposure. Separate fee-for-service cost experience is displayed for prescription drugs. The prescription drug costs shown in Table 1 include all drugs. An adjustment will be made later in the rate development process to reflect the portion of drugs that will be covered by Medicare.

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Table 1 Special Needs BasicCare Aggregate 2005 Fee for Service Cost Experience PMPM for Eligibles with Disabilities					
Population			**Eligible Months**	**PMPM Cost Excluding Rx**	**Rx PMPM**
Duals	Institutional	Metro	19,918	$285.98	$622.75
		Non-Metro	13,036	230.82	484.85
	Community	Metro	233,845	295.67	411.06
		Non-Metro	243,034	269.73	396.40
Non-Duals	Institutional	Metro	8,584	1,464.46	706.17
		Non-Metro	4,546	1,298.23	586.16
	Community	Metro	235,448	822.09	271.65
		Non-Metro	178,307	777.51	347.68

SPENDDOWN

Enrollees with medical spenddowns are required to prepay their monthly spenddown amount to DHS, which in turn passes the spenddown amounts through to the MCOs. The enrollee must meet this monthly obligation in order to retain enrollment in MnDHO-PD.

The fee-for-service experience excludes spenddown amounts. Therefore, spenddown amounts were added into the calculation for each base rate based on 2005 spenddown experience.

Three adjustments were made to the spenddown experience before adding it to the base rates:

1. The 2005 spenddown experience was reduced by 50% to account for the estimated percentage of the disabled population with a medical spenddown who would not enroll in SNBC due to its spenddown requirements.

2. For the community population, the 2005 spenddown experience was reduced by an additional percentage to reflect that some of the medical spenddown is being paid to fee-for-service providers for services not covered under the SNBC program. Per DHS, the percentage reductions, by population group, are as follows:

   - Community, single eligibles, metro counties: 27.4%
   - Community, dual eligibles, metro counties: 42.7%
   - Community, single eligibles, non-metro counties: 31.3%
   - Community, dual eligibles, non-metro counties: 50.2%

3. The value of the first one and a half month's spenddown was estimated and deducted from all base rates. This adjustment was made since DHS assumes 50% of SNBC enrollees with a spenddown requirement will disenroll after the 90-day grace period without having paid their spenddown.

Institutional spenddowns for enrollees in nursing facilities / ICF / ICF-MR are collected directly from nursing facilities through a separate process and are therefore not included in the base rates. As a result, Table 2 reflects only the medical spenddown for both community and institutionalized enrollees.

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Table 2 contains the PMPM amounts of total spenddown added to the base rates. These amounts reflect 2005 spenddown experience adjusted for the three adjustments described above. The spenddown per month (used to calculate the value of the first one and a half month's spenddown) was estimated by dividing the total spenddown dollars over the experience period by the average length of enrollment per member. This effectively assumes that the pattern of spenddown amounts is level by month, and not skewed with higher spenddown amounts in the earliest months.

Table 2
Special Needs BasicCare
Spenddown Amounts Added to the Base Rates

Population			Spenddown PMPM
Duals	Institutional	Metro	$0.86
		Non-Metro	0.46
	Community	Metro	6.91
		Non-Metro	3.40
Non-Duals	Institutional	Metro	1.13
		Non-Metro	0.96
	Community	Metro	2.12
		Non-Metro	1.68

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III. 2009 RATE DEVELOPMENT

For the 2009 rate development, the aggregate base rates were trended to the center of the CY 2009 rating period. The base rates were adjusted to reflect differences in the fee-for-service cost data for geographical region, institutional status, benefit changes, and eligibility for Medicaid only vs. eligibility for both Medicare and Medicaid. The trends were consistent with historical and projected trends of budgeted costs from the Reports and Forecast Division of DHS.

ANNUAL TRENDS, COST OF LIVING ADJUSTMENTS, AND REBASING ADJUSTMENTS

The fee-for-service costs were trended to the center of the CY 2009 contract period using annual trend assumptions, based on data provided by DHS, of 0.9% for Home Health Agency (HHA) services, 5.6% for non-HHA acute care services, and 9.0% for prescription drugs.

In addition to annual trends, the following cost of living adjustments (COLAs) and rebasing adjustments were made to the 2005 fee-for-service data to develop the CY 2009 base rates based on information provided by DHS:

- PMPM costs for COS 046 were increased 1.8% to reflect 2.0% COLAs for ARHMS and CTSS mental health services effective January 1, 2008 and July 1, 2008. These COLAs apply to 46.0% of the costs for COS 046 (1.8% = 4.0% x 46.0%).

- PMPM costs for COS 020 (home health), 051 (physical therapy), 053 (speech therapy), 054 (occupational therapy), and 062 (chemical dependency) were increased 4.0% to reflect 2.0% COLAs effective January 1, 2008 and July 1, 2008.

- PMPM costs for COS 001 and COS 015 were increased 26.0% and 22.0%, respectively, to account for the effect of inpatient hospital rebasing effective January 2007.

ADJUSTMENT FOR UTILIZATION SAVINGS AND ADMINISTRATION / MARGIN REQUIREMENTS

DHS is expecting more cost effective provision of services under the SNBC program resulting in managed care savings from fee-for-service levels. The range of expected savings is 5.0% to 10.0% due to reduced utilization. DHS assumed a utilization reduction of 6.5% from fee-for-service levels. In addition, we expect there to be increased health plan administrative costs and a need for margin due to increased managed care efforts. DHS assumed administrative expenses and margin to be 6.4% and 0.5% of medical expenses, respectively. These three factors combine to a net savings assumption of 0.0% from fee-for-service benefit costs. Table 3 contains a summary of these assumptions.

Table 3
Special Needs BasicCare
Savings Assumptions

	Assumed
Utilization Reduction	6.5%
Administrative Expense	6.4%
Margin	0.5%
Net Savings	0.0%

Net Savings Calculation: (1.00 – 0.065) x (1.00 + 0.064) x (1.00 + 0.005) -1 = 0.000

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ADJUSTMENT FOR OVER / UNDER-PREDICTION OF RISK SCORES BY POPULATION

Testing of the risk factor model indicated a bias of the risk factors for the institutional population to over-predict projected costs by approximately 13% and the community population to under-predict projected costs by approximately 1%. Therefore, the base rates for the institutional population were reduced by 13% and the base rates for the community population were increased by 1% such that the 2009 base rates and risk factors remained budget neutral while better accommodating future population mixes that are different than the population mix use to develop the risk scores. These bias factors were calculated by Greg Gifford.

EXTENDED CHEMICAL DEPENDENCY TREATMENT

The chemical dependency delivery system was redesigned with the goal of focusing resources on the individual needs of the client. The previous 'levels of care' (e.g., outpatient, halfway house, extended care, etc.) were eliminated and a new assessment tool and protocol were put in place January 1, 2008. MCOs were then responsible for all levels of treatment determined necessary during the assessment/ reassessment process. Costs for chemical dependency services COS 062 and 063 were subsequently included in the rates. Chemical dependency housing costs are also the health plans' responsibility; however, plans are reimbursed outside of the SNBC capitation for these costs for COS 063.

MEDICARE ADJUSTMENT FOR PRESCRIPTION DRUGS

Medicare provides prescription drug coverage for the dually eligible enrollees in SNBC. The health plans maintain responsibility for drugs not covered under the standard Medicare Part D plan. DHS supplied information which showed that approximately 2.7% of the cost of prescription drugs for the dual eligible population is not covered by Medicare. Therefore, fee-for-service costs were reduced by 97.3% in the calculation of the base rates for prescription drugs for the dual eligible population.

ADJUSTMENT FOR ZOSTAVAX VACCINE

The shingles vaccine (Zostavax) is covered under SNBC for single eligibles (it is covered under the federal Part D for dual eligibles). MCOs are expected to cover the cost of the serum and administration. Coverage is for individuals 60 years and over whether or not they report a prior episode of shingles.

For the 2009 rate development, DHS estimated 11.0% of the SNBC single eligible population would be ages 60 to 64. We assumed 30% of this population would obtain the one-time Zostavax vaccine in 2009 at a cost of $189.78 per vaccination, resulting in a cost of $0.52 PMPM (0.110 x 0.30 x $189.78 / 12). This cost was included in the 2009 prescription base rates.

The required rate adjustment to reflect the assumed percentage of the population who will receive the one-time Zostavax vaccine in 2010 is made in the CY 2010 Rate Development section of this report.

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ADJUSTMENTS MADE TO RISK SCORES FOR TARGETED MENTAL HEALTH ENHANCEMENT

The risk score model weights (and not the base rates) were adjusted for DHS' targeted mental health enhancement. The targeted enhancement includes the following:

- The opening of new state-operated facilities.
- ACT and IRTS being included in all program benefit sets effective January 2008.
- An increase in payment rates for selected critical access providers of CTSS, mental health behavioral aide services, and ARHMS medication education services.
- An increase in payments for CTSS individual and family skills training by children's therapeutic services and support providers.

Adjusting the risk score model weights (and not the base rates), appropriately allocates the extra revenue to those members DHS intended to help with the targeted mental health enhancement (i.e., those members with mental health diagnoses). Specifically, the Psychiatric Medium and High risk category weights were increased to add the extra revenue into the program for this enhancement.

ADJUSTMENTS FOR MENTAL HEALTH TARGETED CASE MANAGEMENT

On July 1, 2009, SNBC began covering mental health targeted case management (MH-TCM) services that were previously covered via fee-for-service. Table 4 contains the percentage of SNBC eligibles who received MH-TCM services via fee-for-service in 2007, the 2007 PMPM MH-TCM cost for the MH-TCM eligibles, and the 2007 PMPM MH-TCM cost across all SNBC eligibles. In Appendix 2, these amounts are adjusted to reflect an estimated 7% increase in utilization due to an expansion of the MH-TCM eligibility criteria and an additional 5% increase in utilization for trend from 2007 to 2009. These amounts are not included in the base rates and therefore will not be risk adjusted. Instead, the MH-TCM amounts are included in the rates as an add-on and were only included in the rates for July 2009 through December 2009.

Table 4
Special Needs BasicCare
2007 Mental Health Targeted Case Management Experience

Eligibility	% of SNBC Eligibles Receiving MH-TCM Services in 2007	2007 PMPM Costs for MH-TCM Eligibles	2007 PMPM Costs for All SNBC Eligibles
Duals	16.5%	$340.66	$56.21
Non-Duals	13.3%	$383.82	$51.05

DIALECTICAL BEHAVIORAL THERAPY

On January 1, 2009, DHS began covering the cost of dialectical behavioral therapy (DBT) services. DHS estimated the cost of these services for 2009 would be approximately $800,000. These costs were expected to occur almost exclusively within the disabled population, which was expected to be approximately 100,000 eligibles in 2009. Therefore, the expected 2009 cost of DBT services was $0.67 PMPM ($0.67 PMPM = $800,000 / (100,000 x 12). This amount is included in the base rates contained in Appendix 2 and is risk adjusted.

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MEDICAID COPAY CHANGES

Medicaid copays have been reduced since the 2005 fee-for-service base year. In 2005, the maximum prescription drug copay per month was $12. For 2009, this amount was reduced to $7 per month. According to State law, fee-for-service reimbursement rates may not be increased due to the reduction of these copay maximums. Likewise, payments to managed care plans may not be increased, presumably because managed care organizations are expected to follow suit by not adjusting provider reimbursement rates to compensate for this reduction in copays. Therefore, an explicit increase was not included in the rate development for the reduction in copays.

However, to conform to federal requirements, the rates were adjusted to account for monthly copays on prescription drugs and non-emergency visits to the emergency room being limited to 5% of family income for individuals at or below 100% of the federal poverty guidelines. Based on data from DHS, 0.70% of MA enrollee-months were subject to a copay maximum for the year ending July 2008.

Assuming that copays for non-emergency visits to the emergency room are immaterial, the maximum copay that might be waived for the SNBC population is the $7 per enrollee per month for prescription drugs. Multiplying this maximum drug copay per month of $7 by 0.70% gives a benefit cost of $0.05 PMPM. This cost was added to the prescription drug rates in Appendix 2.

This factor assumes non-emergency visits to the emergency room are immaterial, that all SNBC members will have drug copays of the full maximum of $7 per month, that all affected enrollees will have the entire copay waived, and that an SNBC enrollee is typical with respect to income among the population represented in the data received from DHS, which includes fee-for-service as well as managed care enrollees.

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IV. OCTOBER – DECEMBER 2009 RATE DEVELOPMENT

This section of the report contains documentation of the required adjustments to the 2009 rates for legislative and unallotment changes effective October 1, 2009.

ADJUSTMENT FOR PHYSICIAN AND PROFESSIONAL SERVICES RATABLE REDUCTION AND UNALLOTMENT

This legislative ratable reduction reduced the 2009 payment rates for applicable physician and professional services by 5%. In addition, the unallotment added another 1.5% reduction, for a total reduction of 6.5%. Office and outpatient services, preventive medicine services, and family planning services were exempt from this rate reduction when billed by primary care specialties (general practice, internal medicine, pediatrics, geriatrics, and family practice) or by an advanced practice registered nurse or physician assistant practicing in pediatrics, geriatrics, or family practice. The per member per month (PMPM) adjustment factors in Exhibit 2 reflect a modification to the 6.5% reduction for the categories of service (COS) that contain exempt services based on data provided by DHS.

The physician and professional services ratable reduction did not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

ADJUSTMENT FOR BASIC CARE RATABLE REDUCTION AND UNALLOTMENT

This legislative ratable reduction reduced the 2009 payment rates for basic care services by 3%. In addition, the unallotment added another 1.5% reduction, for a total reduction of 4.5%. Physician and professional services, inpatient hospital services, family planning services, mental health services, dental services prescription drugs, medical transportation, Federally Qualified Health Contract services, Rural Health Clinics, and Indian Health Services were exempt from this rate reduction. The PMPM adjustment factors in Exhibit 2 reflect a modification to the 4.5% reduction for the COS that contain exempt services based on data provided by DHS.

The basic care ratable reduction did not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

ADJUSTMENT FOR INPATIENT RATABLE REDUCTION

This legislative ratable reduction reduced the 2009 payment rates for inpatient hospital admissions occurring on or after July 1, 2009 by 1%. Facilities operated by the Indian Health Service and Indian tribes were exempt from this rate reduction; however, it was estimated that this exemption would not have an impact on the rates for the SNBC population.

The inpatient ratable reduction did not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

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ADJUSTMENT FOR REIMBURSEMENT RATES FOR BIRTHS – PHYSICIAN SERVICES

Legislation established new professional services payment rates related to labor, delivery, antepartum, and postpartum care for the following diagnostic related groups (DRGs):

- 371 - Cesarean section deliveries without complications,
- 372 - Vaginal deliveries with complications, and
- 373 - Vaginal deliveries without complications

The new rates were required to be consistent with an increase in the proportion of births by vaginal delivery and a reduction in the percentage of births by cesarean section. This legislative change was estimated to not impact the cost of inpatient maternity services for the SNBC population due to the very small number of births within this population.

ADJUSTMENT FOR REIMBURSEMENT RATES FOR BIRTHS – INPATIENT SERVICES

Legislation also established new facility payment rates for births. For admissions occurring on or after October 1, 2009, the total operating and property payment rate, excluding disproportionate population adjustment, was required to be no greater than $3,528 for the following DRGs:

- 371 - Cesarean section without complicating diagnosis,
- 372 - Vaginal delivery with complicating diagnosis, and
- 373 - Vaginal delivery without complicating diagnosis

The new rates do not apply to newborn care. This legislative change was estimated to not impact the cost of inpatient maternity services for the SNBC population due to the very small number of births within this population.

ADJUSTMENT FOR REDUCTION RELATED TO PROVIDER RATE REDUCTION

The provider rate reduction within the new legislation required a 2.58% reduction in rates for home health services.

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V. 2010 RATE DEVELOPMENT

This section contains documentation of the required adjustments to the October through December 2009 base rates required to develop the CY 2010 base rates.

TRENDS

The 2009 to 2010 trend assumptions, based on data provided by DHS, are -1.0% for Home Health Agency (HHA) services, 5.2% for non-HHA acute care services, and 9.0% for prescription drugs.

ADJUSTMENTS FOR PRESCRIPTION DRUG BENEFITS

Adjustment for Zostavax Vaccine

For the 2009 rate development, $0.52 PMPM was included in the 2009 prescription base rates for the one-time Zostavax vaccine. For 2009, we assumed 30% of the single eligible, ages 60 to 64 SNBC population would obtain the one-time Zostavax vaccine. For 2010, we assumed 20% of this population would obtain the vaccine and the cost per vaccination would increase 9% from 2009 levels. This results in a projected 2010 Zostavax cost of $0.38 PMPM ($0.38 = $0.52 / 0.30 x 0.20 x 1.09). This $0.14 PMPM cost reduction is included in the 2010 prescription base rates in Appendix 1.

Adjustment for Gardasil

The drug Gardasil is covered under SNBC for single eligible males ages 18 to 26 (it is covered under the federal Part D benefit for dual eligibles). MCOs are expected to cover the cost of the drug and administration.

For the 2010 rate development, DHS estimated 2.2% of the SNBC single eligible population would be males ages 18 to 26. DHS also assumed 7% of this population would obtain the three dose Gardasil treatment in 2010 at a cost of $8.50 per dose, resulting in a cost of $0.003 PMPM ($0.003 = 3 x $8.50 x 0.022 x 0.07 / 12). This cost was included in the 2010 prescription base rates.

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ADJUSTMENT FOR DENTAL SERVICES

Effective January 1, 2010, legislation modifies dental coverage for non-pregnant adults as follows:

- Eliminates coverage for fixed bridges
- Limits coverage to:
  - comprehensive exams, limited to once every five years
  - periodic exams, once per year
  - limited exams
  - bitewing x-rays, once per year
  - periapical x-rays
  - panoramic x-rays, once every five years and only if certain conditions are met. Allows panoramic x-rays to be provided once every two years to certain patients who cannot cooperate for intra-oral film
  - prophylaxis, once per year
  - application of fluoride varnish, once per year
  - posterior fillings at the amalgam rate
  - anterior fillings
  - endodontics, limited to root canals on the anterior and premolars only
  - removable prostheses, each dental arch limited to one every six years
  - oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses
  - palliative treatment and sedative fillings for relief of pain
  - full mouth debridement, once every five years
- Provides the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:
  - periodontics, limited to periodontal scaling and root planing once every two years
  - general anesthesia
  - full mouth survey once every five years
- Provides coverage of dental services for children that are medically necessary, and that the following guidelines apply:
  - posterior fillings are paid at the amalgam rate
  - application of sealants once every five years per permanent molar
  - application of fluoride varnish is limited to once every six months

This change in benefit level was estimated to reduce dental costs by 22.5% for CY 2010, based on information provided by DHS.

ADJUSTMENTS FOR MENTAL HEALTH TARGETED CASE MANAGEMENT

The fee-for-service data used to develop the 2009 rates was based on an underlying assumption that MH-TCM services were performed in 75% of the months for which those eligible for MH-TCM were enrolled. In fee-for-service, counties are responsible for the non-federal share of MH-TCM costs, which can create a fiscal disincentive for providing the services. However, under the MCO contracts, the counties no longer share this financial burden and have a greater incentive to provide an increased level of MH-TCM services. To reflect this, the 2010 rates use an assumption that MH-TCM services will be performed in 85% of the months for which those eligible for MH-TCM were enrolled, resulting in an increase of 13.33% (0.85 / 0.75 = 1.1333) to the MH-TCM rates for 2010.

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HEALTH CARE HOME CARE COORDINATION BENEFIT

Beginning July 1, 2010, a new Medicaid benefit is being added for health care home (HCH) care coordination for payments to certified clinics or practitioners meeting new MDH criteria. Payments are to be made for people with one or more chronic conditions. The adjustment to the 2010 rates was based on an analysis of FY 2008 data to determine the presence of chronic conditions within the SNBC population, allocating the population into five categories (zero, one, two, three, or four or more chronic conditions). We determined that due to the number of HCH services that may be certified in 2010 and where members might be served, approximately 1.5 months per person per year with at least one chronic condition could be eligible in 2010.

For the dual population, we assumed there would be no payment for those with one chronic condition since Medicare, as the primary payer, should be fully responsible for the less involved populations. For duals with two or more chronic conditions, we allocated approximately 50% of the estimated value of the Medicaid service because we do not want to supplant Medicare services. Rates for both the community and institutional populations were increased for the HCH benefit.

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VI. SEPTEMBER 2010 THROUGH DECEMBER 2010 RATE DEVELOPMENT

This section of the report contains documentation of the required adjustments to the 2010 rates for legislative changes effective September 1, 2010.

ADJUSTMENT FOR NON-ADMINISTRATIVE MANAGED CARE RATABLE REDUCTION

This legislative ratable reduction language states that the current 2010 payment rates for non-administrative services are to be reduced by 3%. The non-administrative services ratable reduction does not apply to the Medicare cost sharing portion of the rates for dual eligible individuals.

Per the 2010 rate memo, SNBC administrative costs represent approximately 6.4% of the basic care capitation. Thus, for single eligible (I.e., Medicaid only) rates, a 3% reduction to the non-administrative portion of the rates results in an effective 2.81% [(100% – 6.4%) x 3%] reduction applicable to the entire basic care rate. The per member per month (PMPM) adjustment factors in Appendix 2 reflect this 2.81% reduction for each category of service (COS).

For the dual eligible rates in Appendix 2, the PMPM adjustment factors reflect a reduction for only the portion of cost for each COS that is not Medicare cost sharing, resulting in an effective adjustment that is less than 2.81% for many of the COS.

ADJUSTMENT FOR PHYSICIAN AND PROFESSIONAL SERVICES RATABLE REDUCTION

This legislative ratable reduction language states that the current 2010 payment rates for certain physician and professional services are to be reduced by 7%. The reduction does not apply to physical therapy services, occupational therapy services, speech pathology and related services, and services provided by psychiatrists and advanced practice nurses with a specialty in mental health. In addition, the physician and professional services ratable reduction does not apply to the Medicare cost sharing portion of the rates for dual eligible individuals.

Based on discussion with DHS, we understand this 7% reduction is to be applied in addition to the 5% reduction enacted in October 2009 (i.e., the 1.5% unallotment from October 2009 is included in the 7%), resulting in an effective reduction of approximately 5.5% for these services. We used data provided by DHS, both data that was provided for the October 2009 adjustments and additional data regarding psychiatrists and advanced practice nurses with a specialty in mental health, to develop the required adjustments for September 2010.

The PMPM adjustment factors in Appendix 2 reflect this reduction for the applicable COS. As this adjustment is effective October 1, 2010, we applied three-fourths of the PMPM adjustment we would otherwise apply, to recognize that the new rates are effective September 1, 2010. If an adjustment for a particular COS is less than $0.005 PMPM, the adjustment will be reflected as $0.00 PMPM in Appendix 2.

ADJUSTMENT FOR RATE INCREASE FOR THERAPY SERVICES

This legislative language requires the commissioner to classify physical therapy, occupational therapy, and speech language pathology and related services as basic care service and apply the same ratable reduction to these services as other basic care services (4.5%). Since the ratable reduction applied to these services was 6.5% in October 2009, this adjustment effectively increases the payment rates for these services by approximately 2%. This increase does not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. We used data provided by DHS that was provided for the October 2009 adjustments to develop the required adjustments for September 2010.

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The PMPM adjustment factors in Appendix 2 reflect this increase for the applicable COS. As this adjustment is effective October 1, 2010, we applied three-fourths of the PMPM adjustment we would otherwise apply, to recognize that the new rates are effective September 1, 2010. If an adjustment for a particular COS is less than $0.005 PMPM, the adjustment will be reflected as $0.00 PMPM in Appendix 2.

ADJUSTMENT FOR INPATIENT RATABLE REDUCTION

The October 2009 rate adjustments reflected a 1% legislative ratable reduction for inpatient services. This rate adjustment was maintained in the CY 2010 rates. In addition, the trends applied to develop the CY 2010 rates reflected an additional 0.9% ratable reduction for inpatient services. Therefore, no additional adjustment needs to be made to the September 2010 rates for ratable reductions related to inpatient services.

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VII. 2011 RATE DEVELOPMENT

As in past years, in 2011 DHS will issue a single monthly payment to each health plan or its designee for which the health plan must provide the SNBC benefits set forth in the contract for all enrolled persons. The amount of the monthly payment will be equal to the product of the CY 2011 base rates multiplied by the risk factor for each person enrolled in the health plan, updated on a rolling quarterly basis. To ensure that the payments to the health plan reflect the resource needs of the enrolled population as accurately as possible, DHS developed a risk factor assignment methodology which acknowledges each enrollee's diagnosis history. The risk factor weights will be provided in a separate document.

The remainder of this section describes the adjustments to the September through December 2010 base rates required to develop the CY 2011 base rates.

TRENDS

The 2010 to 2011 trend assumptions, based on data provided by DHS, are 11.0% for Home Health Agency (HHA) services, 5.0% for non-HHA acute care services, and 9.0% for prescription drugs.

INCREASE IN DENTAL RATES

Effective January 1, 2011 for managed care, state-operated dental clinics are to be paid using a cost-based payment system based on Medicare cost-finding methods and allowable costs. We understand there are currently five such clinics. We used the fiscal note provided by DHS to develop the required rate adjustment.

The fiscal note estimates a payment increase of $1,185,827 to state operated clinics in FY 2009 dollars for the Medicaid population. DHS indicated that it was reasonable to assume that almost all of the "Medicaid" population in this item of the fiscal note was the MA disabled population, which reflected 1,278,000 member months in FY 2009, of which approximately 49,000 were in managed care (MNDHO, SNBC).

The $1,185,827 payment increase includes adjustments for a 25% service reduction and an increase related to critical access dental eligibility. We trended the FY09 cost to CY11 at an annual rate of 5%, the trend rate assumed for the fiscal note. Across the entire MA disabled population, the projected CY 2011 cost increase amounts to $1.05 PMPM ($1.05 = $1,185,827 x $1.05^{2.5}$ / 1,278,000). The PMPM adjustment factors in Appendix 2 reflect this increase for the dental COS.

INPATIENT RATABLE REDUCTIONS

There are two inpatient ratable reductions that affect the 2011 rates.

- Beginning January 1, 2011, the reduction of 1.9%, currently in place for non-mental health inpatient services, expires and is replaced by a reduction of 1.79%.
- Beginning July 1, 2011, an additional inpatient rate reduction of 1.96% applies to all inpatient services, including mental health. We applied half of this reduction to the 2011 rates for the entire year to reflect the July 1, 2011 effective date.

The inpatient ratable reductions do not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

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ADJUSTMENT FOR REMOVAL OF 1.5% BASIC CARE UNALLOTMENT

A legislative ratable reduction reduced the 2009 payment rates for basic care services by 3%. In addition, an unallotment added another 1.5% reduction, for a total reduction of 4.5%. Physician and professional services, inpatient hospital services, family planning services, mental health services, dental services prescription drugs, medical transportation, Federally Qualified Health Contract services, Rural Health Clinics, and Indian Health Services were exempt from this rate reduction. The 2009 PMPM adjustment factors reflected a modification to the 4.5% reduction for the COS that contain exempt services based on data provided by DHS.

The 1.5% unallotment portion of this reduction is sunsetting in July 2011. The 2011 PMPM adjustment factors in Exhibit 2 reflect the required increases to the rates to account for this change. Instead of applying the full required adjustment to the rates for the last six months of 2011, we applied half of the required adjustment to the rates for the entire year so as to not have multiple sets of rates in 2011.

As with the original basic care ratable reduction, the adjustments made to remove the 1.5% unallotment did not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

Please recall that as of September 2010 legislative language requires the commissioner to classify physical therapy, occupational therapy, and speech language pathology and related services as basic care service and apply the same ratable reduction to these services as other basic care services (4.5%). The sunsetting of the 1.5% unallotment in July 2011 also applies to these services and the appropriate adjustments were made in Exhibit 2 for these services.

HEALTH CARE HOME

Health Care Home (HCH) payments were required beginning the second half of calendar year 2010. An adjustment was included in the 2010 rates to reflect the increased cost to the MCOs. Per the documentation supplied by DHS, the HCH payment will be required for the entire 2011 contract.

For the 2011 rates, we developed an adjustment that recognizes more current cost and utilization assumptions provided by DHS. The 2011 PMPM adjustments in Appendix 2 reflect the full-year 2011 PMPM costs less the six-month 2010 PMPM costs trended to 2011.

Table 5 contains the projected 2011 enrollment distribution by HCH Tier, based on information provided by DHS for the disabled population.

Table 5
Special Needs BasicCare
Projected 2011 Enrollment Distribution for HCH

Tier	Enrollment Distribution
0	19.26%
1	8.28%
2	23.64%
3	24.76%
4	24.06%
Total	100.00%

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Table 6 contains projected average HCH payments PMPM for enrollees projected to receive services, as provided by DHS. These averages include a 15% add-on for enrollees who have a primary language other than English or a serious and persistent mental illness. Payments for Tier 3 and 4 for SNBC dual eligibles are projected at 50% of the rate for SNBC non-duals due to the involvement of Medicare's care coordination function.

Table 6
Special Needs BasicCare
Projected 2011 Average Health Care Home Payments PMPM

Tier	SNBC Duals	SNBC Non-Duals
0	$0.00	$0.00
1	$10.47	$10.47
2	$21.00	$21.00
3	$21.06	$42.12
4	$31.64	$63.27

We calculated the weighted average projected payment PMPM for each population, assuming 1.5 months of payments on average per eligible. The 1.5 months of payments was chosen by DHS as its best estimate. This weighted average, assuming 1.5 months of coverage, is $2.33 and $3.94 PMPM for SNBC duals and non-duals, respectively.

VARICELLA VACCINE FOR ADULTS

Currently, the varicella (chicken pox) vaccine is a managed care covered service for children up to age 18, while adults aged 19 and up are covered on a FFS basis. DHS has decided to begin covering the vaccine for adults under the managed care programs in 2011. This coverage will include serum costs for individuals over the age of 21. In addition, as with other vaccines, this coverage excludes the costs for individuals living in border counties who receive their vaccines in states other than Minnesota.

DHS provided 2009 fee-for-service utilization data for managed care enrollees. We allocated the utilization across the impacted adult populations (including PMAP, MNCare, Seniors, PGAMC, and SNBC) and assumed no change in utilization rates for 2011. Based on a 2009 cost per dose of $83.16 (based on DHS serum and administration costs of $81.66 and $1.50, respectively) trended forward two years at the 5% annual acute trend rate, the projected cost of providing these vaccinations is $0.02 PMPM. Similar to the prior year adjustment for coverage of the Zostovax vaccine, this $0.02 PMPM required increase to the rates is included in the 2011 prescription drug base rates in Appendices 1 and 2.

PPACA PROVISIONS

The recently enacted federal health reform legislation (PPACA) requires drug manufacturers to pay rebates to the State. As this provision is expected to reduce or eliminate rebates paid to the plans, a rate increase is necessary. We asked the plans to provide information regarding (A) the ratio of 2009 rebates to 2009 drug cost before rebates, and (B) the ratio of projected 2011 rebates to 2011 drug cost before rebates. We also considered information regarding the plans' confidence in their estimate of this second item. The percentage increase in the prescription costs associated with this provision is calculated as (1 - B) / (1 – A) -1, which equals 3.91%. The 2011 prescription drug base rates in Appendices 1 and 2 reflect this increase.

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ADJUSTMENTS FOR MENTAL HEALTH TARGETED CASE MANAGEMENT

Two changes are being made for the MH-TCM rates for 2011:

> New assumptions are being used to develop the MH-TCM base rates. Table 7 contains a summary of these assumptions,

Table 7 Special Needs BasicCare 2011 Mental Health Targeted Case Management Pricing Assumptions	
A. % of SNBC enrollees that are PIN eligible	33.8%
B. % of PIN eligibles that are eligible for MH-TCM services	80.0%
C. % of months MH-TCM services performed for those eligible for MH-TCM	85.0%
D. Estimated 2011 PMPM cost for MH-TCM eligibles	$469.93
Overall 2011 MH-TCM Base Rate (A x B x C x D)	**$108.01**
Dual 2011 MH-TCM Base Rate	**$111.94**
Non-Dual 2011 MH-TCM Base Rate	**$101.66**

The percentage of SNBC enrollees that are PIN eligible was based on an analysis performed by DHS of FY 2010 SNBC enrollees. The percentage of PIN eligibles that are eligible for MH-TCM services and the percentage of months MH-TCM services are performed for those eligible for MH-TCM are the most recent estimates by DHS.

The estimated 2011 PMPM cost for MH-TCM eligibles is based on county-specific MH-TCM cost information for FY 2011, provided by DHS, which was weighted using the current distribution of SNBC enrollment by county and trended to CY 2011 using an annual trend assumption of -3.7%. The trend assumption was based on recent changes in MH-TCM costs over the last two fiscal years.

The relationship of the dual and non-dual rates is based on the original 2007 MH-TCM experience used to develop the MH-TCM rates in 2009.

> The MH-TCM rates will be risk adjusted for 2011. The plan-specific risk scores will be based on:

- How each plan's percentage of SNBC enrollees that are PIN eligible compares to the overall SNBC percentage of 33.8%.
- How each plan's estimated 2011 PMPM costs for MH-TCM eligibles, based on the plan-specific distribution of SNBC enrollees by county, compares to the overall SNBC PMPM cost of $469.93.

For example, if 30.0% of a plan's SNBC enrollees are PIN eligible and the estimated 2011 PMPM weighted average cost for MH-TCM eligibles in the plan's counties is $500.00, the plan's risk score would be 0.944 (0.944 = 30.0% / 33.8% x $500.00 / $469.93).

The MH-TCM risk scores will be provided to each plan prior to the beginning of the CY 2011 contract year. The weighted average risk scores across all plans will be 1.000 for CY 2011.

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HOSPICE CARE SERVICES

Effective retroactive from March 23, 2010, legislation provides that a recipient of MA age 21 or under who elects to receive hospice care does not waive coverage for services related to the treatment of the condition for which a diagnosis of terminal illness has been made. Less than 0.001% of the base fee-for-service member months for individuals with disabilities were member months associated with individuals age 21 or under who have utilized hospice services. Due to this small percentage, we estimate providing coverage for services related to the treatment of the condition for which a diagnosis of terminal illness has been made will result in additional costs of less than $0.01 PMPM; therefore, no adjustment to the rates for this legislation was made.

SERVICES PROVIDED IN BIRTH CENTERS

Legislation establishes MA coverage for services provided in a licensed birth center by a licensed health professional if such services would otherwise be covered if provided in a hospital. It also provides that licensed traditional midwives are to be paid 100% of what a physician would receive for performing the same services and that facility fees will be reimbursed at a rate of 70% of what a hospital would receive for an uncomplicated vaginal birth.

Similar to other past legislative changes related to services related to births, no adjustments were made to the rates due to the very small number of births within the SNBC population.

CHEMICAL DEPENDANCY RATE REFORM

Chemical dependency rate reform will be legislative will take effect in CY 2011. This legislation is intended to be budget neutral. As a result, no adjustments were made to rates for this legislation.

COSTS BY SERVICE CATEGORY

Appendix 2 contains actuarial cost models which show the distribution of PMPM costs by service category for the eight base rate population combinations. For the 2005 base data, the total cost of prescription drugs is included in the dual eligible cost models. The spenddown amounts shown in Appendix 1 are the total adjusted spenddown amounts contained in Table 2.

CAPITATION RATE COMPONENTS

Appendix 1A contains the components required to develop the CY 2011 capitation rates for each combination of:

- Medicaid only vs. Dual eligibility,
- Population group (Institutional vs. Community), and
- Region (Metro vs. non-Metro).

Appendices 1B and 1C contain templates of the spreadsheets that will be used by DHS to develop CY 2011 capitation rates for Non-County Based Purchasing (non-CBP) and CBP plans, respectively. The Plan Risk Factors in Appendices 1B and 1C, for both acute and MH-TCM services, are for illustrative purposes only. They are not intended to reflect the risk scores of any particular plan for CY 2011.

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MEDICAL EDUCATION RESEARCH COST ADJUSTMENT

DHS will continue to make payments to the Medical Education Research Cost (MERC) Trust Fund on behalf of the MCO. As a result, the CY 2011 SNBC final base rates were adjusted for aggregate MERC reductions based on estimates of potential SNBC eligibility by county and the following percentages:

- 6.3% for Hennepin County
- 2.0% for Anoka, Carver, Dakota, Ramsey, Scott, and Washington Counties
- 1.6% for all other Counties

DIFFERENTIAL HOSPITAL UTILIZATION ADJUSTMENT

Because of differential hospital utilization (DHU) in the fee-for-service base data, DHU is continuing to be removed from single eligible base rates for SNBC and will be added back after the risk adjustment is calculated. This DHU adjustment is only applied to the single eligible population as Medicare is responsible for the hospital costs of dual eligible population.

The CY 2011 SNBC final base rates for single eligibles were adjusted for aggregate DHU reductions based on estimates of potential SNBC eligibility by county and the percentages below. The DHU amounts added back into the rates are county specific based on the percentages below.

- 3.2% for Hennepin County
- 2.6% for Anoka, Carver, Dakota, Ramsey, Scott, and Washington Counties
- 0.7% for all other Counties

LEGISLATED PREMIUM TAX

The CY 2011 final capitation rates continue to include the legislated premium tax of 1%. Final base rates for the CBP plans do not include the premium tax adjustment.

WITHHOLD

A 9.5% withhold adjustment required by legislation continues to be removed from the rates, excluding MERC and the NF-Add on. Withhold returns will be calculated for each MCO based on risk adjusted reimbursed amounts paid to the MCO plus DHU, excluding MERC and the NF-Add on.

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VIII. SNBC NURSING FACILITY ADD-ON RATE

The health plan will be responsible for the first 100 days of nursing facility care for new admissions. The nursing facility per diem costs for persons who resided in nursing facilities prior to enrollment in the health plan are paid on a fee-for-service basis by the Medical Assistance program. For dual eligibles, Medicare covered skilled nursing facility days are counted toward the 100 days health plan liability. The 100 days may be consecutive days or total days for multiple admissions for a contract year.

The aggregate nursing facility rate for the SNBC population is calculated by the following formula:

Monthly Rate	=	Annual Frequency of Nursing Facility Admissions / 12
	x	Average Length-of-Stay
	x	Average Charge per Day

The calculations of the initial rate and subsequent adjustments are outlined on pages 3 and 4 of Appendix 3:

- Section A contains the calculation of the initial rate. The initial rate is equal to the expected nursing facility costs for days in CY 2011 resulting from admissions occurring in CY 2011, divided by projected community eligible months in CY 2011. The initial rates PMPM for CY 2011 are $13.17 and $11.16 for the single eligible and dual eligible community populations, respectively.

- Section B contains the calculation of the tail rate. The tail rate is equal to the expected nursing facility costs for days in CY 2011 resulting from admissions occurring in CY 2010, divided by projected community eligible months in CY 2011. The tail rates PMPM for CY 2011 are $2.12 and $2.32 for the single eligible and dual eligible community populations, respectively.

- Section C contains the calculations of the value of the enrollment adjustment based on updated enrollment. There is an enrollment adjustment for CY 2011 of $0.34 and $2.96 for the single eligible and dual eligible community populations, respectively. The positive enrollment adjustment accounts for plans being underpaid in CY 2010 due to the CY 2010 rates being based on <u>projected</u> CY 2010 enrollment. Actual 2010 enrollment indicates the CY 2010 rates should have been set slightly higher.

- Section D contains the initial base rates for CY 2011 of $15.63 and $16.44 for the single eligible and dual eligible community populations, respectively. In addition, the initial base rate was decreased by 1.7% so that disenrollment fees do not need to be charged. Without this adjustment, a disenrollment fee would need to be paid to DHS by the managed care organization (MCO) when an institutionalized SNBC enrollee disenrolls during the 100-day benefit period. The resulting final base rates for CY 2011 are $15.36 and $16.16 for the single eligible and dual eligible community populations, respectively.

The data source for the calculation of the frequency and average length-of-stay (ALOS) consists of fee-for-service experience data from CY 2005 for eligibles with disabilities. This data was compiled by DHS staff. The data reflects experience from the single eligible population (those eligible only for Medicaid) and the dually eligible population (those eligible for both Medicare and Medicaid benefits).

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FREQUENCY

The frequency of admission is expressed as the expected number of admissions per eligible on an annual basis. The annual frequencies of admission are 1.5% for both the single eligible and dual eligible community populations.

AVERAGE LENGTH-OF-STAY

The ALOS is 72 days and 73 days for the single eligible and dual eligible community populations, respectively. These amounts include only the first 100 days per stay for all admissions combined. Skilled nursing facility days reimbursed by Medicare will be included in the 100-day pre-funded liability, with lower payments due to Medicare's portion. This is reflected by lowering the ALOS used to calculate the initial rate by 10.3 days for the dual eligible community eligibles. In the NF Add-on rate calculation, the length-of-stay is adjusted to exclude days which occur beyond the contract period.

CHARGE PER DAY

An initial charge per day of $163.38 was based on the projected 2008 nursing facility charge per day, prior to any COLA adjustments, using information prepared by DHS for the disabled fee-for-service population. The charge reflects Medicaid reimbursed amounts. This charge per day was adjusted as follows:

- Increased 1.87% to reflect the COLA for nursing facility services effective January 1, 2008.
- Increased an additional 3.4%, 1.1%, and 0.5% for nursing facility trend from 2008 to 2009, from 2009 to 2010, and from 2010 to 2011, respectively. The 1.1% trend from 2009 to 2010 includes the impact of the legislation's suspension of nursing facility rebasing for FY 2010.
- Decreased 3% to reflect legislation effective September 1, 2010 which included ratable reduction language stating that NF rates for non-administrative services were to be reduced by 3%. This rateable reduction continues to apply in CY 2011 and therefore needs to be reflected in the CY 2011 NF rates.

This results in a final projected CY 2011 charge per day of $169.61 ($169.61 = $163.38 x 1.0187 x 1.034 x 1.011 x 1.005 x 0.97).

LEGISLATED PREMIUM TAX

The CY 2011 SNBC NF add-on rates include the legislated premium tax of 1%, which is added to the rates in Appendix 1A. Final CY 2011 SNBC NF add-on rates for the CBP plans do not include the premium tax adjustment.

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BASE RATE CALCULATION

The single and dual eligible base rate calculations use the following formula:

$$\frac{\text{Admits}}{\text{Eligible Months}} \times \frac{\text{Days}}{\text{Admit}} \times \frac{\$}{\text{Day}} = \frac{\$}{\text{Eligible Months}}$$

The base rate calculation only considers nursing facility days that occur within the contract period and is therefore dependent on the enrollment assumptions by month. Enrollment assumptions by month were provided by DHS and are shown in the detailed aggregate rate calculations contained on pages 1 and 2 of Appendix 3.

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Appendix 1

SNBC 2011 Base Rate Tables

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Appendix 1A
Special Needs BasicCare
Development of Calendar Year 2011 Rate Components Per Member Per Month (PMPM)

Population			A	B	C	D	E	F	G	H	I	J	K
			Estimated Distibution of 2010 Enrollment	From Appendix 2			Initial Base Rate	MERC Adjstmt.	Composite MERC Adjstmt.	DHU Adjstmt.	Composite DHU Adjstmt.	Base Rate Premium Tax	Composite Base Rate Premium Tax
				Acute Base Rate	Rx Base Rate	Spenddown Adjustment							
Duals	Institutional	Metro 1	6	$346.86	$24.70	$0.84	$372.40	$23.46	$17.96	N/A	N/A	$3.52	$3.58
		Metro 2	2	346.86	24.70	0.84	372.40	7.45	17.96	N/A	N/A	3.69	3.58
		Metro 3	1	346.86	24.70	0.84	372.40	5.96	17.96	N/A	N/A	3.70	3.58
		Non-Metro	136	$278.36	$19.22	$0.45	$298.03	$4.77	$4.77	N/A	N/A	$2.96	$2.96
	Community	Metro 1	421	$411.37	$18.91	$6.72	$437.00	$27.53	$17.21	N/A	N/A	$4.14	$4.24
		Metro 2	375	411.37	18.91	6.72	437.00	8.74	17.21	N/A	N/A	4.33	4.24
		Metro 3	114	411.37	18.91	6.72	437.00	6.99	17.21	N/A	N/A	4.34	4.24
		Non-Metro	1,725	$371.92	$18.24	$3.30	$393.46	$6.30	$6.30	N/A	N/A	$3.91	$3.91
Non-Duals	Institutional	Metro 1	1	$1,863.16	$1,041.13	$1.10	$2,905.39	$183.04	$80.77	$92.97	$67.99	$26.56	$27.85
		Metro 2	3	1,863.16	1,041.13	1.10	2,905.39	58.11	80.77	75.54	67.99	28.00	27.85
		Metro 3	1	1,863.16	1,041.13	1.10	2,905.39	46.49	80.77	20.34	67.99	28.67	27.85
		Non-Metro	9	$1,635.17	$864.29	$0.93	$2,500.39	$40.01	$40.01	$17.50	$17.50	$24.68	$24.68
	Community	Metro 1	431	$1,196.61	$465.25	$2.06	$1,663.92	$104.83	$70.14	$53.25	$45.80	$15.21	$15.63
		Metro 2	323	1,196.61	465.25	2.06	1,663.92	33.28	70.14	43.26	45.80	16.03	15.63
		Metro 3	70	1,196.61	465.25	2.06	1,663.92	26.62	70.14	11.65	45.80	16.42	15.63
		Non-Metro	672	$1,107.46	$595.32	$1.63	$1,704.41	$27.27	$27.27	$11.93	$11.93	$16.82	$16.82

Population			L	M	N	O	P	Q	R	S	T
			Non-CBP Final Base Rate with MERC and DHU Removed	CBP Final Base Rate with MERC and DHU Removed	MERC Add-Back	DHU Add-Back for Non-CBP (includes Premium Tax)	DHU Add-Back for CBP	NF Add-On for Non-CBP (includes Premium Tax)	From App. 3 NF Add-On for CBP	MHTCM Add-On for Non-CBP (includes Premium Tax)	From App. 2 MHTCM Add-On for CBP
Duals	Institutional	Metro 1	$358.02	N/A	$23.46	N/A	N/A	N/A	N/A	$113.07	$111.94
		Metro 2	358.02	N/A	7.45	N/A	N/A	N/A	N/A	113.07	111.94
		Metro 3	358.02	N/A	5.96	N/A	N/A	N/A	N/A	113.07	111.94
		Non-Metro	$296.22	$293.26	$4.77	N/A	N/A	N/A	N/A	$113.07	$111.94
	Community	Metro 1	$424.03	N/A	$27.53	N/A	N/A	$16.32	N/A	$113.07	$111.94
		Metro 2	424.03	N/A	8.74	N/A	N/A	16.32	N/A	113.07	111.94
		Metro 3	424.03	N/A	6.99	N/A	N/A	16.32	N/A	113.07	111.94
		Non-Metro	$391.07	$387.16	$6.30	N/A	N/A	$16.32	$16.16	$113.07	$111.94
Non-Duals	Institutional	Metro 1	$2,784.48	N/A	$183.04	$93.91	N/A	N/A	N/A	$102.69	$101.66
		Metro 2	2,784.48	N/A	58.11	76.30	N/A	N/A	N/A	102.69	101.66
		Metro 3	2,784.48	N/A	46.49	20.54	N/A	N/A	N/A	102.69	101.66
		Non-Metro	$2,467.56	$2,442.88	$40.01	$17.68	$17.50	N/A	N/A	$102.69	$101.66
	Community	Metro 1	$1,563.61	N/A	$104.83	$53.78	N/A	$15.52	N/A	$102.69	$101.66
		Metro 2	1,563.61	N/A	33.28	43.70	N/A	15.52	N/A	102.69	101.66
		Metro 3	1,563.61	N/A	26.62	11.77	N/A	15.52	N/A	102.69	101.66
		Non-Metro	$1,682.03	$1,665.21	$27.27	$12.05	$11.93	$15.52	$15.36	$102.69	$101.66

Metro 1 - Hennepin County
Metro 2 - Anoka, Carver, Dakota, Ramsey, Scott, and Washington Counties
Metro 3 - Sherburne and Wright Counties
Non-Metro - All other counties

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Appendix 1B
Special Needs BasicCare
Calendar Year 2011 Capitation Payment Rates
Non-CBP Plans

Rate Regions			MERC Carve Out	DHU Add-on [1]	MERC + DHU	Risk Adjustment Base Rate [1,2]	Plan Acute Risk Factor [3]	Plan RA Rate [1,2,3]	Plan RA Rate + DHU - Withhold [1,3]	Plan RA Rate + DHU + MERC - Withhold [1,3]	NF Add-on [1]	Plan MH-TCM Risk Factor	MH-TCM Add-on - Withhold [1]	Total Plan Rate (Includes MERC) [1,3]	Plan Reimbursement Amount (Excludes MERC) [1,3]
			1	2		3	4	5	6	7	8	9	10	11	12
			App. 1A (N)	App. 1A (O)		App. 1A (L)		(3 x 4)	(2 + 5) x 0.905	(6 + 1)	App. 1A (Q)		App. 1A (S) x 0.905 x 9	(7 + 8 + 10)	(6 + 8 + 10)
Hennepin	**Institutionalized**	**Dual**	$23.46	N/A	$23.46	$358.02	1.2008	$429.91	$389.07	$412.53	N/A	1.0000	$102.33	$514.85	$491.39
		Non- Dual	183.04	$93.91	276.95	2,784.48	1.3576	3,780.21	3,506.08	3,689.12	N/A	1.0000	92.93	3,782.05	3,599.01
	Non-Institutionalized	**Dual**	27.53	N/A	27.53	424.03	1.2008	509.18	460.81	488.34	$16.32	1.0000	$102.33	606.99	579.46
		Non- Dual	104.83	53.78	158.61	1,563.61	1.3576	2,122.76	1,969.77	2,074.60	15.52	1.0000	92.93	2,183.06	2,078.23
Metro	**Institutionalized**	**Dual**	$7.45	N/A	$7.45	$358.02	1.2008	$429.91	$389.07	$396.52	N/A	1.0000	$102.33	$498.84	$491.39
		Non- Dual	58.11	$76.30	134.41	2,784.48	1.3576	3,780.21	3,490.14	3,548.25	N/A	1.0000	92.93	3,641.19	3,583.08
	Non-Institutionalized	**Dual**	8.74	N/A	8.74	424.03	1.2008	509.18	460.81	469.55	$16.32	1.0000	$102.33	588.20	579.46
		Non- Dual	33.28	43.70	76.98	1,563.61	1.3576	2,122.76	1,960.65	1,993.93	15.52	1.0000	92.93	2,102.38	2,069.10
NW Metro	**Institutionalized**	**Dual**	$5.96	N/A	$5.96	$358.02	1.2008	$429.91	$389.07	$395.03	N/A	1.0000	$102.33	$497.35	$491.39
		Non- Dual	46.49	$20.54	67.03	2,784.48	1.3576	3,780.21	3,439.68	3,486.17	N/A	1.0000	92.93	3,579.10	3,532.61
	Non-Institutionalized	**Dual**	6.99	N/A	6.99	424.03	1.2008	509.18	460.81	467.80	$16.32	1.0000	$102.33	586.45	579.46
		Non- Dual	26.62	11.77	38.39	1,563.61	1.3576	2,122.76	1,931.75	1,958.37	15.52	1.0000	92.93	2,066.83	2,040.21
Non-Metro	**Institutionalized**	**Dual**	$4.77	N/A	$4.77	$296.22	1.2008	$355.70	$321.91	$326.68	N/A	1.0000	$102.33	$429.01	$424.24
		Non- Dual	40.01	$17.68	57.69	2,467.56	1.3576	3,349.96	3,047.71	3,087.72	N/A	1.0000	92.93	3,180.66	3,140.65
	Non-Institutionalized	**Dual**	6.30	N/A	6.30	391.07	1.2008	469.60	424.99	431.29	$16.32	1.0000	$102.33	549.93	543.63
		Non- Dual	27.27	12.05	39.32	1,682.03	1.3576	2,283.52	2,077.49	2,104.76	15.52	1.0000	92.93	2,213.22	2,185.95

[1] Includes 1% premium tax.

[2] Does not include MERC Carve-Out or DHU Add-On. Includes 1% premium tax.

[3] The plan acute risk factor and risk adjusted rates will change each quarter

Rate Regions:

Hennepin:	Hennepin County
Metro:	Anoka, Carver, Dakota, Ramsey, Scott & Washington Counties
NW Metro:	Sherburne & Wright Counties
Non-Metro:	All other counties not previously listed

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Appendix 1C
Special Needs BasicCare
Calendar Year 2011 Capitation Payment Rates
CBP Plans

Rate Regions			MERC Carve Out	DHU Add-on	MERC + DHU	Risk Adjustment Base Rate [1]	Plan Acute Risk Factor [2]	Plan RA Rate [1,2]	Plan RA Rate + DHU - Withhold [2]	Plan RA Rate + DHU + MERC - Withhold [2]	NF Add-on	Plan MH-TCM Risk Factor	MH-TCM Add-on - Withhold	Total Plan Rate (Includes MERC) [2]	Plan Reimbursement Amount (Excludes MERC) [2]
			1	2		3	4	5	6	7	8	9	10	11	12
			App. 1A (N)	App. 1A (P)		App. 1A (M)		(3 x 4)	(2 + 5) x 0.905	(6 + 1)	App. 1A (R)		App. 1A (S) x 0.905 x 9	(7 + 8 + 10)	(6 + 8 + 10)
Non-Metro	**Institutionalized**	**Dual**	$4.77	N/A	$4.77	$293.26	1.2008	$352.15	$318.69	$323.46	N/A	1.0000	$101.31	$424.77	$420.00
		Non- Dual	40.01	$17.50	57.51	2,442.88	1.3576	3,316.45	3,017.23	3,057.24	N/A	1.0000	92.00	3,149.24	3,109.23
	Non-Institutionalized	**Dual**	6.30	N/A	6.30	387.16	1.2008	464.90	420.74	427.04	$16.16	1.0000	101.31	544.50	538.20
		Non- Dual	27.27	11.93	39.20	1,665.21	1.3576	2,260.69	2,056.72	2,083.99	15.36	1.0000	92.00	2,191.35	2,164.08

[1] Does not include MERC Carve-Out or DHU Add-On.

[2] The plan risk factor and risk adjusted rates will change each quarter

Rate Regions:

Hennepin:	Hennepin County
Metro:	Anoka, Carver, Dakota, Ramsey, Scott & Washington Counties
NW Metro:	Sherburne & Wright Counties
Non-Metro:	All other counties not previously listed

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Appendix 2

SNBC PMPM Cost Models

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Appendix 2
Special Need BasicCare
2011 Per Member Per Month Rate Development

Population: Dual Eligibles, Metro Counties, Institutional

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	January - August 2010 PMPM Rates	September - December 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	MH-TCM 2011 Assumption Adjustment	2011 PMPM Rates
001	Inpatient Hospital General	$35.88	$48.95	$48.81	$51.35	$50.96	1.050	$0.00	($0.14)	$0.00	$0.00	$0.00	$0.00	$0.00	$53.37
006	Rehabilitation	0.15	0.17	0.17	$0.18	$0.18	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.19
007	Outpatient Hospital Services	14.66	15.88	15.82	$16.64	$16.63	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$17.47
015	Inpatient Long Term Hospital	0.65	0.86	0.85	$0.89	$0.87	1.050	$0.00	($0.01)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.90
020	Home Health Services	0.09	0.09	0.09	$0.09	$0.09	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.10
032	Medical Supply / DME	33.98	36.80	36.11	$37.99	$37.41	1.050	$0.00	$0.00	$0.13	$0.00	$0.00	$0.00	$0.00	$39.41
036	Transport, Special	46.48	50.33	50.33	$52.95	$51.46	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$54.03
037	Transport, Ambulance	7.46	8.08	8.08	$8.50	$8.48	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.90
041	Anesthesia	1.52	1.65	1.65	$1.74	$1.74	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.83
043	Physician Services	41.42	44.85	44.55	$46.87	$46.58	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$48.91
045	Dental	19.13	20.72	20.72	$16.89	$16.42	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$18.29
046	Mental Health	29.47	32.50	32.50	$34.19	$33.58	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$35.26
051	Physical Therapy	6.87	7.74	7.56	$7.95	$7.91	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$0.00	$8.33
053	Speech Therapy	2.71	3.06	2.97	$3.12	$3.10	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$3.27
054	Occupational Therapy	9.68	10.91	10.46	$11.00	$10.91	1.050	$0.00	$0.00	$0.06	$0.00	$0.00	$0.00	$0.00	$11.51
055	Podiatry	0.70	0.76	0.76	$0.80	$0.80	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.84
057	Chiropractic	0.04	0.05	0.05	$0.05	$0.05	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.05
058	Audiology	0.51	0.55	0.54	$0.57	$0.56	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.59
062	Chemical Dependency	0.59	0.67	0.67	$0.70	$0.68	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.71
063	CD Extended Care / Halfway House	0.00	0.00	0.00	$0.00	$0.00	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
072	Hospice	1.33	1.44	1.44	$1.51	$1.47	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.54
074	Inpatient Hospital 45 Day Psych Contract	0.69	0.75	0.75	$0.79	$0.79	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.83
075	Eyeglasses / Contact Lenses	2.08	2.25	2.15	$2.26	$2.20	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$0.00	$2.33
076	Prosthetics and Orthotics	2.86	3.10	3.03	$3.19	$3.17	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$3.34
077	Hearing Aids	0.78	0.85	0.84	$0.88	$0.86	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.90
078	Vision Care	2.26	2.44	2.36	$2.48	$2.42	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.54
079	Radiology, Technical Component	10.96	11.86	11.82	$12.43	$12.41	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$13.03
080	Laboratory	1.12	1.22	1.20	$1.26	$1.26	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.33
082	Federal Qualified Health Contract Service	2.84	3.07	3.07	$3.23	$3.14	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.30
087	End-Stage Renal Dialysis	7.72	8.36	8.36	$8.79	$8.79	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.23
091	Nurse Practitioner Services	1.06	1.15	1.15	$1.21	$1.21	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.27
999	Unable to Define	0.25	0.28	0.28	$0.29	$0.29	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.30
	Dialectical Behavioral Therapy	0.67	0.58	0.58	$0.61	$0.59	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.62
	Health Care Home Care Coordination	0.00	0.00	0.00	$1.17	$1.14	1.050	$0.00	$0.00	$0.00	$1.13	$0.00	$0.00	$0.00	$2.33
	Total Acute Base Rate	$286.65	$321.97	$319.72	$332.61	$328.15									$346.86
	Prescription Drugs	$622.75	$20.70	$20.70	$22.42	$21.79	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$0.93	$0.00	$24.70
	Spenddown	1.98	0.86	0.86	$0.86	$0.84	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.84
	Grand Total	$911.38	$343.53	$341.28	$355.89	$350.78	$18.37	$1.05	($0.15)	$0.27	$1.13	$0.02	$0.93	$0.00	$372.40
	Mental Health Targeted Case Management	$56.21	$54.94	$54.94	$65.50	$63.53	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45.23	$111.94
	2005 Eligible Months	19,918													

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Appendix 2
Special Need BasicCare
2011 Per Member Per Month Rate Development

Population: Dual Eligibles, Non-Metro Counties, Institutional

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	January - August 2010 PMPM Rates	September - December 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	MH-TCM 2011 Assumption Adjustment	2011 PMPM Rates
001	Inpatient Hospital General	$22.95	$31.31	$31.29	$32.92	$32.85	1.050	$0.00	($0.02)	$0.00	$0.00	$0.00	$0.00	$0.00	$34.47
006	Rehabilitation	0.15	0.17	0.17	$0.18	$0.18	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.19
007	Outpatient Hospital Services	15.60	16.90	16.76	$17.63	$17.60	1.050	$0.00	$0.00	$0.03	$0.00	$0.00	$0.00	$0.00	$18.51
014	Inpatient Hospital IMD	0.10	0.11	0.11	$0.12	$0.12	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.13
015	Inpatient Long Term Hospital	1.00	1.32	1.31	$1.38	$1.34	1.050	$0.00	($0.01)	$0.00	$0.00	$0.00	$0.00	$0.00	$1.40
020	Home Health Services	0.06	0.06	0.06	$0.06	$0.06	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.07
032	Medical Supply / DME	37.43	40.53	39.42	$41.47	$40.83	1.050	$0.00	$0.00	$0.20	$0.00	$0.00	$0.00	$0.00	$43.08
036	Transport, Special	46.92	50.81	50.81	$53.45	$51.95	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$54.55
037	Transport, Ambulance	6.27	6.79	6.79	$7.14	$7.14	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.50
041	Anesthesia	1.17	1.26	1.26	$1.33	$1.33	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.40
043	Physician Services	36.30	39.31	39.23	$41.27	$41.20	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$43.26
045	Dental	18.03	19.52	19.52	$15.91	$15.46	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.28
046	Mental Health	10.33	11.39	11.39	$11.98	$11.85	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$12.44
051	Physical Therapy	4.14	4.66	4.65	$4.89	$4.89	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.13
053	Speech Therapy	1.04	1.17	1.17	$1.23	$1.23	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.29
054	Occupational Therapy	3.54	3.99	3.95	$4.16	$4.15	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$4.36
055	Podiatry	0.44	0.47	0.47	$0.49	$0.49	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.51
056	Ambulatory Surgery	0.18	0.20	0.20	$0.21	$0.21	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.22
057	Chiropractic	0.13	0.14	0.14	$0.15	$0.15	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.16
058	Audiology	0.30	0.32	0.31	$0.33	$0.33	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.35
062	Chemical Dependency	0.76	0.86	0.86	$0.90	$0.87	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.91
063	CD Extended Care / Halfway House	0.00	0.00	0.00	$0.00	$0.00	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
072	Hospice	2.72	2.94	2.94	$3.09	$3.00	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.15
074	Inpatient Hospital 45 Day Psych Contract	0.07	0.08	0.08	$0.08	$0.08	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.08
075	Eyeglasses / Contact Lenses	1.57	1.70	1.62	$1.70	$1.65	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$1.75
076	Prosthetics and Orthotics	2.81	3.05	3.01	$3.17	$3.16	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$3.33
077	Hearing Aids	0.50	0.55	0.54	$0.57	$0.55	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.58
078	Vision Care	1.59	1.73	1.69	$1.78	$1.75	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.84
079	Radiology, Technical Component	8.69	9.41	9.37	$9.86	$9.84	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$10.33
080	Laboratory	1.18	1.28	1.26	$1.33	$1.33	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.40
082	Federal Qualified Health Contract Service	0.09	0.10	0.10	$0.11	$0.11	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.12
083	Rural Health Clinic Services	1.31	1.41	1.41	$1.48	$1.47	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.54
087	End-Stage Renal Dialysis	2.91	3.15	3.15	$3.31	$3.31	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.48
088	Public Health Nursing	0.02	0.02	0.02	$0.02	$0.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.02
091	Nurse Practitioner Services	0.39	0.42	0.42	$0.44	$0.44	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.46
999	Unable to Define	0.11	0.12	0.12	$0.13	$0.13	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.14
	Dialectical Behavioral Therapy	0.67	0.58	0.58	$0.61	$0.59	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.62
	Health Care Home Care Coordination	0.00	0.00	0.00	$1.17	$1.14	1.050	$0.00	$0.00	$0.00	$1.13	$0.00	$0.00	$0.00	$2.33
	Total Acute Base Rate	$231.49	$257.83	$256.18	$266.05	$262.80									$278.36
	Prescription Drugs	$484.85	$16.13	$16.13	$17.44	$16.95	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$0.72	$0.00	$19.22
	Spenddown	1.06	0.46	0.46	$0.46	$0.45	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.45
	Grand Total	$717.40	$274.42	$272.77	$283.95	$280.20	$14.67	$1.05	($0.03)	$0.26	$1.13	$0.02	$0.72	$0.00	$298.03
	Mental Health Targeted Case Management	$56.21	$54.94	$54.94	$65.50	$63.53	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45.23	$111.94
	2005 Eligible Months	13,036													

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Appendix 2
Special Need BasicCare
2011 Per Member Per Month Rate Development

Population: Dual Eligibles, Metro Counties, Community

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	January - August 2010 PMPM Rates	September - December 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	MH-TCM 2011 Assumption Adjustment	2011 PMPM Rates
001	Inpatient Hospital General	$28.81	$45.64	$45.57	$47.94	$47.78	1.050	$0.00	($0.07)	$0.00	$0.00	$0.00	$0.00	$0.00	$50.10
006	Rehabilitation	0.20	0.25	0.25	$0.26	$0.26	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.27
007	Outpatient Hospital Services	15.45	19.43	19.38	$20.39	$20.39	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$21.42
014	Inpatient Hospital IMD	0.11	0.14	0.14	$0.15	$0.15	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.16
015	Inpatient Long Term Hospital	4.82	7.40	7.33	$7.71	$7.53	1.050	$0.00	($0.07)	$0.00	$0.00	$0.00	$0.00	$0.00	$7.84
020	Home Health Services	24.40	26.58	25.89	$25.63	$24.91	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$27.65
029	RTC - Mental Health	0.57	0.72	0.72	$0.76	$0.74	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.78
032	Medical Supply / DME	21.46	26.98	26.29	$27.66	$27.28	1.050	$0.00	$0.00	$0.13	$0.00	$0.00	$0.00	$0.00	$28.77
036	Transport, Special	12.02	15.12	15.12	$15.91	$15.46	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.23
037	Transport, Ambulance	3.43	4.31	4.31	$4.53	$4.52	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.75
041	Anesthesia	0.99	1.25	1.25	$1.32	$1.32	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.39
043	Physician Services	38.04	47.82	47.54	$50.01	$49.77	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$52.26
045	Dental	13.77	17.31	17.31	$14.11	$13.71	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.45
046	Mental Health	86.10	110.23	110.23	$115.96	$113.19	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$118.85
051	Physical Therapy	1.54	2.01	1.98	$2.08	$2.08	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.19
053	Speech Therapy	0.48	0.62	0.59	$0.62	$0.62	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.65
054	Occupational Therapy	2.10	2.75	2.61	$2.75	$2.72	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$0.00	$2.87
055	Podiatry	0.34	0.43	0.42	$0.44	$0.44	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.46
056	Ambulatory Surgery	0.04	0.04	0.04	$0.04	$0.04	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.04
057	Chiropractic	0.54	0.68	0.68	$0.72	$0.72	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.76
058	Audiology	0.15	0.19	0.19	$0.20	$0.20	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.21
062	Chemical Dependency	5.55	7.26	7.26	$7.64	$7.43	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.80
063	CD Extended Care / Halfway House	1.10	1.38	1.38	$1.45	$1.41	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.48
072	Hospice	3.43	4.31	4.31	$4.53	$4.40	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.62
074	Inpatient Hospital 45 Day Psych Contract	2.02	2.54	2.54	$2.67	$2.65	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.78
075	Eyeglasses / Contact Lenses	1.95	2.46	2.35	$2.47	$2.40	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$0.00	$2.54
076	Prosthetics and Orthotics	1.69	2.12	2.07	$2.18	$2.16	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$2.28
077	Hearing Aids	0.60	0.76	0.75	$0.79	$0.77	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.81
078	Vision Care	1.05	1.32	1.28	$1.35	$1.32	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.39
079	Radiology, Technical Component	11.28	14.18	14.11	$14.84	$14.80	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.54
080	Laboratory	1.39	1.74	1.71	$1.80	$1.80	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$1.90
082	Federal Qualified Health Contract Service	3.63	4.56	4.56	$4.80	$4.67	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.90
083	Rural Health Clinic Services	0.01	0.02	0.02	$0.02	$0.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.02
087	End-Stage Renal Dialysis	5.44	6.84	6.84	$7.20	$7.20	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.56
088	Public Health Nursing	0.05	0.06	0.06	$0.06	$0.06	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.06
090	Nurse Midwife Services	0.01	0.01	0.01	$0.01	$0.01	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01
091	Nurse Practitioner Services	0.22	0.27	0.27	$0.28	$0.28	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.29
999	Unable to Define	0.88	1.11	1.11	$1.17	$1.17	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.23
	Dialectical Behavioral Therapy	0.67	0.68	0.68	$0.72	$0.70	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.74
	Health Care Home Care Coordination	0.00	0.00	0.00	$1.17	$1.14	1.050	$0.00	$0.00	$0.00	$1.13	$0.00	$0.00	$0.00	$2.33
	Total Acute Base Rate	$296.34	$381.52	$379.15	$394.33	$388.22									$411.37
	Prescription Drugs	$411.06	$15.87	$15.87	$17.16	$16.68	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$0.71	$0.00	$18.91
	Spenddown	27.85	6.91	6.91	$6.91	$6.72	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.72
	Grand Total	$735.25	$404.30	$401.93	$418.40	$411.62	$22.41	$1.05	($0.14)	$0.20	$1.13	$0.02	$0.71	$0.00	$437.00
	Mental Health Targeted Case Management	$56.21	$63.78	$63.78	$76.04	$73.76	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$34.49	$111.94
	NF Add-on					$13.36									$16.16
	2005 Eligible Months	233,845													

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Appendix 2
Special Need BasicCare
2011 Per Member Per Month Rate Development

Population: Dual Eligibles, Non-Metro Counties, Community

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	January - August 2010 PMPM Rates	September - December 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	MH-TCM 2011 Assumption Adjustment	2011 PMPM Rates
001	Inpatient Hospital General	$21.82	$34.56	$34.54	$36.34	$36.29	1.050	$0.00	($0.02)	$0.00	$0.00	$0.00	$0.00	$0.00	$38.08
006	Rehabilitation	0.11	0.13	0.13	$0.14	$0.14	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.15
007	Outpatient Hospital Services	16.41	20.62	20.56	$21.63	$21.63	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$22.72
014	Inpatient Hospital IMD	1.60	2.01	2.00	$2.10	$2.07	1.050	$0.00	($0.01)	$0.00	$0.00	$0.00	$0.00	$0.00	$2.16
015	Inpatient Long Term Hospital	1.16	1.78	1.76	$1.85	$1.81	1.050	$0.00	($0.02)	$0.00	$0.00	$0.00	$0.00	$0.00	$1.88
020	Home Health Services	22.98	25.03	24.38	$24.14	$23.46	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$26.04
029	RTC - Mental Health	8.00	10.06	10.06	$10.58	$10.28	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$10.79
032	Medical Supply / DME	20.45	25.70	25.05	$26.35	$25.97	1.050	$0.00	$0.00	$0.12	$0.00	$0.00	$0.00	$0.00	$27.39
036	Transport, Special	10.26	12.90	12.90	$13.57	$13.19	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$13.85
037	Transport, Ambulance	2.99	3.76	3.76	$3.96	$3.96	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.16
041	Anesthesia	0.96	1.20	1.20	$1.26	$1.26	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.32
043	Physician Services	34.54	43.42	43.20	$45.45	$45.27	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$47.53
045	Dental	16.16	20.32	20.32	$16.57	$16.10	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.96
046	Mental Health	77.79	99.60	99.60	$104.78	$102.26	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$107.37
051	Physical Therapy	1.76	2.30	2.30	$2.42	$2.42	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.54
053	Speech Therapy	0.23	0.30	0.29	$0.31	$0.31	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.33
054	Occupational Therapy	0.34	0.44	0.44	$0.46	$0.46	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.48
055	Podiatry	0.35	0.44	0.44	$0.46	$0.46	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.48
056	Ambulatory Surgery	0.12	0.15	0.15	$0.16	$0.16	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.17
057	Chiropractic	0.95	1.19	1.19	$1.25	$1.25	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.31
058	Audiology	0.14	0.18	0.18	$0.19	$0.19	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.20
062	Chemical Dependency	4.55	5.95	5.95	$6.26	$6.09	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.39
063	CD Extended Care / Halfway House	0.91	1.15	1.15	$1.21	$1.18	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.24
072	Hospice	1.93	2.42	2.42	$2.55	$2.48	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.60
074	Inpatient Hospital 45 Day Psych Contract	0.58	0.73	0.73	$0.77	$0.77	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.81
075	Eyeglasses / Contact Lenses	2.40	3.02	2.88	$3.03	$2.95	1.050	$0.00	$0.00	$0.03	$0.00	$0.00	$0.00	$0.00	$3.12
076	Prosthetics and Orthotics	1.47	1.85	1.81	$1.90	$1.89	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$1.99
077	Hearing Aids	0.75	0.95	0.94	$0.99	$0.96	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.01
078	Vision Care	1.38	1.74	1.68	$1.77	$1.74	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.83
079	Radiology, Technical Component	11.45	14.40	14.34	$15.09	$15.05	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.80
080	Laboratory	1.30	1.63	1.61	$1.69	$1.69	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.78
082	Federal Qualified Health Contract Service	0.49	0.61	0.61	$0.64	$0.62	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.65
083	Rural Health Clinic Services	0.83	1.04	1.04	$1.09	$1.08	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.13
087	End-Stage Renal Dialysis	1.39	1.74	1.74	$1.83	$1.83	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.92
088	Public Health Nursing	0.32	0.40	0.38	$0.40	$0.39	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.41
090	Nurse Midwife Services	0.01	0.01	0.01	$0.01	$0.01	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01
091	Nurse Practitioner Services	0.28	0.36	0.36	$0.38	$0.38	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.40
999	Unable to Define	0.59	0.74	0.74	$0.78	$0.78	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.82
	Dialectical Behavioral Therapy	0.67	0.68	0.68	$0.72	$0.70	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.74
	Health Care Home Care Coordination	0.00	0.00	0.00	$1.17	$1.14	1.050	$0.00	$0.00	$0.00	$1.13	$0.00	$0.00	$0.00	$2.33
	Total Acute Base Rate	$270.40	$345.51	$343.52	$356.23	$350.67									$371.92
	Prescription Drugs	$396.40	$15.31	$15.31	$16.55	$16.09	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$0.69	$0.00	$18.24
	Spenddown	15.77	3.40	3.40	$3.40	$3.30	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.30
	Grand Total	$682.56	$364.22	$362.23	$376.18	$370.06	$20.39	$1.05	($0.05)	$0.17	$1.13	$0.02	$0.69	$0.00	$393.46
	Mental Health Targeted Case Management	$56.21	$63.78	$63.78	$76.04	$73.76	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$34.49	$111.94
	NF Add-on					$13.36									$16.16
	2005 Eligible Months	243,034													

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the State of Minnesota in setting rates for capitated programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Appendix 2
Special Need BasicCare
2011 Per Member Per Month Rate Development

Population: Single Eligibles, Metro Counties, Institutional

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	January - August 2010 PMPM Rates	September - December 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	MH-TCM 2011 Assumption Adjustment	2011 PMPM Rates
001	Inpatient Hospital General	$693.66	$946.45	$936.99	$985.71	$958.03	1.050	$0.00	($9.29)	$0.00	$0.00	$0.00	$0.00	$0.00	$996.64
006	Rehabilitation	7.32	7.93	7.85	$8.26	$8.03	1.050	$0.00	($0.08)	$0.00	$0.00	$0.00	$0.00	$0.00	$8.35
007	Outpatient Hospital Services	64.76	70.12	67.01	$70.49	$68.51	1.050	$0.00	$0.00	$0.57	$0.00	$0.00	$0.00	$0.00	$72.51
014	Inpatient Hospital IMD	1.98	2.14	2.12	$2.23	$2.17	1.050	$0.00	($0.02)	$0.00	$0.00	$0.00	$0.00	$0.00	$2.26
015	Inpatient Long Term Hospital	8.70	11.49	11.38	$11.97	$11.63	1.050	$0.00	($0.11)	$0.00	$0.00	$0.00	$0.00	$0.00	$12.10
020	Home Health Services	0.73	0.68	0.66	$0.65	$0.63	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.70
032	Medical Supply / DME	77.77	84.21	81.81	$86.06	$83.64	1.050	$0.00	$0.00	$0.44	$0.00	$0.00	$0.00	$0.00	$88.26
036	Transport, Special	40.18	43.51	43.51	$45.77	$44.48	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$46.70
037	Transport, Ambulance	57.90	62.70	62.70	$65.96	$64.11	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$67.32
040	Child and Teen Checkup	0.05	0.05	0.05	$0.05	$0.05	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.05
041	Anesthesia	9.34	10.12	10.12	$10.65	$10.35	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$10.87
043	Physician Services	162.01	175.44	166.10	$174.74	$164.19	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$172.40
045	Dental	19.07	20.65	20.65	$16.84	$16.37	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$18.24
046	Mental Health	42.94	47.35	47.35	$49.81	$48.41	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50.83
051	Physical Therapy	46.12	51.94	48.56	$51.09	$50.48	1.050	$0.00	$0.00	$0.43	$0.00	$0.00	$0.00	$0.00	$53.43
053	Speech Therapy	15.09	17.00	15.89	$16.72	$16.52	1.050	$0.00	$0.00	$0.14	$0.00	$0.00	$0.00	$0.00	$17.49
054	Occupational Therapy	40.90	46.07	43.08	$45.32	$44.78	1.050	$0.00	$0.00	$0.38	$0.00	$0.00	$0.00	$0.00	$47.40
055	Podiatry	2.44	2.64	2.47	$2.60	$2.42	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.54
056	Ambulatory Surgery	0.54	0.59	0.56	$0.59	$0.57	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$0.60
057	Chiropractic	0.09	0.10	0.09	$0.09	$0.09	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.09
058	Audiology	0.70	0.76	0.71	$0.75	$0.70	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.74
062	Chemical Dependency	3.50	3.94	3.94	$4.14	$4.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.22
063	CD Extended Care / Halfway House	0.02	0.03	0.03	$0.03	$0.03	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.03
072	Hospice	2.44	2.64	2.64	$2.78	$2.70	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.84
074	Inpatient Hospital 45 Day Psych Contract	21.18	22.94	22.94	$24.13	$23.45	1.050	$0.00	($0.24)	$0.00	$0.00	$0.00	$0.00	$0.00	$24.38
075	Eyeglasses / Contact Lenses	2.24	2.43	2.32	$2.44	$2.37	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$0.00	$2.51
076	Prosthetics and Orthotics	14.46	15.65	14.95	$15.73	$15.29	1.050	$0.00	$0.00	$0.13	$0.00	$0.00	$0.00	$0.00	$16.18
077	Hearing Aids	1.50	1.63	1.61	$1.69	$1.64	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.73
078	Vision Care	2.46	2.66	2.49	$2.62	$2.44	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.56
079	Radiology, Technical Component	54.96	59.51	55.65	$58.54	$54.48	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$57.20
080	Laboratory	35.13	38.04	36.33	$38.22	$37.15	1.050	$0.00	$0.00	$0.31	$0.00	$0.00	$0.00	$0.00	$39.32
082	Federal Qualified Health Contract Service	7.83	8.48	8.48	$8.92	$8.67	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.10
083	Rural Health Clinic Services	0.02	0.02	0.02	$0.02	$0.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.02
087	End-Stage Renal Dialysis	17.62	19.08	18.24	$19.19	$18.65	1.050	$0.00	$0.00	$0.15	$0.00	$0.00	$0.00	$0.00	$19.74
090	Nurse Midwife Services	0.02	0.02	0.02	$0.02	$0.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.02
091	Nurse Practitioner Services	8.78	9.51	8.93	$9.39	$8.77	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.21
	Dialectical Behavioral Therapy	0.67	0.58	0.58	$0.61	$0.59	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.62
	Health Care Home Care Coordination	0.00	0.00	0.00	$2.51	$2.44	1.050	$0.00	$0.00	$0.00	$1.38	$0.00	$0.00	$0.00	$3.94
	Total Acute Base Rate	$1,465.13	$1,789.10	$1,748.83	$1,837.35	$1,778.89									$1,863.16
	Prescription Drugs	$706.17	$867.80	$867.80	$945.77	$919.21	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$39.18	$0.00	$1,041.13
	Spenddown	2.63	1.13	1.13	$1.13	$1.10	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.10
	Grand Total	$2,173.93	$2,658.03	$2,617.76	$2,784.25	$2,699.20	$171.71	$1.05	($9.74)	$2.60	$1.38	$0.02	$39.18	$0.00	$2,905.39
	Mental Health Targeted Case Management	$51.05	$49.90	$49.90	$59.49	$57.71	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$41.06	$101.66
	2005 Eligible Months	8,584													

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Appendix 2
Special Need BasicCare
2011 Per Member Per Month Rate Development

Population: Single Eligibles, Non-Metro Counties, Institutional

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	January - August 2010 PMPM Rates	September - December 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	MH-TCM 2011 Assumption Adjustment	2011 PMPM Rates
001	Inpatient Hospital General	$551.80	$752.90	$745.54	$784.31	$762.29	1.050	$0.00	($7.39)	$0.00	$0.00	$0.00	$0.00	$0.00	$793.01
006	Rehabilitation	9.84	10.65	10.55	$11.10	$10.79	1.050	$0.00	($0.10)	$0.00	$0.00	$0.00	$0.00	$0.00	$11.22
007	Outpatient Hospital Services	53.00	57.39	54.81	$57.66	$56.04	1.050	$0.00	$0.00	$0.47	$0.00	$0.00	$0.00	$0.00	$59.32
014	Inpatient Hospital IMD	6.41	6.94	6.87	$7.23	$7.03	1.050	$0.00	($0.07)	$0.00	$0.00	$0.00	$0.00	$0.00	$7.31
015	Inpatient Long Term Hospital	17.31	22.87	22.64	$23.82	$23.15	1.050	$0.00	($0.22)	$0.00	$0.00	$0.00	$0.00	$0.00	$24.08
020	Home Health Services	0.62	0.58	0.57	$0.56	$0.54	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.60
032	Medical Supply / DME	73.25	79.32	76.66	$80.65	$78.39	1.050	$0.00	$0.00	$0.49	$0.00	$0.00	$0.00	$0.00	$82.80
036	Transport, Special	68.56	74.24	74.24	$78.10	$75.91	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$79.71
037	Transport, Ambulance	43.38	46.97	46.97	$49.41	$48.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50.42
040	Child and Teen Checkup	0.03	0.04	0.04	$0.04	$0.04	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.04
041	Anesthesia	8.87	9.60	9.60	$10.10	$9.82	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$10.31
043	Physician Services	154.67	167.49	158.67	$166.92	$156.90	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$164.75
045	Dental	18.46	19.99	19.99	$16.30	$15.84	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.68
046	Mental Health	27.24	30.04	30.04	$31.60	$30.71	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$32.25
051	Physical Therapy	46.48	52.35	48.95	$51.50	$50.88	1.050	$0.00	$0.00	$0.43	$0.00	$0.00	$0.00	$0.00	$53.86
053	Speech Therapy	12.94	14.57	13.62	$14.33	$14.16	1.050	$0.00	$0.00	$0.12	$0.00	$0.00	$0.00	$0.00	$14.99
054	Occupational Therapy	39.25	44.21	41.46	$43.62	$43.07	1.050	$0.00	$0.00	$0.35	$0.00	$0.00	$0.00	$0.00	$45.57
055	Podiatry	0.90	0.97	0.91	$0.96	$0.89	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.93
056	Ambulatory Surgery	1.27	1.37	1.31	$1.38	$1.34	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$1.42
057	Chiropractic	0.28	0.30	0.28	$0.29	$0.27	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.28
058	Audiology	0.42	0.45	0.42	$0.44	$0.41	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.43
062	Chemical Dependency	4.38	4.93	4.93	$5.19	$5.04	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.29
063	CD Extended Care / Halfway House	0.00	0.00	0.00	$0.00	$0.00	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
072	Hospice	4.13	4.47	4.47	$4.70	$4.57	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.80
074	Inpatient Hospital 45 Day Psych Contract	15.53	16.82	16.82	$17.69	$17.19	1.050	$0.00	($0.18)	$0.00	$0.00	$0.00	$0.00	$0.00	$17.87
075	Eyeglasses / Contact Lenses	2.18	2.36	2.26	$2.38	$2.31	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$0.00	$2.44
076	Prosthetics and Orthotics	21.35	23.12	22.08	$23.23	$22.58	1.050	$0.00	$0.00	$0.19	$0.00	$0.00	$0.00	$0.00	$23.90
077	Hearing Aids	0.47	0.51	0.50	$0.53	$0.52	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.55
078	Vision Care	2.12	2.30	2.16	$2.27	$2.13	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.24
079	Radiology, Technical Component	54.63	59.16	55.35	$58.23	$54.21	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$56.92
080	Laboratory	31.75	34.38	32.83	$34.54	$33.57	1.050	$0.00	$0.00	$0.29	$0.00	$0.00	$0.00	$0.00	$35.53
082	Federal Qualified Health Contract Service	1.61	1.74	1.74	$1.83	$1.78	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.87
083	Rural Health Clinic Services	8.06	8.73	8.73	$9.18	$8.92	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.37
087	End-Stage Renal Dialysis	12.85	13.92	13.31	$14.00	$13.61	1.050	$0.00	$0.00	$0.11	$0.00	$0.00	$0.00	$0.00	$14.40
088	Public Health Nursing	0.01	0.01	0.01	$0.01	$0.01	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01
090	Nurse Midwife Services	0.02	0.02	0.02	$0.02	$0.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.02
091	Nurse Practitioner Services	4.16	4.50	4.25	$4.47	$4.19	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.40
	Dialectical Behavioral Therapy	0.67	0.58	0.58	$0.61	$0.59	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.62
	Health Care Home Care Coordination	0.00	0.00	0.00	$2.51	$2.44	1.050	$0.00	$0.00	$0.00	$1.38	$0.00	$0.00	$0.00	$3.94
	Total Acute Base Rate	$1,298.90	$1,570.79	$1,534.18	$1,611.70	$1,560.17									$1,635.17
	Prescription Drugs	$586.16	$720.42	$720.42	$785.12	$763.07	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$32.52	$0.00	$864.29
	Spenddown	2.26	0.96	0.96	$0.96	$0.93	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.93
	Grand Total	$1,887.32	$2,292.17	$2,255.56	$2,397.78	$2,324.17	$146.72	$1.05	($7.96)	$2.49	$1.38	$0.02	$32.52	$0.00	$2,500.38
	Mental Health Targeted Case Management	$51.05	$49.90	$49.90	$59.49	$57.71	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$41.06	$101.66
	2005 Eligible Months	4,546													

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Appendix 2
Special Need BasicCare
2011 Per Member Per Month Rate Development

Population: Single Eligibles, Metro Counties, Community

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	January - August 2010 PMPM Rates	September - December 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	MH-TCM 2011 Assumption Adjustment	2011 PMPM Rates
001	Inpatient Hospital General	$337.31	$534.30	$528.96	$556.47	$540.84	1.050	$0.00	($5.24)	$0.00	$0.00	$0.00	$0.00	$0.00	$562.64
006	Rehabilitation	6.65	8.36	8.28	$8.71	$8.47	1.050	$0.00	($0.08)	$0.00	$0.00	$0.00	$0.00	$0.00	$8.81
007	Outpatient Hospital Services	44.96	56.52	53.98	$56.79	$55.20	1.050	$0.00	$0.00	$0.47	$0.00	$0.00	$0.00	$0.00	$58.43
014	Inpatient Hospital IMD	0.89	1.12	1.11	$1.17	$1.14	1.050	$0.00	($0.01)	$0.00	$0.00	$0.00	$0.00	$0.00	$1.19
015	Inpatient Long Term Hospital	13.08	20.05	19.85	$20.88	$20.29	1.050	$0.00	($0.20)	$0.00	$0.00	$0.00	$0.00	$0.00	$21.11
020	Home Health Services	16.90	18.41	17.94	$17.76	$17.26	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$19.16
029	RTC - Mental Health	2.74	3.45	3.45	$3.63	$3.53	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.71
032	Medical Supply / DME	37.39	47.01	44.95	$47.29	$45.96	1.050	$0.00	$0.00	$0.38	$0.00	$0.00	$0.00	$0.00	$48.64
036	Transport, Special	5.18	6.51	6.51	$6.85	$6.66	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.99
037	Transport, Ambulance	15.14	19.03	19.03	$20.02	$19.46	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$20.43
040	Child and Teen Checkup	0.05	0.06	0.06	$0.06	$0.06	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.06
041	Anesthesia	4.82	6.05	6.05	$6.36	$6.18	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.49
043	Physician Services	107.29	134.88	127.60	$134.24	$126.26	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$132.57
045	Dental	11.88	14.94	14.94	$12.18	$11.84	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$13.48
046	Mental Health	67.78	86.78	86.78	$91.29	$88.73	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$93.17
051	Physical Therapy	3.38	4.41	4.12	$4.33	$4.28	1.050	$0.00	$0.00	$0.04	$0.00	$0.00	$0.00	$0.00	$4.53
053	Speech Therapy	0.77	1.00	0.93	$0.98	$0.97	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$1.03
054	Occupational Therapy	2.18	2.85	2.66	$2.80	$2.76	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$0.00	$2.92
055	Podiatry	0.93	1.17	1.09	$1.15	$1.07	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.12
056	Ambulatory Surgery	1.20	1.51	1.44	$1.51	$1.47	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$1.56
057	Chiropractic	0.67	0.84	0.79	$0.83	$0.78	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.82
058	Audiology	0.20	0.26	0.24	$0.25	$0.23	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.24
062	Chemical Dependency	11.33	14.82	14.82	$15.59	$15.15	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.91
063	CD Extended Care / Halfway House	1.56	1.96	1.96	$2.06	$2.00	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.10
072	Hospice	6.78	8.53	8.53	$8.97	$8.72	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.16
074	Inpatient Hospital 45 Day Psych Contract	31.56	39.68	39.68	$41.74	$40.57	1.050	$0.00	($0.42)	$0.00	$0.00	$0.00	$0.00	$0.00	$42.18
075	Eyeglasses / Contact Lenses	1.99	2.50	2.39	$2.51	$2.44	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$0.00	$2.58
076	Prosthetics and Orthotics	3.92	4.92	4.70	$4.94	$4.80	1.050	$0.00	$0.00	$0.04	$0.00	$0.00	$0.00	$0.00	$5.08
077	Hearing Aids	0.40	0.50	0.49	$0.52	$0.51	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.54
078	Vision Care	1.11	1.39	1.30	$1.37	$1.27	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.33
079	Radiology, Technical Component	37.98	47.75	44.65	$46.97	$43.71	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45.90
080	Laboratory	16.82	21.15	20.20	$21.25	$20.65	1.050	$0.00	$0.00	$0.17	$0.00	$0.00	$0.00	$0.00	$21.86
082	Federal Qualified Health Contract Service	16.98	21.34	21.34	$22.45	$21.82	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$22.91
083	Rural Health Clinic Services	0.07	0.09	0.09	$0.09	$0.09	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.09
087	End-Stage Renal Dialysis	8.28	10.41	9.94	$10.46	$10.17	1.050	$0.00	$0.00	$0.09	$0.00	$0.00	$0.00	$0.00	$10.77
088	Public Health Nursing	0.15	0.18	0.17	$0.18	$0.17	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.18
090	Nurse Midwife Services	0.12	0.15	0.14	$0.15	$0.15	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.16
091	Nurse Practitioner Services	1.65	2.08	2.00	$2.10	$1.99	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.09
999	Unable to Define	0.01	0.01	0.01	$0.01	$0.01	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01
	Dialectical Behavioral Therapy	0.67	0.68	0.68	$0.72	$0.70	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.74
	Health Care Home Care Coordination	0.00	0.00	0.00	$2.51	$2.44	1.050	$0.00	$0.00	$0.00	$1.38	$0.00	$0.00	$0.00	$3.94
	Total Acute Base Rate	$822.76	$1,147.65	$1,123.85	$1,180.15	$1,140.80									$1,196.61
	Prescription Drugs	$271.65	$387.86	$387.86	$422.63	$410.76	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$17.51	$0.00	$465.25
	Spenddown	6.96	2.12	2.12	$2.12	$2.06	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.06
	Grand Total	$1,101.36	$1,537.63	$1,513.83	$1,604.90	$1,553.62	$95.04	$1.05	($5.95)	$1.26	$1.38	$0.02	$17.51	$0.00	$1,663.92
	Mental Health Targeted Case Management	$51.05	$57.93	$57.93	$69.07	$67.00	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$31.31	$101.66
	NF Add-on					$15.44									$15.36
	2005 Eligible Months	235,448													

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Appendix 2
Special Need BasicCare
2011 Per Member Per Month Rate Development

Population: Single Eligibles, Non-Metro Counties, Community

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	January - August 2010 PMPM Rates	September - December 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	MH-TCM 2011 Assumption Adjustment	2011 PMPM Rates
001	Inpatient Hospital General	$261.13	$413.63	$409.49	$430.78	$418.68	1.050	$0.00	($4.06)	$0.00	$0.00	$0.00	$0.00	$0.00	$435.56
006	Rehabilitation	7.72	9.71	9.61	$10.11	$9.83	1.050	$0.00	($0.10)	$0.00	$0.00	$0.00	$0.00	$0.00	$10.23
007	Outpatient Hospital Services	49.95	62.79	60.09	$63.21	$61.43	1.050	$0.00	$0.00	$0.50	$0.00	$0.00	$0.00	$0.00	$65.00
014	Inpatient Hospital IMD	7.38	9.28	9.19	$9.67	$9.40	1.050	$0.00	($0.09)	$0.00	$0.00	$0.00	$0.00	$0.00	$9.78
015	Inpatient Long Term Hospital	10.08	15.46	15.31	$16.11	$15.66	1.050	$0.00	($0.15)	$0.00	$0.00	$0.00	$0.00	$0.00	$16.29
020	Home Health Services	19.64	21.39	20.84	$20.63	$20.05	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$22.26
029	RTC - Mental Health	17.15	21.56	21.56	$22.68	$22.04	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$23.14
032	Medical Supply / DME	40.04	50.33	48.31	$50.82	$49.39	1.050	$0.00	$0.00	$0.37	$0.00	$0.00	$0.00	$0.00	$52.23
036	Transport, Special	6.28	7.90	7.90	$8.31	$8.08	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.48
037	Transport, Ambulance	15.83	19.90	19.90	$20.93	$20.34	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$21.36
040	Child and Teen Checkup	0.05	0.06	0.06	$0.06	$0.06	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.06
041	Anesthesia	6.12	7.70	7.70	$8.10	$7.87	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.26
043	Physician Services	116.73	146.74	138.61	$145.82	$137.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$143.87
045	Dental	14.87	18.69	18.69	$15.24	$14.81	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.60
046	Mental Health	79.84	102.22	102.22	$107.54	$104.52	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$109.75
051	Physical Therapy	4.43	5.79	5.41	$5.69	$5.62	1.050	$0.00	$0.00	$0.05	$0.00	$0.00	$0.00	$0.00	$5.95
053	Speech Therapy	0.58	0.76	0.71	$0.75	$0.74	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$0.78
054	Occupational Therapy	1.31	1.71	1.60	$1.68	$1.66	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$1.76
055	Podiatry	1.01	1.27	1.20	$1.26	$1.18	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.24
056	Ambulatory Surgery	2.25	2.83	2.70	$2.84	$2.76	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$0.00	$2.92
057	Chiropractic	1.35	1.69	1.58	$1.66	$1.54	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.62
058	Audiology	0.18	0.22	0.21	$0.22	$0.20	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.21
062	Chemical Dependency	9.01	11.78	11.78	$12.39	$12.04	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$12.64
063	CD Extended Care / Halfway House	1.14	1.43	1.43	$1.50	$1.46	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.53
072	Hospice	5.40	6.79	6.79	$7.14	$6.94	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.29
074	Inpatient Hospital 45 Day Psych Contract	13.45	16.91	16.91	$17.79	$17.29	1.050	$0.00	($0.18)	$0.00	$0.00	$0.00	$0.00	$0.00	$17.98
075	Eyeglasses / Contact Lenses	2.43	3.06	2.92	$3.07	$2.98	1.050	$0.00	$0.00	$0.03	$0.00	$0.00	$0.00	$0.00	$3.15
076	Prosthetics and Orthotics	4.90	6.16	5.88	$6.19	$6.02	1.050	$0.00	$0.00	$0.05	$0.00	$0.00	$0.00	$0.00	$6.37
077	Hearing Aids	0.62	0.78	0.77	$0.81	$0.79	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.83
078	Vision Care	1.67	2.10	1.97	$2.07	$1.93	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.03
079	Radiology, Technical Component	44.87	56.41	52.74	$55.48	$51.63	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$54.21
080	Laboratory	18.72	23.54	22.48	$23.65	$22.99	1.050	$0.00	$0.00	$0.20	$0.00	$0.00	$0.00	$0.00	$24.33
082	Federal Qualified Health Contract Service	2.04	2.56	2.56	$2.69	$2.61	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.74
083	Rural Health Clinic Services	3.75	4.72	4.72	$4.97	$4.83	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.07
087	End-Stage Renal Dialysis	2.88	3.62	3.46	$3.64	$3.54	1.050	$0.00	$0.00	$0.03	$0.00	$0.00	$0.00	$0.00	$3.75
088	Public Health Nursing	0.46	0.58	0.56	$0.59	$0.57	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.60
090	Nurse Midwife Services	0.05	0.06	0.06	$0.06	$0.06	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.06
091	Nurse Practitioner Services	2.20	2.77	2.69	$2.83	$2.71	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.85
	Dialectical Behavioral Therapy	0.67	0.68	0.68	$0.72	$0.70	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.74
	Health Care Home Care Coordination	0.00	0.00	0.00	$2.51	$2.44	1.050	$0.00	$0.00	$0.00	$1.38	$0.00	$0.00	$0.00	$3.94
	Total Acute Base Rate	$778.18	$1,065.58	$1,041.29	$1,092.23	$1,054.41									$1,107.46
	Prescription Drugs	$347.68	$496.26	$496.26	$540.79	$525.60	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$22.40	$0.00	$595.32
	Spenddown	5.85	1.68	1.68	$1.68	$1.63	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.63
	Grand Total	$1,131.70	$1,563.52	$1,539.23	$1,634.70	$1,581.64	$101.23	$1.05	($4.57)	$1.27	$1.38	$0.02	$22.40	$0.00	$1,704.41
	Mental Health Targeted Case Management	$51.05	$57.93	$57.93	$69.07	$67.00	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$31.31	$101.66
	NF Add-on					$15.44									$15.36
	2005 Eligible Months	178,307													

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Appendix 3

SNBC 2011 NF Add-On Rate Development

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the State of Minnesota in setting rates for capitated programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Appendix 3

Special Needs BasicCare
Preliminary 100 Day Nursing Facility Add-On Rate Calculation
Calendar Year 2010
Single Eligible Population

	1/09 - 9/09	1/09 - 8/10	
	$14.01	$15.29	
	$172.09	$173.99	
	0.125%	0.125%	
	10/09 - 12/09	9/10 - 12/10	CY 2011
NF Add-On	$13.92	$14.82	$15.36
Per Diem	$171.06	$168.77	$169.61
Monthly Freq	0.125%	0.125%	0.125%

		(1)	(2)	(3)	NF Days for Admissions in Month by Contract Period			Health Plan Payments to NF for Admissions in Month by Contract Period		
Year	Month	Monthly Enrollment	Total NF Add-On Paid to Health Plans	Admissions	CY2009	CY2010	CY2011	CY 2009	CY 2010	CY 2011
2009	January	940	13,167	1.1750	72.0	0.0		14,559	0	
	February	947	13,265	1.1838	72.0	0.0		14,667	0	
	March	984	13,784	1.2300	72.0	0.0		15,240	0	
	April	1,027	14,386	1.2838	72.0	0.0		15,906	0	
	May	1,061	14,862	1.3263	72.0	0.0		16,433	0	
	June	1,079	15,114	1.3488	72.0	0.0		16,712	0	
	July	1,105	15,479	1.3813	72.0	0.0		17,114	0	
	August	1,173	16,431	1.4663	72.0	0.0		18,168	0	
	September	1,329	18,616	1.6613	72.0	0.0		20,584	0	
	October	1,400	19,488	1.7500	54.6	17.4		16,331	5,312	
	November	1,452	20,212	1.8150	35.0	37.0		10,858	11,693	
	December	1,440	20,045	1.8000	12.6	59.4		3,879	18,604	
Total 2009 Contract Period		13,937	$194,849		60.3	11.7		$180,451	$35,609	
2010	January	1,430	21,865	1.7875		72.0	0.0		22,393	0
	February	1,463	22,369	1.8288		72.0	0.0		22,909	0
	March	1,508	23,057	1.8850		72.0	0.0		23,614	0
	April	1,548	23,669	1.9350		72.0	0.0		24,240	0
	May	1,584	24,219	1.9800		72.0	0.0		24,804	0
	June	1,594	24,372	1.9925		72.0	0.0		24,961	0
	July	1,627	24,877	2.0338		72.0	0.0		25,477	0
	August	1,647	25,183	2.0588		72.0	0.0		25,791	0
	September	1,667	24,705	2.0838		72.0	0.0		25,321	0
	October	1,687	25,001	2.1088		54.6	17.4		19,416	6,239
	November	1,717	25,446	2.1463		35.0	37.0		12,667	13,480
	December	1,747	25,891	2.1838		12.6	59.4		4,643	22,002
Total 2010 Contract Period		19,219	$290,654			61.8	10.2		$256,235	$41,721
2011	January	1,547	23,762	1.9338			72.0			23,615
	February	1,570	24,109	1.9620			72.0			23,960
	March	1,589	24,411	1.9865			72.0			24,260
	April	1,606	24,671	2.0078			72.0			24,519
	May	1,621	24,892	2.0257			72.0			24,737
	June	1,632	25,071	2.0403			72.0			24,916
	July	1,643	25,239	2.0540			72.0			25,083
	August	1,654	25,407	2.0676			72.0			25,250
	September	1,668	25,627	2.0855			72.0			25,469
	October	1,686	25,894	2.1072			54.6			19,498
	November	1,702	26,137	2.1270			35.0			12,616
	December	1,717	26,369	2.1459			12.6			4,585
Total 2011 Contract Period		19,635	$301,589				62.1			$258,507
Grand Total								$203,118	$291,844	$300,228

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Appendix 3

Special Needs BasicCare
Preliminary 100 Day Nursing Facility Add-On Rate Calculation
Calendar Year 2011
Dual Eligible Population

	1/09 - 9/09	1/09 - 8/10	
	$13.75	$13.35	
	$172.09	$173.99	
	0.125%	0.125%	
	10/09 - 12/09	9/10 - 12/10	CY 2011
NF Add-On	$13.67	$12.95	$16.16
Per Diem	$171.06	$168.77	$169.61
Monthly Freq	0.125%	0.125%	0.125%

		(1)	(2)	(3)	NF Days for Admissions in Month by Contract Period *			Health Plan Payments to NF for Admissions in Month by Contract Period		
Year	Month	Monthly Enrollment	Total NF Add-On Paid to Health Plans	Admissions	CY2009	CY2010	CY2011	CY 2009	CY 2010	CY 2010
2009	January	1,849	25,428	2.3113	73.0	0.0		29,035	0	
	February	1,900	26,129	2.3750	73.0	0.0		29,836	0	
	March	1,956	26,899	2.4450	73.0	0.0		30,715	0	
	April	2,016	27,724	2.5200	73.0	0.0		31,658	0	
	May	2,101	28,893	2.6263	73.0	0.0		32,992	0	
	June	2,165	29,773	2.7063	73.0	0.0		33,997	0	
	July	2,218	30,502	2.7725	73.0	0.0		34,830	0	
	August	2,336	32,125	2.9200	73.0	0.0		36,683	0	
	September	2,509	34,504	3.1363	73.0	0.0		39,399	0	
	October	2,668	36,472	3.3350	55.3	17.7		31,555	10,263	
	November	2,735	37,387	3.4188	35.5	37.5		20,735	22,332	
	December	2,734	37,374	3.4175	12.8	60.2		7,467	35,812	
Total 2009 Contract Period		27,187	$373,212		61.4	11.6		$358,904	$68,407	
2010	January	2,747	36,672	3.4338		73.0	0.0		43,613	0
	February	2,778	37,086	3.4725		73.0	0.0		44,105	0
	March	2,804	37,433	3.5050		73.0	0.0		44,518	0
	April	2,835	37,847	3.5438		73.0	0.0		45,010	0
	May	2,856	38,128	3.5700		73.0	0.0		45,344	0
	June	2,861	38,194	3.5763		73.0	0.0		45,423	0
	July	2,892	38,608	3.6150		73.0	0.0		45,915	0
	August	2,924	39,035	3.6550		73.0	0.0		46,423	0
	September	2,912	37,710	3.6400		73.0	0.0		44,846	0
	October	2,916	37,762	3.6450		55.3	17.7		34,027	10,935
	November	2,922	37,840	3.6525		35.5	37.5		21,857	23,258
	December	2,925	37,879	3.6563		12.8	60.2		7,881	37,349
Total 2010 Contract Period		34,372	$454,196			63.2	9.8		$468,961	$71,542
2011	January	2,425	39,188	3.0313			73.0			37,532
	February	2,460	39,761	3.0756			73.0			38,080
	March	2,491	40,258	3.1140			73.0			38,556
	April	2,518	40,688	3.1473			73.0			38,968
	May	2,540	41,051	3.1753			73.0			39,316
	June	2,559	41,347	3.1983			73.0			39,599
	July	2,576	41,624	3.2197			73.0			39,865
	August	2,593	41,901	3.2411			73.0			40,130
	September	2,615	42,264	3.2692			73.0			40,478
	October	2,643	42,704	3.3032			55.3			30,989
	November	2,667	43,105	3.3342			35.5			20,051
	December	2,691	43,487	3.3638			12.8			7,287
Total 2011 Contract Period		30,778	$497,378				63.0			$410,851
Grand Total								$403,114	$537,368	$482,393

* Days that are 100% covered by Medicare are included.

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Appendix 3

Special Needs BasicCare
Preliminary 100 Day Nursing Facility Add-On Rate Calculation
Calendar Year 2011
Single Eligible Population

Rate Component	1/10 - 8/10	9/10 - 12/10	2011
Section A			
Monthly Claim Frequency (Rounded)	0.125%		0.125%
(x) Truncated Medicaid Length of Stay	61.8		62.1
(x) Charge per Day	$173.99		$169.61
= Initial Rate (1)	$13.43		$13.17
Section B			
2011 NF $ for 2010 Admits			$41,721
(/) 2011 Eligible Months			19,635
= Tail Rate (2)	$1.83		$2.12
Section C			
2010 NF Rates to Health Plans			($290,654)
2009 Enrollment Adjustment in 2010			$5,574
(+) 2010 NF $ for 2009 Admits			$35,609
(+) 2010 NF $ for 2010 Admits			$256,235
= Enrollment Adjustment Dollars			$6,763
(/) 2011 Eligible Months			19,635
= Enrollment Adjustment Rate (3)	$0.29		$0.34
Section D			
Initial Base Rate = (1)+(2)+(3)	$15.55	$15.08	$15.63
Disenrollment Fee Adjustment	0.983	0.983	0.983
Final Base Rate	$15.29	$14.82	$15.36

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Appendix 3

Special Needs BasicCare
Preliminary 100 Day Nursing Facility Add-On Rate Calculation
Calendar Year 2011
Dual Eligible Population

Rate Component	1/10 - 8/10	9/10 - 12/10	2011
Section A			
Monthly Claim Frequency (Rounded)	0.125%		0.125%
(x) Truncated Medicaid Length of Stay	52.9		52.7
(x) Charge per Day	$173.99		$169.61
= Initial Rate (1)	$11.50		$11.16
Section B			
2011 NF $ for 2010 Admits			$71,542
(/) 2011 Eligible Months			30,778
= Tail Rate (2)	$1.85		$2.32
Section C			
2010 NF Rates to Health Plans			($454,196)
2009 Enrollment Adjustment in 2010			$7,906
(+) 2010 NF $ for 2009 Admits			$68,407
(+) 2010 NF $ for 2010 Admits			$468,961
= Enrollment Adjustment Dollars			$91,077
(/) 2011 Eligible Months			30,778
= Enrollment Adjustment Rate (3)	$0.23		$2.96
Section D			
Initial Base Rate = (1)+(2)+(3)	$13.58	$13.17	$16.44
Disenrollment Fee Adjustment	0.983	0.983	0.983
Final Base Rate	$13.35	$12.95	$16.16

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Appendix T
Rate Setting Report
SNBC - Capitation Rate Adjustment
Preferred Integrated Networks (PINs)

15800 Bluemound Road
Suite 400
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 784 2748

milliman.com

Eric P. Goetsch, FSA, MAAA
Principal and Consulting Actuary

eric.goetsch@milliman.com

November 15, 2010

Ms. Pam Parker
Director, Special Needs Purchasing
Minnesota Department of Human Services
540 Cedar Street
Elmer L. Anderson Human Services Building
St. Paul, MN 55155-3854

RE: Rate Development for SNBC PINs for Calendar Year 2011

Dear Pam:

The attached report describes the development of the rates for the Special Needs BasicCare (SNBC) Preferred Integrated Networks (PINs) demonstration project for the calendar year 2011 contract period.

Sincerely,

Eric Goetsch, FSA, MAAA
Principal and Consulting Actuary

EPG/zh

Attachments

Special Needs BasicCare
Preferred Integrated Networks
Base Rate Development
For Calendar Year 2011
Medica

Prepared for:
Minnesota Department of Human Services

Prepared by:
Milliman, Inc.

Eric P. Goetsch, FSA, MAAA
Principal and Consulting Actuary

Roman G. Kelly
Actuarial Analyst

15800 Bluemound Road
Suite 400
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 784 2748

milliman.com

November 15, 2010

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Appendix 1: SNBC PINs 2011 Base Rate Tables
Appendix 2: SNBC PINs PMPM Cost Models
Appendix 3: SNBC PINs 2011 NF Add-On Rate Development

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the State of Minnesota in setting rates for capitated programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

I. INTRODUCTION

This report documents the calendar year (CY) 2011 base rate development for the Special Needs BasicCare (SNBC) program. The rates in this report are for the Preferred Integrated Network (PINs) demonstration project designed to integrate mental health treatment within the mainstream health care delivery system, ensure coordination with social services, and improve outcomes through timely and effective care.

Expected outcomes of the SNBC PINs demonstration project include improvement in access and quality of physical and mental health care for persons with serious mental illness, while maintaining access to county administered social services. The PINs will effectively manage the range of treatment and supportive services each enrollee requires in order to maintain the highest possible level of health, mental wellness and function.

The report assumes the reader is familiar with the basic aspects of the SNBC program, the PINs demonstration project, the disabled population groups to be covered under the program, the Minnesota Medicaid program, and managed care rating principles.

The layout of this report was structured so as to describe all the information used to develop the CY 2011 base rates from the 2005 base experience while at the same time distinguishing the developmental components for the CY 2009 rate development, October through December 2009 rate adjustment, the CY 2010 rate development, September through December 2010 rate adjustment, and the CY 2011 rate development. This approach was taken to allow the user to more easily understand what adjustments were new to the 2011 rate development.

The CY 2011 payments to health plans will be a product of the base rates included in this report and the risk factors developed by Greg Gifford of the Minnesota Department of Health. Comparisons were done to demonstrate the consistency of the data being used to develop the base rates and the data being used to develop the risk factors.

CAVEATS AND LIMITATIONS

This report is intended for use by the Minnesota Department of Human Services (DHS) and participating health plan(s) as they negotiate a contract to provide most basic State plan services to people with disabilities in CY 2011 (Personal Care Assistant and Private Duty Nursing basic State plan services will remain fee-for-service Medicaid). The information contained in this report may not be suitable for other purposes or audiences. It is our understanding that DHS intends to distribute this report to the health plan(s) participating in SNBC PINs, as well as to CMS to document the rate development.

The results presented in this letter are estimates only based on historical fee-for-service experience. Actual CY 2011 experience will vary from these estimates.

We relied on data and information supplied to us by DHS. We did not audit or attempt any independent verification of such data. If this data is incomplete or inaccurate, then our conclusions will be incomplete or inaccurate.

This report was prepared specifically for DHS and the development of CY 2011 base rates for SNBC PINs and may not be appropriate for other purposes. This report should only be viewed in its entirety. Milliman does not intend to benefit any third party and assumes no duty or liability to other parties who receive this work.

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the State of Minnesota in setting rates for capitated programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

This report is a summary of the base rate development and does not address all of the issues detailed in the CMS checklist. This report also does not contain an actuarial certification for the premium rates. This information will be provided in a separate report at a later date.

This report and its use are subject to the terms of the contract between Milliman and DHS effective July 1, 2009.

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the State of Minnesota in setting rates for capitated programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

II. 2005 BASE EXPERIENCE

Base rates for the SNBC PINs program are based on projections of historical fee-for-service Medicaid data for eligibles with disabilities.

DESCRIPTION OF SNBC PINS RATE CATEGORIES

SNBC PINs has four base rates for the SNBC PINs population. Base rates are based on combinations of:

- ***Medicare Coverage:*** Medicaid only vs. Medicaid and Medicare (dual eligible). Dual eligible enrollees must be enrolled in both Parts A and B of Medicare.

- ***Institutional Status:*** Population categories of Institutionalized (NF / ICF) vs. Community (all other population categories).

BASE RATE CALCULATION METHODOLOGY

The base rate development is based on CY 2005 fee-for-service data, provided by DHS, for eligibles with disabilities. We relied on this data as given, but did perform reasonableness tests where possible. Comparisons were done to demonstrate the consistency of the data used to develop the base rates and the data used to develop the risk factors.

The fee-for-service data was analyzed to calculate aggregate per member per month (PMPM) amounts for acute care services and prescription drugs that are not covered by Medicare.

Nursing facility institutional costs are accounted for in the nursing facility add-on rate, which is only applicable to the community population. Nursing facility costs for persons who resided in a nursing facility prior to enrollment in SNBC PINs will be paid on a fee-for-service basis. Additionally, nursing facility costs after the health plan's 100-day nursing facility liability period will be paid on a fee-for-service basis.

The CY 2011 base rates in Appendix 1 are net of third party collections since third party revenues were removed from the 2005 fee-for-service cost experience.

The 2005 aggregate fee-for-service combined cost experience for acute services for combinations of population groups are shown in Table 1 along with the associated eligible months of exposure. Separate fee-for-service cost experience is displayed for prescription drugs. The prescription drug costs shown in Table 1 include all drugs. An adjustment will be made later in the rate development process to reflect the portion of drugs that will be covered by Medicare.

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Table 1 Special Needs BasicCare Preferred Integrated Network Aggregate 2005 Fee for Service Cost Experience PMPM for Eligibles with Disabilities					
Population			**Eligible Months**	**PMPM Cost Excluding Rx**	**Rx PMPM**
Duals	Institutional	Metro	19,918	$285.98	$622.75
		Non-Metro	13,036	230.82	484.85
	Community	Metro	233,845	295.67	411.06
		Non-Metro	243,034	269.73	396.40
Non-Duals	Institutional	Metro	8,584	1,464.46	706.17
		Non-Metro	4,546	1,298.23	586.16
	Community	Metro	235,448	822.09	271.65
		Non-Metro	178,307	777.51	347.68

SPENDDOWN

Enrollees with medical spenddowns are required to prepay their monthly spenddown amount to DHS, which in turn passes the spenddown amounts through to the MCOs. The enrollee must meet this monthly obligation in order to retain enrollment in MnDHO-PD.

The fee-for-service experience excludes spenddown amounts. Therefore, spenddown amounts were added into the calculation for each base rate based on 2005 spenddown experience.

Three adjustments were made to the spenddown experience before adding it to the base rates:

1. The 2005 spenddown experience was reduced by 50% to account for the estimated percentage of the disabled population with a medical spenddown who would not enroll in SNBC PINs due to its spenddown requirements.

2. For the community population, the 2005 spenddown experience was reduced by an additional percentage to reflect that some of the medical spenddown is being paid to fee-for-service providers for services not covered under the SNBC PINs program. Per DHS, the percentage reductions, by population group, are as follows:

   - Community, single eligibles, metro counties: 27.4%
   - Community, dual eligibles, metro counties: 42.7%
   - Community, single eligibles, non-metro counties: 31.3%
   - Community, dual eligibles, non-metro counties: 50.2%

3. The value of the first one and a half month's spenddown was estimated and deducted from all base rates. This adjustment was made since DHS assumes 50% of SNBC PINs enrollees with a spenddown requirement will disenroll after the 90-day grace period without having paid their spenddown.

Institutional spenddowns for enrollees in nursing facilities / ICF / ICF-MR are collected directly from nursing facilities through a separate process and are therefore not included in the base rates. As a result, Table 2 reflects only the medical spenddown for both community and institutionalized enrollees.

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Table 2 contains the PMPM amounts of total spenddown added to the base rates. These amounts reflect 2005 spenddown experience adjusted for the three adjustments described above. The spenddown per month (used to calculate the value of the first one and a half month's spenddown) was estimated by dividing the total spenddown dollars over the experience period by the average length of enrollment per member. This effectively assumes that the pattern of spenddown amounts is level by month, and not skewed with higher spenddown amounts in the earliest months.

Table 2
Special Needs BasicCare Preferred Integrated Networks
Spenddown Amounts Added to the Base Rates

Population			Spenddown PMPM
Duals	Institutional	Metro	$0.86
		Non-Metro	0.46
	Community	Metro	6.91
		Non-Metro	3.40
Non-Duals	Institutional	Metro	1.13
		Non-Metro	0.96
	Community	Metro	2.12
		Non-Metro	1.68

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III. 2009 RATE DEVELOPMENT

For the 2009 rate development, the aggregate base rates were trended to the center of the CY 2009 rating period. The base rates were adjusted to reflect differences in the fee-for-service cost data for geographical region, institutional status, benefit changes, and eligibility for Medicaid only vs. eligibility for both Medicare and Medicaid. The trends were consistent with historical and projected trends of budgeted costs from the Reports and Forecast Division of DHS.

ANNUAL TRENDS, COST OF LIVING ADJUSTMENTS, AND REBASING ADJUSTMENTS

The fee-for-service costs were trended to the center of the CY 2009 contract period using annual trend assumptions, based on data provided by DHS, of 0.9% for Home Health Agency (HHA) services, 5.6% for non-HHA acute care services, and 9.0% for prescription drugs.

In addition to annual trends, the following cost of living adjustments (COLAs) and rebasing adjustments were made to the 2005 fee-for-service data to develop the CY 2009 base rates based on information provided by DHS:

- PMPM costs for COS 046 were increased 1.8% to reflect 2.0% COLAs for ARHMS and CTSS mental health services effective January 1, 2008 and July 1, 2008. These COLAs apply to 46.0% of the costs for COS 046 (1.8% = 4.0% x 46.0%).

- PMPM costs for COS 020 (home health), 051 (physical therapy), 053 (speech therapy), 054 (occupational therapy), and 062 (chemical dependency) were increased 4.0% to reflect 2.0% COLAs effective January 1, 2008 and July 1, 2008.

- PMPM costs for COS 001 and COS 015 were increased 26.0% and 22.0%, respectively, to account for the effect of inpatient hospital rebasing effective January 2007.

ADJUSTMENT FOR UTILIZATION SAVINGS AND ADMINISTRATION / MARGIN REQUIREMENTS

DHS is expecting more cost effective provision of services under the SNBC PINs program resulting in managed care savings from fee-for-service levels. The range of expected savings is 5.0% to 10.0% due to reduced utilization. DHS assumed a utilization reduction of 6.5% from fee-for-service levels. In addition, we expect there to be increased health plan administrative costs and a need for margin due to increased managed care efforts. DHS assumed administrative expenses and margin to be 6.4% and 0.5% of medical expenses, respectively. These three factors combine to a net savings assumption of 0.0% from fee-for-service benefit costs. Table 3 contains a summary of these assumptions.

Table 3
Special Needs BasicCare Preferred Integrated Networks
Savings Assumptions

	Assumed
Utilization Reduction	6.5%
Administrative Expense	6.4%
Margin	0.5%
Net Savings	0.0%

Net Savings Calculation: (1.00 – 0.065) x (1.00 + 0.064) x (1.00 + 0.005) -1 = 0.000

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ADJUSTMENT FOR OVER / UNDER-PREDICTION OF RISK SCORES BY POPULATION

Testing of the risk factor model indicated a bias of the risk factors for the institutional population to over-predict projected costs by approximately 13% and the community population to under-predict projected costs by approximately 1%. Therefore, the base rates for the institutional population were reduced by 13% and the base rates for the community population were increased by 1% such that the 2009 base rates and risk factors remained budget neutral while better accommodating future population mixes that are different than the population mix use to develop the risk scores. These bias factors were calculated by Greg Gifford.

EXTENDED CHEMICAL DEPENDENCY TREATMENT

The chemical dependency delivery system was redesigned with the goal of focusing resources on the individual needs of the client. The previous 'levels of care' (e.g. outpatient, halfway house, extended care, etc.) were eliminated and a new assessment tool and protocol were put in place January 1, 2008. MCOs were then responsible for all levels of treatment determined necessary during the assessment/ reassessment process. Costs for chemical dependency services COS 062 and 063 were subsequently included in the rates. Chemical dependency housing costs are also the health plans' responsibility; however, plans are reimbursed outside of the SNBC PINs capitation for these costs for COS 063.

MEDICARE ADJUSTMENT FOR PRESCRIPTION DRUGS

Medicare provides prescription drug coverage for the dually eligible enrollees in SNBC PINs. The health plans maintain responsibility for drugs not covered under the standard Medicare Part D plan. DHS supplied information which showed that approximately 2.7% of the cost of prescription drugs for the dual eligible population is not covered by Medicare. Therefore, fee-for-service costs were reduced by 97.3% in the calculation of the base rates for prescription drugs for the dual eligible population.

ADJUSTMENT FOR ZOSTAVAX VACCINE

The shingles vaccine (Zostavax) is covered under SNBC PINs for single eligibles (it is covered under the federal Part D for dual eligibles). MCOs are expected to cover the cost of the serum and administration. Coverage is for individuals 60 years and over whether or not they report a prior episode of shingles.

For the 2009 rate development, DHS estimated 11.0% of the SNBC PINs single eligible population would be ages 60 to 64. We assumed 30% of this population would obtain the one-time Zostavax vaccine in 2009 at a cost of $189.78 per vaccination, resulting in a cost of $0.52 PMPM (0.110 x 0.30 x $189.78 / 12). This cost was included in the 2009 prescription base rates.

The required rate adjustment to reflect the assumed percentage of the population who will receive the one-time Zostavax vaccine in 2010 is made in the CY 2010 Rate Development section of this report.

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ADJUSTMENTS MADE TO RISK SCORES FOR TARGETED MENTAL HEALTH ENHANCEMENT

The risk score model weights (and not the base rates) were adjusted for DHS' targeted mental health enhancement. The targeted enhancement includes the following:

- The opening of new state-operated facilities.
- ACT and IRTS being included in all program benefit sets effective January 2008.
- An increase in payment rates for selected critical access providers of CTSS, mental health behavioral aide services, and ARHMS medication education services.
- An increase in payments for CTSS individual and family skills training by children's therapeutic services and support providers.

Adjusting the risk score model weights (and not the base rates), appropriately allocates the extra revenue to those members DHS intended to help with the targeted mental health enhancement (i.e., those members with mental health diagnoses). Specifically, the Psychiatric Medium and High risk category weights were increased to add the extra revenue into the program for this enhancement.

ADJUSTMENTS FOR MENTAL HEALTH TARGETED CASE MANAGEMENT

On September 1, 2009, SNBC PINs began covering mental health targeted case management (MH-TCM) services that were previously covered via fee-for-service. Table 4 contains the estimated percentage of Medica's potential PINs population that would both (1) meet the MH-TCM eligibility criteria (90%) and (2) receive MH-TCM services in a given month (90%). Table 4 also contains the average monthly FY 2008 MH-TCM cost for those individuals receiving MH-TCM services in a given month and the FY 2008 PMPM MH-TCM cost across all of Medica's potential PINs population that would meet the SNBC eligibility criteria.

The Table 4 amounts are adjusted in Appendix 2 to reflect an estimated 7% increase in utilization due to an expansion of the MH-TCM eligibility criteria. Since these amounts are not included in the base rates, they will not be risk adjusted. Instead, the MH-TCM amounts will be included in the rates as an add-on.

Table 4
Special Needs BasicCare Preferred Integrated Networks
2009 Rate Development
Mental Health Targeted Case Management Add On Development

Eligibility	% of Medica's Potential PINs Population that Both Meet MH-TCM Eligibility Criteria and Receive MH-TCM Services in a Given Month in FY 2008	Average Monthly Cost in FY 2008 for Those Individuals Receiving MH-TCM Services for a Given Month	FY 2008 PMPM MH-TCM Costs for Medica's Potential PINs Population Meeting the SNBC Eligibility Criteria
Duals	81% (81% = 90% x 90%)	$366.02	$296.48
Non-Duals	81% (81% = 90% x 90%)	$410.31	$332.35

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ADJUSTMENT FOR COVERAGE OF PREVENTIVE VISITS

An adjustment was made to the fee for service claim costs for preventive care visits. It is assumed additional visits will be incurred by the health plans as the health plans are to facilitate annual physician visits for SNBC members for primary and preventive care. Therefore, an additive adjustment was made to the 2009 rate development. For the non-duals, projected costs were increased $4.00 PMPM based on an estimate average cost of a preventive exam being $48, including the exam and any associated lab work. For duals, projected costs only include the cost sharing associated with the preventive exam, which would be 20%, or $0.80 PMPM. This adjustment was made to the Physician Services line (COS 043) in Appendix 2.

DIALECTICAL BEHAVIORAL THERAPY

On January 1, 2009, DHS began covering the cost of dialectical behavioral therapy (DBT) services. DHS estimated the cost of these services for 2009 would be approximately $ 800,000. These costs were expected to occur almost exclusively within the disabled population, which was expected to be approximately 100,000 eligibles in 2009. Therefore, the expected 2009 cost of DBT services was $0.67 PMPM ($0.67 PMPM = $800,000 / (100,000 x 12). This amount is included in the base rates contained in Appendix 2 and is risk adjusted.

MEDICAID COPAY CHANGES

Medicaid copays have been reduced since the 2005 fee-for-service base year. In 2005, the maximum prescription drug copay per month was $12. For 2009, this amount was reduced to $7 per month. According to State law, fee-for-service reimbursement rates may not be increased due to the reduction of these copay maximums. Likewise, payments to managed care plans may not be increased, presumably because managed care organizations are expected to follow suit by not adjusting provider reimbursement rates to compensate for this reduction in copays. Therefore, an explicit increase was not included in the rate development for the reduction in copays.

However, to conform to federal requirements, the rates were adjusted to account for monthly copays on prescription drugs and non-emergency visits to the emergency room being limited to 5% of family income for individuals at or below 100% of the federal poverty guidelines. Based on data from DHS, 0.70% of MA enrollee-months were subject to a copay maximum for the year ending July 2008.

Assuming that copays for non-emergency visits to the emergency room are immaterial, the maximum copay that might be waived for the SNBC PINs population is the $7 per enrollee per month for prescription drugs. Multiplying this maximum drug copay per month of $7 by 0.70% gives a benefit cost of $0.05 PMPM. This cost was added to the prescription drug rates in Appendix 2.

This factor assumes non-emergency visits to the emergency room are immaterial, that all SNBC PINs members will have drug copays of the full maximum of $7 per month, that all affected enrollees will have the entire copay waived, and that an SNBC PINs enrollee is typical with respect to income among the population represented in the data received from DHS, which includes fee-for-service as well as managed care enrollees.

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IV. OCTOBER – DECEMBER 2009 RATE DEVELOPMENT

This section of the report contains documentation of the required adjustments to the 2009 rates for legislative and unallotment changes effective October 1, 2009.

ADJUSTMENT FOR PHYSICIAN AND PROFESSIONAL SERVICES RATABLE REDUCTION AND UNALLOTMENT

This legislative ratable reduction reduced the 2009 payment rates for applicable physician and professional services by 5%. In addition, the unallotment added another 1.5% reduction, for a total reduction of 6.5%. Office and outpatient services, preventive medicine services, and family planning services were exempt from this rate reduction when billed by primary care specialties (general practice, internal medicine, pediatrics, geriatrics, and family practice) or by an advanced practice registered nurse or physician assistant practicing in pediatrics, geriatrics, or family practice. The per member per month (PMPM) adjustment factors in Exhibit 2 reflect a modification to the 6.5% reduction for the categories of service (COS) that contain exempt services based on data provided by DHS.

The physician and professional services ratable reduction did not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

ADJUSTMENT FOR BASIC CARE RATABLE REDUCTION AND UNALLOTMENT

This legislative ratable reduction reduced the 2009 payment rates for basic care services by 3%. In addition, the unallotment added another 1.5% reduction, for a total reduction of 4.5%. Physician and professional services, inpatient hospital services, family planning services, mental health services, dental services prescription drugs, medical transportation, Federally Qualified Health Contract services, Rural Health Clinics, and Indian Health Services were exempt from this rate reduction. The PMPM adjustment factors in Exhibit 2 reflect a modification to the 4.5% reduction for the COS that contain exempt services based on data provided by DHS.

The basic care ratable reduction did not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

ADJUSTMENT FOR INPATIENT RATABLE REDUCTION

This legislative ratable reduction reduced the 2009 payment rates for inpatient hospital admissions occurring on or after July 1, 2009 by 1%. Facilities operated by the Indian Health Service and Indian tribes were exempt from this rate reduction; however, it was estimated that this exemption would not have an impact on the rates for the SNBC PINs population.

The inpatient ratable reduction did not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

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ADJUSTMENT FOR REIMBURSEMENT RATES FOR BIRTHS – PHYSICIAN SERVICES

Legislation established new professional services payment rates related to labor, delivery, antepartum, and postpartum care for the following diagnostic related groups (DRGs):

- 371 - Cesarean section deliveries without complications,
- 372 - Vaginal deliveries with complications, and
- 373 - Vaginal deliveries without complications

The new rates were required to be consistent with an increase in the proportion of births by vaginal delivery and a reduction in the percentage of births by cesarean section. This legislative change was estimated to not impact the cost of inpatient maternity services for the SNBC PINs population due to the very small number of births within this population.

ADJUSTMENT FOR REIMBURSEMENT RATES FOR BIRTHS – INPATIENT SERVICES

Legislation also established new facility payment rates for births. For admissions occurring on or after October 1, 2009, the total operating and property payment rate, excluding disproportionate population adjustment, was required to be no greater than $3,528 for the following DRGs:

- 371 - Cesarean section without complicating diagnosis,
- 372 - Vaginal delivery with complicating diagnosis, and
- 373 - Vaginal delivery without complicating diagnosis

The new rates do not apply to newborn care. This legislative change was estimated to not impact the cost of inpatient maternity services for the SNBC PINs population due to the very small number of births within this population.

ADJUSTMENT FOR REDUCTION RELATED TO PROVIDER RATE REDUCTION

The provider rate reduction within the new legislation required a 2.58% reduction in rates for home health services.

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V. 2010 RATE DEVELOPMENT

This section contains documentation of the required adjustments to the October through December 2009 base rates required to develop the CY 2010 base rates.

TRENDS

The 2009 to 2010 trend assumptions, based on data provided by DHS, are -1.0% for Home Health Agency (HHA) services, 5.2% for non-HHA acute care services, and 9.0% for prescription drugs.

ADJUSTMENTS FOR PRESCRIPTION DRUG BENEFITS

Adjustment for Zostavax Vaccine

For the 2009 rate development, $0.52 PMPM was included in the 2009 prescription base rates for the one-time Zostavax vaccine. For 2009, we assumed 30% of the single eligible, ages 60 to 64 SNBC PINs population would obtain the one-time Zostavax vaccine. For 2010, we assumed 20% of this population would obtain the vaccine and the cost per vaccination would increase 9% from 2009 levels. This results in a projected 2010 Zostavax cost of $0.38 PMPM ($0.38 = $0.52 / 0.30 x 0.20 x 1.09). This $0.14 PMPM cost reduction is included in the 2010 prescription base rates in Appendix 1.

Adjustment for Gardasil

The drug Gardasil is covered under SNBC PINs for single eligible males ages 18 to 26 (it is covered under the federal Part D benefit for dual eligibles). MCOs are expected to cover the cost of the drug and administration.

For the 2010 rate development, DHS estimated 2.2% of the SNBC PINs single eligible population would be males ages 18 to 26. DHS also assumed 7% of this population would obtain the three dose Gardasil treatment in 2010 at a cost of $8.50 per dose, resulting in a cost of $0.003 PMPM ($0.003 = 3 x $8.50 x 0.022 x 0.07 / 12). This cost was included in the 2010 prescription base rates.

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ADJUSTMENT FOR DENTAL SERVICES

Effective January 1, 2010, legislation modifies dental coverage for non-pregnant adults as follows:

- Eliminates coverage for fixed bridges
- Limits coverage to:
  - comprehensive exams, limited to once every five years
  - periodic exams, once per year
  - limited exams
  - bitewing x-rays, once per year
  - periapical x-rays
  - panoramic x-rays, once every five years and only if certain conditions are met. Allows panoramic x-rays to be provided once every two years to certain patients who cannot cooperate for intra-oral film
  - prophylaxis, once per year
  - application of fluoride varnish, once per year
  - posterior fillings at the amalgam rate
  - anterior fillings
  - endodontics, limited to root canals on the anterior and premolars only
  - removable prostheses, each dental arch limited to one every six years
  - oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses
  - palliative treatment and sedative fillings for relief of pain
  - full mouth debridement, once every five years.
- Provides the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:
  - periodontics, limited to periodontal scaling and root planing once every two years
  - general anesthesia
  - full mouth survey once every five years
- Provides coverage of dental services for children that are medically necessary, and that the following guidelines apply:
  - posterior fillings are paid at the amalgam rate
  - application of sealants once every five years per permanent molar
  - application of fluoride varnish is limited to once every six months

This change in benefit level was estimated to reduce dental costs by 22.5% for CY 2010, based on information provided by DHS.

ADJUSTMENTS FOR MENTAL HEALTH TARGETED CASE MANAGEMENT

For 2010, the average monthly cost for those individuals receiving MH-TCM services for a given month is assumed to be $625. Using the base rates in Table 4, this results in a 2010 MH-TCM rate adjustment factor of $625 / $366.02 = 1.7076 for duals and $625 / $410.31 = 1.5232 for non-duals.

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ADJUSTMENT FOR THE UNDER PREDICTION OF THE NON-DD POPULATION

Testing of the risk factor model indicated a bias of the risk factors for the non-developmentally disabled population to under-predict projected costs by approximately 7.74% for duals and 1.74% for non-duals assuming a distribution of 65% with mental disability and 35% with physical disability within the SNBC PINs population. Therefore, the 2010 base rates were increased by 7.74% for duals and 1.74% for non-duals to account for this under-prediction. These bias factors were calculated by Greg Gifford.

HEALTH CARE HOME CARE COORDINATION BENEFIT

Beginning July 1, 2010, a new Medicaid benefit is being added for health care home (HCH) care coordination for payments to certified clinics or practitioners meeting new MDH criteria. Payments are to be made for people with one or more chronic conditions. The adjustment to the 2010 rates was based on an analysis of FY 2008 data to determine the presence of chronic conditions within the SNBC PINs population, allocating the population into five categories (zero, one, two, three, or four or more chronic conditions). We determined that due to the number of HCH services that may be certified in 2010 and where members might be served, approximately 1.5 months per person per year with at least one chronic condition could be eligible in 2010.

For the dual population, we assumed there would be no payment for those with one chronic condition since Medicare, as the primary payer, should be fully responsible for the less involved populations. For duals with two or more chronic conditions, we allocated approximately 50% of the estimated value of the Medicaid service because we do not want to supplant Medicare services. Rates for both the community and institutional populations were increased for the HCH benefit.

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VI. SEPTEMBER 2010 THROUGH DECEMBER 2010 RATE DEVELOPMENT

This section of the report contains documentation of the required adjustments to the 2010 rates for legislative changes effective September 1, 2010.

ADJUSTMENT FOR NON-ADMINISTRATIVE MANAGED CARE RATABLE REDUCTION

This legislative ratable reduction language states that the current 2010 payment rates for non-administrative services are to be reduced by 3%. The non-administrative services ratable reduction does not apply to the Medicare cost sharing portion of the rates for dual eligible individuals.

Per the 2010 rate memo, SNBC PINs administrative costs represent approximately 6.4% of the basic care capitation. Thus, for single eligible (I.e., Medicaid only) rates, a 3% reduction to the non-administrative portion of the rates results in an effective 2.81% [(100% – 6.4%) x 3%] reduction applicable to the entire basic care rate. The per member per month (PMPM) adjustment factors in Appendix 2 reflect this 2.81% reduction for each category of service (COS).

For the dual eligible rates in Appendix 2, the PMPM adjustment factors reflect a reduction for only the portion of cost for each COS that is not Medicare cost sharing, resulting in an effective adjustment that is less than 2.81% for many of the COS.

ADJUSTMENT FOR PHYSICIAN AND PROFESSIONAL SERVICES RATABLE REDUCTION

This legislative ratable reduction language states that the current 2010 payment rates for certain physician and professional services are to be reduced by 7%. The reduction does not apply to physical therapy services, occupational therapy services, speech pathology and related services, and services provided by psychiatrists and advanced practice nurses with a specialty in mental health. In addition, the physician and professional services ratable reduction does not apply to the Medicare cost sharing portion of the rates for dual eligible individuals.

Based on discussion with DHS, we understand this 7% reduction is to be applied in addition to the 5% reduction enacted in October 2009 (i.e., the 1.5% unallotment from October 2009 is included in the 7%), resulting in an effective reduction of approximately 5.5% for these services. We used data provided by DHS, both data that was provided for the October 2009 adjustments and additional data regarding psychiatrists and advanced practice nurses with a specialty in mental health, to develop the required adjustments for September 2010.

The PMPM adjustment factors in Appendix 2 reflect this reduction for the applicable COS. As this adjustment is effective October 1, 2010, we applied three-fourths of the PMPM adjustment we would otherwise apply, to recognize that the new rates are effective September 1, 2010. If an adjustment for a particular COS is less than $0.005 PMPM, the adjustment will be reflected as $0.00 PMPM in Appendix 2.

ADJUSTMENT FOR RATE INCREASE FOR THERAPY SERVICES

This legislative language requires the commissioner to classify physical therapy, occupational therapy, and speech language pathology and related services as basic care service and apply the same ratable reduction to these services as other basic care services (4.5%). Since the ratable reduction applied to these services was 6.5% in October 2009, this adjustment effectively increases the payment rates for these services by approximately 2%. This increase does not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. We used data provided by DHS that was provided for the October 2009 adjustments to develop the required adjustments for September 2010.

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The PMPM adjustment factors in Appendix 2 reflect this increase for the applicable COS. As this adjustment is effective October 1, 2010, we applied three-fourths of the PMPM adjustment we would otherwise apply, to recognize that the new rates are effective September 1, 2010. If an adjustment for a particular COS is less than $0.005 PMPM, the adjustment will be reflected as $0.00 PMPM in Appendix 2.

ADJUSTMENT FOR INPATIENT RATABLE REDUCTION

The October 2009 rate adjustments reflected a 1% legislative rateable reduction for inpatient services. This rate adjustment was maintained in the CY 2010 rates. In addition, the trends applied to develop the CY 2010 rates reflected an additional 0.9% rateable reduction for inpatient services. Therefore, no additional adjustment needs to be made to the September 2010 rates for rateable reductions related to inpatient services.

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VII. 2011 RATE DEVELOPMENT

As in past years, in 2011 DHS will issue a single monthly payment to each health plan or its designee for which the health plan must provide the SNBC PINs benefits set forth in the contract for all enrolled persons. The amount of the monthly payment will be equal to the product of the CY 2011 base rates multiplied by the risk factor for each person enrolled in the health plan, updated on a rolling quarterly basis. To ensure that the payments to the health plan reflect the resource needs of the enrolled population as accurately as possible, DHS developed a risk factor assignment methodology which acknowledges each enrollee's diagnosis history. The risk factor weights will be provided in a separate document.

The remainder of this section describes the adjustments to the September through December 2010 base rates required to develop the CY 2011 base rates.

TRENDS

The 2011 trend assumptions, based on data provided by DHS, are 11.0% for Home Health Agency (HHA) services, 5.0% for non-HHA acute care services, 9.0% for prescription drugs, and 0.0% for MH-TCM.

INCREASE IN DENTAL RATES

Effective January 1, 2011 for managed care, state-operated dental clinics are to be paid using a cost-based payment system based on Medicare cost-finding methods and allowable costs. We understand there are currently five such clinics. We used the fiscal note provided by DHS to develop the required rate adjustment.

The fiscal note estimates a payment increase of $1,185,827 to state operated clinics in FY 2009 dollars for the Medicaid population. DHS indicated that it was reasonable to assume that almost all of the "Medicaid" population in this item of the fiscal note was the MA disabled population, which reflected 1,278,000 member months in FY 2009, of which approximately 49,000 were in managed care.

The $1,185,827 payment increase includes adjustments for a 25% service reduction and an increase related to critical access dental eligibility. We trended the FY09 cost to CY11 at an annual rate of 5%, the trend rate assumed for the fiscal note. Across the entire MA disabled population, the projected CY 2011 cost increase amounts to $1.05 PMPM ($1.05 = $1,185,827 x $1.05^{2.5}$ / 1,278,000). The PMPM adjustment factors in Appendix 2 reflect this increase for the dental COS.

INPATIENT RATABLE REDUCTIONS

There are two inpatient ratable reductions that affect the rates beginning January 1, 2011.

- The temporary reduction of 1.9%, currently in place, expires and is replaced by a permanent reduction of 1.79%
- An additional inpatient rate reduction of 1.96%.

Thus, the total reduction effective January 1, 2011 is 1.85% (1.0185 = 1.0179 / 1.0190 x 1.0196), which is the reduction reflected in Appendix 2.

The inpatient ratable reduction did not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

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ADJUSTMENT FOR REMOVAL OF 1.5% BASIC CARE UNALLOTMENT

A legislative ratable reduction reduced the 2009 payment rates for basic care services by 3%. In addition, an unallotment added another 1.5% reduction, for a total reduction of 4.5%. Physician and professional services, inpatient hospital services, family planning services, mental health services, dental services prescription drugs, medical transportation, Federally Qualified Health Contract services, Rural Health Clinics, and Indian Health Services were exempt from this rate reduction. The 2009 PMPM adjustment factors reflected a modification to the 4.5% reduction for the COS that contain exempt services based on data provided by DHS.

The 1.5% unallotment portion of this reduction is sunsetting in July 2011. The 2011 PMPM adjustment factors in Exhibit 2 reflect the required increases to the rates to account for this change. Instead of applying the full required adjustment to the rates for the last six months of 2011, we applied half of the required adjustment to the rates for the entire year so as to not have multiple sets of rates in 2011.

As with the original basic care ratable reduction, the adjustments made to remove the 1.5% unallotment did not apply to the Medicare cost sharing portion of the rates for dual eligible individuals. Therefore, the PMPM ratable reductions in Exhibit 2 also include adjustments to reflect the portion of the rate for each COS that is for covering Medicare cost sharing amounts, as provided by DHS.

Please recall that as of September 2010 legislative language requires the commissioner to classify physical therapy, occupational therapy, and speech language pathology and related services as basic care service and apply the same ratable reduction to these services as other basic care services (4.5%). The sunsetting of the 1.5% unallotment in July 2011 also applies to these services and the appropriate adjustments were made in Exhibit 2 for these services.

HEALTH CARE HOME

Health Care Home (HCH) payments were required beginning the second half of calendar year 2010. An adjustment was included in the 2010 rates to reflect the increased cost to the MCOs. Per the documentation supplied by DHS, the HCH payment will be required for the entire 2011 contract.

For the 2011 rates, we developed an adjustment that recognizes more current cost and utilization assumptions provided by DHS. The 2011 PMPM adjustments in Appendix 2 reflect the full-year 2011 PMPM costs less the six-month 2010 PMPM costs trended to 2011.

Table 5 contains the projected 2011 enrollment distribution by HCH Tier, based on information provided by DHS for the disabled population.

Table 5
Special Needs BasicCare Preferred Integrated Networks
Projected 2011 Enrollment Distribution for HCH

Tier	Enrollment Distribution
0	19.26%
1	8.28%
2	23.64%
3	24.76%
4	24.06%
Total	100.00%

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Table 6 contains projected average HCH payments PMPM for enrollees projected to receive services, as provided by DHS. These averages include a 15% add-on for enrollees who have a primary language other than English or a serious and persistent mental illness. Payments for Tier 3 and 4 for SNBC dual eligibles are projected at 50% of the rate for SNBC non-duals due to the involvement of Medicare's care coordination function.

Table 6
Special Needs BasicCare Preferred Integrated Networks
Projected 2011 Average Health Care Home Payments PMPM

Tier	SNBC Duals	SNBC Non-Duals
0	$0.00	$0.00
1	$10.47	$10.47
2	$21.00	$21.00
3	$21.06	$42.12
4	$31.64	$63.27

We calculated the weighted average projected payment PMPM for each population, assuming 1.5 months of payments on average per eligible. The 1.5 months of payments was chosen by DHS as its best estimate. This weighted average, assuming 1.5 months of coverage, is $2.33 and $3.94 PMPM for SNBC duals and non-duals, respectively.

VARICELLA VACCINE FOR ADULTS

Currently, the varicella (chicken pox) vaccine is a managed care covered service for children up to age 18, while adults aged 19 and up are covered on a FFS basis. DHS has decided to begin covering the vaccine for adults under the managed care programs in 2011. This coverage will include serum costs for individuals over the age of 21. In addition, as with other vaccines, this coverage excludes the costs for individuals living in border counties who receive their vaccines in states other than Minnesota.

DHS provided 2009 fee-for-service utilization data for managed care enrollees. We allocated the utilization across the impacted adult populations (including PMAP, MNCare, Seniors, PGAMC, and SNBC) and assumed no change in utilization rates for 2011. Based on a 2009 cost per dose of $83.16 (based on DHS serum and administration costs of $81.66 and $1.50, respectively) trended forward two years at the 5% annual acute trend rate, the projected cost of providing these vaccinations is $0.02 PMPM. Similar to the prior year adjustment for coverage of the Zostovax vaccine, this $0.02 PMPM required increase to the rates is included in the 2011 prescription drug base rates in Appendices 1 and 2.

PPACA PROVISIONS

The recently enacted federal health reform legislation (PPACA) requires drug manufacturers to pay rebates to the State. As this provision is expected to reduce or eliminate rebates paid to the plans, a rate increase is necessary. We asked the plans to provide information regarding (A) the ratio of 2009 rebates to 2009 drug cost before rebates, and (B) the ratio of projected 2011 rebates to 2011 drug cost before rebates. We also considered information regarding the plans' confidence in their estimate of this second item. The percentage increase in the prescription costs associated with this provision is calculated as (1 - B) / (1 – A) -1, which equals 3.91%. The 2011 prescription drug base rates in Appendices 1 and 2 reflect this increase.

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HOSPICE CARE SERVICES

Effective retroactive from March 23, 2010, legislation provides that a recipient of MA age 21 or under who elects to receive hospice care does not waive coverage for services related to the treatment of the condition for which a diagnosis of terminal illness has been made. Less than 0.001% of the base fee-for-service member months for individuals with disabilities were member months associated with individuals age 21 or under who have utilized hospice services. Due to this small percentage, we estimate providing coverage for services related to the treatment of the condition for which a diagnosis of terminal illness has been made will result in additional costs of less than $0.01 PMPM; therefore, no adjustment to the rates for this legislation was made.

SERVICES PROVIDED IN BIRTH CENTERS

Legislation establishes MA coverage for services provided in a licensed birth center by a licensed health professional if such services would otherwise be covered if provided in a hospital. It also provides that licensed traditional midwives are to be paid 100% of what a physician would receive for performing the same services and that facility fees will be reimbursed at a rate of 70% of what a hospital would receive for an uncomplicated vaginal birth.

Similar to other past legislative changes related to services related to births, no adjustments were made to the rates due to the very small number of births within the SNBC population.

CHEMICAL DEPENDANCY RATE REFORM

Chemical dependency rate reform will be legislative will take effect in CY 2011. This legislation is intended to be budget neutral. As a result, no adjustments were made to rates for this legislation.

COSTS BY SERVICE CATEGORY

Appendix 2 contains actuarial cost models which show the distribution of PMPM costs by service category for the eight base rate population combinations. For the 2005 base data, the total cost of prescription drugs is included in the dual eligible cost models. The spenddown amounts shown in Appendix 1 are the total adjusted spenddown amounts contained in Table 2.

CAPITATION RATE COMPONENTS

Appendix 1A contains the components required to develop the CY 2011 capitation rates for each combination of:

- Medicaid only vs. Dual eligibility and
- Population group (Institutional vs. Community)

Appendix 1B contains templates of the spreadsheets that will be used by DHS to develop CY 2011 capitation rates for SNBC PINs. The Plan Risk Factors in Appendix 1B are for illustrative purposes only. They are not intended to reflect actual PINs risk scores for CY 2011.

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MEDICAL EDUCATION RESEARCH COST ADJUSTMENT

DHS will make payments to the Medical Education Research Cost (MERC) Trust Fund on behalf of the MCO. As a result, the CY 2011 SNBC PINs final base rates were adjusted for a MERC reduction percentage of 2.0% for Anoka, Carver, Dakota, Ramsey, Scott, and Washington Counties.

DIFFERENTIAL HOSPITAL UTILIZATION ADJUSTMENT

Because of differential hospital utilization (DHU) in the fee-for-service base data, DHU was removed from single eligible base rates for SNBC PINs and will be added back after the risk adjustment is calculated. This DHU adjustment is only applied to the single eligible population as Medicare is responsible for the hospital costs of dual eligible population.

The CY 2011 SNBC PINs final base rates for single eligibles were adjusted for aggregate DHU reductions based on percentage of 2.6% for Anoka, Carver, Dakota, Ramsey, Scott, and Washington Counties.

LEGISLATED PREMIUM TAX

The CY 2011 final capitation rates include the legislated premium tax of 1%.

WITHHOLD

A 9.5% withhold adjustment required by legislation was removed from the rates, excluding MERC and the NF-Add on. Withhold returns will be calculated for each MCO based on risk adjusted reimbursed amounts paid to the MCO plus DHU, excluding MERC and the NF-Add on.

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VIII. SNBC PINS NURSING FACILITY ADD-ON RATE

The health plan will be responsible for the first 100 days of nursing facility care for new admissions. The nursing facility per diem costs for persons who resided in nursing facilities prior to enrollment in the health plan are paid on a fee-for-service basis by the Medical Assistance program. For dual eligibles, Medicare covered skilled nursing facility days are counted toward the 100 days health plan liability. The 100 days may be consecutive days or total days for multiple admissions for a contract year.

The aggregate nursing facility rate for the SNBC PINs population is calculated by the following formula:

Monthly Rate	=	Annual Frequency of Nursing Facility Admissions / 12
	x	Average Length-of-Stay
	x	Average Charge per Day

The calculations of the initial rate and subsequent adjustments are outlined on pages 3 and 4 of Appendix 3:

- Section A contains the calculation of the initial rate. The initial rate is equal to the expected nursing facility costs for days in CY 2011 resulting from admissions occurring in CY 2011, divided by projected community eligible months in CY 2011. The initial rates PMPM for CY 2011 are $13.17 and $11.16 for the single eligible and dual eligible community populations, respectively.

- Section B contains the calculation of the tail rate. The tail rate is equal to the expected nursing facility costs for days in CY 2011 resulting from admissions occurring in CY 2010, divided by projected community eligible months in CY 2011. The tail rates PMPM for CY 2011 are $2.12 and $2.32 for the single eligible and dual eligible community populations, respectively.

- Section C contains the calculations of the value of the enrollment adjustment based on updated enrollment. There is an enrollment adjustment for CY 2011 of $0.34 and $2.96 for the single eligible and dual eligible community populations, respectively. The enrollment adjustments account for plans being underpaid in CY 2010 due to the CY 2010 rates being based on <u>projected</u> CY 2010 enrollment.

- Section D contains the initial base rates for CY 2011 of $15.63 and $16.44 for the single eligible and dual eligible community populations, respectively. In addition, the initial base rate was decreased by 1.7% so that disenrollment fees do not need to be charged. Without this adjustment, a disenrollment fee would need to be paid to DHS by the managed care organization (MCO) when an institutionalized SNBC PINs enrollee disenrolls during the 100-day benefit period. The resulting final base rates for CY 2011 are $15.36 and $16.16 for the single eligible and dual eligible community populations, respectively.

The data source for the calculation of the frequency, average length-of-stay (ALOS), and average charge per day consists of fee-for-service experience data from CY 2005 for eligibles with disabilities. This data was compiled by DHS staff. The data reflects experience from the single eligible population (those eligible only for Medicaid) and the dually eligible population (those eligible for both Medicare and Medicaid benefits).

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FREQUENCY

The frequency of admission is expressed as the expected number of admissions per eligible on an annual basis. The annual frequencies of admission are 1.5% for both the single eligible and dual eligible community populations.

AVERAGE LENGTH-OF-STAY

The ALOS is 72 days and 73 days for the single eligible and dual eligible community populations, respectively. These amounts include only the first 100 days per stay for all admissions combined. Skilled nursing facility days reimbursed by Medicare will be included in the 100-day pre-funded liability, with lower payments due to Medicare's portion. This is reflected by lowering the ALOS used to calculate the initial rate by 10.3 days for the dual eligible community eligibles. In the NF Add-on rate calculation, the length-of-stay is adjusted to exclude days which occur beyond the contract period.

CHARGE PER DAY

An initial charge per day of $163.38 was based on the projected 2008 nursing facility charge per day, prior to any COLA adjustments, using information prepared by DHS for the disabled fee-for-service population. The charge reflects Medicaid reimbursed amounts. This charge per day was adjusted as follows:

- Increased 1.87% to reflect the COLA for nursing facility services effective January 1, 2008.
- Increased an additional 3.4%, 1.1%, and 0.5% for nursing facility trend from 2008 to 2009, from 2009 to 2010, and from 2010 to 2011, respectively. The 1.1% trend from 2009 to 2010 includes the impact of the legislation's suspension of nursing facility rebasing for FY 2010.
- Decreased 3% to reflect legislation effective September 1, 2010 which included ratable reduction language stating that NF rates for non-administrative services were to be reduced by 3%. This rateable reduction continues to apply in CY 2011 and therefore needs to be reflected in the CY 2011 NF rates.

This results in a final projected CY 2011 charge per day of $169.61 ($169.61 = $163.38 x 1.0187 x 1.034 x 1.011 x 1.005 x 0.97).

LEGISLATED PREMIUM TAX

The CY 2011 SNBC PINs NF add-on rates include the legislated premium tax of 1%, which is added to the rates in Appendix 1A. Final CY 2011 SNBC PINs NF add-on rates for the CBP plans do not include the premium tax adjustment.

BASE RATE CALCULATION

The single and dual eligible base rate calculations use the following formula:

$$\frac{\text{Admits}}{\text{Eligible Months}} \times \frac{\text{Days}}{\text{Admit}} \times \frac{\$}{\text{Day}} = \frac{\$}{\text{Eligible Months}}$$

The base rate calculation only considers nursing facility days that occur within the contract period and is therefore dependent on the enrollment assumptions by month. Enrollment assumptions by month were

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provided by DHS and are shown in the detailed aggregate rate calculations contained on pages 1 and 2 of Appendix 3.

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Appendix 1

SNBC PINs 2011 Base Rate Tables

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Appendix 1A
Special Needs BasicCare - Preferred Integrated Networks
Development of Calendar Year 2011 Rate Components Per Member Per Month (PMPM)
Medica

Population			A	B	C	D	E	F	G	H
			From Appendix 2							
			Acute Base Rate	Rx Base Rate	Spenddown Adjustment	Initial Base Rate	Base Rate MERC Adjstmt.	MHTCM MERC Adjstmt.	DHU Adjstmt.	Base Rate Premium Tax
Duals	Institutional	Metro 2	$374.28	$26.63	$0.84	$401.75	$8.04	$10.10	N/A	$3.98
	Community	Metro 2	443.79	20.38	6.72	470.89	9.42	11.72	N/A	4.66
Non-Duals	Institutional	Metro 2	1,890.55	1,059.25	1.10	2,950.90	59.02	10.10	$76.72	28.44
	Community	Metro 2	1,216.62	473.36	2.06	1,692.04	33.84	11.72	43.99	16.31

Population			I	J	K	L	M	N	O	P	Q
			Non-CBP Final Base Rate with MERC and DHU Removed	CBP Final Base Rate with MERC and DHU Removed	MERC Add-Back	DHU Add-Back for Non-CBP (includes Premium Tax)	DHU Add-Back for CBP	NF Add-On for Non-CBP (includes Premium Tax)	From App. 3 NF Add-On for CBP	MHTCM Add-On for Non-CBP (includes Premium Tax)	From App. 2 MHTCM Add-On for CBP
Duals	Institutional	Metro 2	$397.69	N/A	$18.13	N/A	N/A	N/A	N/A	$509.94	$504.94
	Community	Metro 2	466.13	N/A	21.14	N/A	N/A	$16.32	N/A	592.02	586.22
Non-Duals	Institutional	Metro 2	2,843.60	N/A	69.12	$77.50	N/A	N/A	N/A	509.94	504.94
	Community	Metro 2	1,630.52	N/A	45.56	44.44	N/A	15.52	N/A	592.00	586.20

Metro 2 - Anoka, Carver, Dakota, Ramsey, Scott, and Washington Counties

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Appendix 1B
Special Needs BasicCare - Preferred Integrated Networks
Calendar Year 2011 Capitation Payment Rates
Medica

Rate Regions			MERC Carve Out	DHU Add-on [1]	MERC + DHU	Risk Adjustment Base Rate [1,2]	Plan Risk Factor [3]	Plan RA Rate [1,2,3]	Plan RA Rate + DHU - Withhold [1,3]	Plan RA Rate + DHU + MERC - Withhold [1,3]	NF Add-on [1]	MH-TCM Add-on - Withhold [1]	Total Plan Rate (Includes MERC) [1,3]	Plan Reimbursement Amount (Excludes MERC) [1,3]
			1	2		3	4	5	6	7	8	9	10	11
			App. 1A (K)	App. 1A (L)		App. 1A (I)		(3 x 4)	(2 + 5) x 0.905	(6 + 1)	App. 1A (N)	[App. 1A (P) x 0.905] - App. 1A (F)	(7 + 8 + 9)	(6 + 8 + 9)
Metro 2	**Institutionalized**	**Dual**	$18.13	N/A	$18.13	$397.69	1.5983	$635.63	$575.24	$593.37	N/A	$451.40	$1,044.77	$1,026.64
		Non- Dual	69.12	$77.50	146.62	2,843.60	1.7009	4,836.68	4,447.33	4,516.45	N/A	451.40	4,967.85	4,898.73
	Non-Institutionalized	**Dual**	21.14	N/A	21.14	466.13	1.5983	745.02	674.24	695.38	$16.32	$524.06	1,235.76	1,214.62
		Non- Dual	45.56	44.44	90.00	1,630.52	1.7009	2,773.35	2,550.10	2,595.66	15.52	524.04	3,135.22	3,089.66

[1] Includes 1% premium tax.

[2] Does not include MERC Carve-Out or DHU Add-On. Includes 1% premium tax.

[3] The plan risk factor and risk adjusted rates will change each quarter

Rate Regions:

Metro 2: Anoka, Carver, Dakota, Ramsey, Scott & Washington Counties

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Appendix 2

SNBC PINs PMPM Cost Models

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Appendix 2
Special Need BasicCare - Preferred Integrated Networks (PINs)
2011 Per Member Per Month Rate Development

Population: Dual Eligibles, Metro Counties, Institutional

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	2010 PMPM Rates	Sept - Dec 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	2011 PMPM Rates
001	Inpatient Hospital General	$35.88	$48.95	$48.81	$55.32	$54.90	1.050	$0.00	($0.30)	$0.00	$0.00	$0.00	$0.00	$57.34
006	Rehabilitation	0.15	0.17	0.17	$0.19	$0.19	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.20
007	Outpatient Hospital Services	14.66	15.88	15.82	$17.93	$17.92	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$18.83
015	Inpatient Long Term Hospital	0.65	0.86	0.85	$0.96	$0.94	1.050	$0.00	($0.02)	$0.00	$0.00	$0.00	$0.00	$0.97
020	Home Health Services	0.09	0.09	0.09	$0.10	$0.10	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.11
032	Medical Supply / DME	33.98	36.80	36.11	$40.93	$40.31	1.050	$0.00	$0.00	$0.13	$0.00	$0.00	$0.00	$42.45
036	Transport, Special	46.48	50.33	50.33	$57.05	$55.45	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$58.22
037	Transport, Ambulance	7.46	8.08	8.08	$9.16	$9.14	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.60
041	Anesthesia	1.52	1.65	1.65	$1.87	$1.87	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.96
043	Physician Services	41.42	45.65	45.35	$51.40	$51.10	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$53.66
045	Dental	19.13	20.72	20.72	$18.20	$17.69	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$19.62
046	Mental Health	29.47	32.50	32.50	$36.84	$36.18	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37.99
051	Physical Therapy	6.87	7.74	7.56	$8.57	$8.53	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$8.98
053	Speech Therapy	2.71	3.06	2.97	$3.37	$3.35	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$3.53
054	Occupational Therapy	9.68	10.91	10.46	$11.86	$11.76	1.050	$0.00	$0.00	$0.06	$0.00	$0.00	$0.00	$12.41
055	Podiatry	0.70	0.76	0.76	$0.86	$0.86	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.90
057	Chiropractic	0.04	0.05	0.05	$0.06	$0.06	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.06
058	Audiology	0.51	0.55	0.54	$0.61	$0.60	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.63
062	Chemical Dependency	0.59	0.67	0.67	$0.76	$0.74	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.78
063	CD Extended Care / Halfway House	0.00	0.00	0.00	$0.00	$0.00	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
072	Hospice	1.33	1.44	1.44	$1.63	$1.58	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.66
074	Inpatient Hospital 45 Day Psych Contract	0.69	0.75	0.75	$0.85	$0.85	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.89
075	Eyeglasses / Contact Lenses	2.08	2.25	2.15	$2.44	$2.37	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$2.51
076	Prosthetics and Orthotics	2.86	3.10	3.03	$3.43	$3.41	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$3.59
077	Hearing Aids	0.78	0.85	0.84	$0.95	$0.92	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.97
078	Vision Care	2.26	2.44	2.36	$2.67	$2.61	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.74
079	Radiology, Technical Component	10.96	11.86	11.82	$13.40	$13.38	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$14.05
080	Laboratory	1.12	1.22	1.20	$1.36	$1.36	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.43
082	Federal Qualified Health Contract Service	2.84	3.07	3.07	$3.48	$3.38	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.55
087	End-Stage Renal Dialysis	7.72	8.36	8.36	$9.48	$9.48	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.95
091	Nurse Practitioner Services	1.06	1.15	1.15	$1.30	$1.30	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.37
999	Unable to Define	0.25	0.28	0.28	$0.32	$0.32	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.34
	Dialectical Behavioral Therapy	0.67	0.58	0.58	$0.66	$0.64	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.67
	Health Care Home Care Coordination	0.00	0.00	0.00	$1.17	$1.14	1.050	$0.00	$0.00	$0.00	$1.13	$0.00	$0.00	$2.33
	Total Acute Base Rate	$286.65	$322.77	$320.52	$359.17	$354.43								$374.28
	Prescription Drugs	$622.75	$20.70	$20.70	$24.17	$23.49	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$1.00	$26.63
	Spenddown	1.98	0.86	0.86	$0.86	$0.84	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.84
	Grand Total	$911.38	$344.33	$342.08	$384.19	$378.76	$19.84	$1.05	($0.33)	$0.27	$1.13	$0.02	$1.00	$401.75
	Mental Health Targeted Case Management	$296.48	$289.79	$289.79	$520.56	$504.94	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$504.94
	2005 Eligible Months	19,918												

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2011 Per Member Per Month Rate Development

Population: Dual Eligibles, Metro Counties, Community

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	2010 PMPM Rates	Sept - Dec 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	2011 PMPM Rates
001	Inpatient Hospital General	$28.81	$45.64	$45.57	$51.65	$51.48	1.050	$0.00	($0.15)	$0.00	$0.00	$0.00	$0.00	$53.90
006	Rehabilitation	0.20	0.25	0.25	$0.28	$0.28	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.29
007	Outpatient Hospital Services	15.45	19.43	19.38	$21.97	$21.97	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$23.08
014	Inpatient Hospital IMD	0.11	0.14	0.14	$0.16	$0.16	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.17
015	Inpatient Long Term Hospital	4.82	7.40	7.33	$8.31	$8.11	1.050	$0.00	($0.15)	$0.00	$0.00	$0.00	$0.00	$8.37
020	Home Health Services	24.40	26.58	25.89	$27.61	$26.83	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$29.78
029	RTC - Mental Health	0.57	0.72	0.72	$0.82	$0.80	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.84
032	Medical Supply / DME	21.46	26.98	26.29	$29.80	$29.39	1.050	$0.00	$0.00	$0.13	$0.00	$0.00	$0.00	$30.99
036	Transport, Special	12.02	15.12	15.12	$17.14	$16.66	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.49
037	Transport, Ambulance	3.43	4.31	4.31	$4.89	$4.88	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.12
041	Anesthesia	0.99	1.25	1.25	$1.42	$1.42	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.49
043	Physician Services	38.04	48.62	48.34	$54.79	$54.55	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$57.28
045	Dental	13.77	17.31	17.31	$15.21	$14.78	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$16.57
046	Mental Health	86.10	110.23	110.23	$124.94	$121.96	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$128.06
051	Physical Therapy	1.54	2.01	1.98	$2.24	$2.24	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.36
053	Speech Therapy	0.48	0.62	0.59	$0.67	$0.66	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.70
054	Occupational Therapy	2.10	2.75	2.61	$2.96	$2.92	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$3.08
055	Podiatry	0.34	0.43	0.42	$0.48	$0.48	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.50
056	Ambulatory Surgery	0.04	0.04	0.04	$0.05	$0.05	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.05
057	Chiropractic	0.54	0.68	0.68	$0.77	$0.77	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.81
058	Audiology	0.15	0.19	0.19	$0.22	$0.22	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.23
062	Chemical Dependency	5.55	7.26	7.26	$8.23	$8.00	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.40
063	CD Extended Care / Halfway House	1.10	1.38	1.38	$1.56	$1.52	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.60
072	Hospice	3.43	4.31	4.31	$4.89	$4.75	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.99
074	Inpatient Hospital 45 Day Psych Contract	2.02	2.54	2.54	$2.88	$2.86	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.00
075	Eyeglasses / Contact Lenses	1.95	2.46	2.35	$2.66	$2.59	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$2.74
076	Prosthetics and Orthotics	1.69	2.12	2.07	$2.35	$2.33	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$2.46
077	Hearing Aids	0.60	0.76	0.75	$0.85	$0.83	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.87
078	Vision Care	1.05	1.32	1.28	$1.45	$1.42	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.49
079	Radiology, Technical Component	11.28	14.18	14.11	$15.99	$15.95	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.75
080	Laboratory	1.39	1.74	1.71	$1.94	$1.94	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$2.04
082	Federal Qualified Health Contract Service	3.63	4.56	4.56	$5.17	$5.03	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.28
083	Rural Health Clinic Services	0.01	0.02	0.02	$0.02	$0.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.02
087	End-Stage Renal Dialysis	5.44	6.84	6.84	$7.75	$7.75	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.14
088	Public Health Nursing	0.05	0.06	0.06	$0.07	$0.07	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.07
090	Nurse Midwife Services	0.01	0.01	0.01	$0.01	$0.01	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01
091	Nurse Practitioner Services	0.22	0.27	0.27	$0.31	$0.31	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.33
999	Unable to Define	0.88	1.11	1.11	$1.26	$1.26	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.32
	Dialectical Behavioral Therapy	0.67	0.68	0.68	$0.77	$0.75	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.79
	Health Care Home Care Coordination	0.00	0.00	0.00	$1.17	$1.14	1.050	$0.00	$0.00	$0.00	$1.13	$0.00	$0.00	$2.33
	Total Acute Base Rate	$296.34	$382.32	$379.95	$425.67	$419.14								$443.79
	Prescription Drugs	$411.06	$15.87	$15.87	$18.50	$17.98	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$0.77	$20.38
	Spenddown	27.85	6.91	6.91	$6.91	$6.72	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.72
	Grand Total	$735.25	$405.10	$402.73	$451.08	$443.84	$24.19	$1.05	($0.30)	$0.20	$1.13	$0.02	$0.77	$470.89
	Mental Health Targeted Case Management	$296.48	$336.43	$336.43	$604.35	$586.22	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$586.22
	NF Add-on													$16.16
	2005 Eligible Months	233,845												

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Appendix 2
Special Need BasicCare - Preferred Integrated Networks (PINs)
2011 Per Member Per Month Rate Development

Population: Single Eligibles, Metro Counties, Institutional

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	2010 PMPM Rates	Sept - Dec 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	2011 PMPM Rates
001	Inpatient Hospital General	$693.66	$946.45	$936.99	$1,002.86	$974.70	1.050	$0.00	($18.90)	$0.00	$0.00	$0.00	$0.00	$1,004.54
006	Rehabilitation	7.32	7.93	7.85	$8.40	$8.16	1.050	$0.00	($0.16)	$0.00	$0.00	$0.00	$0.00	$8.41
007	Outpatient Hospital Services	64.76	70.12	67.01	$71.72	$69.71	1.050	$0.00	$0.00	$0.57	$0.00	$0.00	$0.00	$73.77
014	Inpatient Hospital IMD	1.98	2.14	2.12	$2.27	$2.21	1.050	$0.00	($0.04)	$0.00	$0.00	$0.00	$0.00	$2.28
015	Inpatient Long Term Hospital	8.70	11.49	11.38	$12.18	$11.84	1.050	$0.00	($0.23)	$0.00	$0.00	$0.00	$0.00	$12.20
020	Home Health Services	0.73	0.68	0.66	$0.66	$0.64	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.71
032	Medical Supply / DME	77.77	84.21	81.81	$87.56	$85.10	1.050	$0.00	$0.00	$0.44	$0.00	$0.00	$0.00	$89.80
036	Transport, Special	40.18	43.51	43.51	$46.57	$45.26	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$47.52
037	Transport, Ambulance	57.90	62.70	62.70	$67.11	$65.23	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$68.49
040	Child and Teen Checkup	0.05	0.05	0.05	$0.05	$0.05	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.05
041	Anesthesia	9.34	10.12	10.12	$10.83	$10.53	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$11.06
043	Physician Services	162.01	179.44	170.10	$182.06	$171.31	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$179.88
045	Dental	19.07	20.65	20.65	$17.13	$16.65	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$18.53
046	Mental Health	42.94	47.35	47.35	$50.68	$49.26	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$51.72
051	Physical Therapy	46.12	51.94	48.56	$51.97	$51.33	1.050	$0.00	$0.00	$0.43	$0.00	$0.00	$0.00	$54.33
053	Speech Therapy	15.09	17.00	15.89	$17.01	$16.80	1.050	$0.00	$0.00	$0.14	$0.00	$0.00	$0.00	$17.78
054	Occupational Therapy	40.90	46.07	43.08	$46.11	$45.55	1.050	$0.00	$0.00	$0.38	$0.00	$0.00	$0.00	$48.21
055	Podiatry	2.44	2.64	2.47	$2.64	$2.46	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.58
056	Ambulatory Surgery	0.54	0.59	0.56	$0.60	$0.58	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.61
057	Chiropractic	0.09	0.10	0.09	$0.10	$0.10	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.11
058	Audiology	0.70	0.76	0.71	$0.76	$0.71	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.75
062	Chemical Dependency	3.50	3.94	3.94	$4.22	$4.10	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.31
063	CD Extended Care / Halfway House	0.02	0.03	0.03	$0.03	$0.03	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.03
072	Hospice	2.44	2.64	2.64	$2.83	$2.75	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.89
074	Inpatient Hospital 45 Day Psych Contract	21.18	22.94	22.94	$24.55	$23.86	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$25.05
075	Eyeglasses / Contact Lenses	2.24	2.43	2.32	$2.48	$2.41	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$2.55
076	Prosthetics and Orthotics	14.46	15.65	14.95	$16.00	$15.55	1.050	$0.00	$0.00	$0.13	$0.00	$0.00	$0.00	$16.46
077	Hearing Aids	1.50	1.63	1.61	$1.72	$1.67	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.76
078	Vision Care	2.46	2.66	2.49	$2.67	$2.49	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.61
079	Radiology, Technical Component	54.96	59.51	55.65	$59.56	$55.47	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$58.24
080	Laboratory	35.13	38.04	36.33	$38.88	$37.79	1.050	$0.00	$0.00	$0.31	$0.00	$0.00	$0.00	$39.99
082	Federal Qualified Health Contract Service	7.83	8.48	8.48	$9.08	$8.83	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.27
083	Rural Health Clinic Services	0.02	0.02	0.02	$0.02	$0.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.02
087	End-Stage Renal Dialysis	17.62	19.08	18.24	$19.52	$18.97	1.050	$0.00	$0.00	$0.15	$0.00	$0.00	$0.00	$20.07
090	Nurse Midwife Services	0.02	0.02	0.02	$0.02	$0.02	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.02
091	Nurse Practitioner Services	8.78	9.51	8.93	$9.56	$8.93	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.38
	Dialectical Behavioral Therapy	0.67	0.58	0.58	$0.62	$0.60	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.63
	Health Care Home Care Coordination	0.00	0.00	0.00	$2.51	$2.44	1.050	$0.00	$0.00	$0.00	$1.38	$0.00	$0.00	$3.94
	Total Acute Base Rate	$1,465.13	$1,793.10	$1,752.83	$1,873.56	$1,814.11								$1,890.55
	Prescription Drugs	$706.17	$867.80	$867.80	$962.22	$935.20	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$39.86	$1,059.25
	Spenddown	2.63	1.13	1.13	$1.13	$1.10	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.10
	Grand Total	$2,173.93	$2,662.03	$2,621.76	$2,836.91	$2,750.41	$174.91	$1.05	($19.33)	$2.60	$1.38	$0.02	$39.86	$2,950.89
	Mental Health Targeted Case Management	$332.35	$324.85	$324.85	$520.56	$504.94	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$504.94
	2005 Eligible Months	8,584												

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Appendix 2
Special Need BasicCare - Preferred Integrated Networks (PINs)
2011 Per Member Per Month Rate Development

Population: Single Eligibles, Metro Counties, Community

COS	Description	DHS 2005 Liability PMPM	January - September 2009 PMPM Rates	October - December 2009 PMPM Rates	2010 PMPM Rates	Sept - Dec 2010 PMPM Rates	Trend	Increase in Dental Rates	Inpatient Ratable Reduction	Removal of Basic Care 1.5% Unallotment	Health Care Home	Varicella Vaccine for Adults	PPACA Provisions	2011 PMPM Rates
001	Inpatient Hospital General	$337.31	$534.30	$528.96	$566.15	$550.25	1.050	$0.00	($10.67)	$0.00	$0.00	$0.00	$0.00	$567.09
006	Rehabilitation	6.65	8.36	8.28	$8.86	$8.61	1.050	$0.00	($0.17)	$0.00	$0.00	$0.00	$0.00	$8.87
007	Outpatient Hospital Services	44.96	56.52	53.98	$57.78	$56.16	1.050	$0.00	$0.00	$0.47	$0.00	$0.00	$0.00	$59.44
014	Inpatient Hospital IMD	0.89	1.12	1.11	$1.19	$1.16	1.050	$0.00	($0.02)	$0.00	$0.00	$0.00	$0.00	$1.20
015	Inpatient Long Term Hospital	13.08	20.05	19.85	$21.25	$20.65	1.050	$0.00	($0.40)	$0.00	$0.00	$0.00	$0.00	$21.28
020	Home Health Services	16.90	18.41	17.94	$18.07	$17.56	1.110	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$19.49
029	RTC - Mental Health	2.74	3.45	3.45	$3.69	$3.59	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.77
032	Medical Supply / DME	37.39	47.01	44.95	$48.11	$46.76	1.050	$0.00	$0.00	$0.38	$0.00	$0.00	$0.00	$49.48
036	Transport, Special	5.18	6.51	6.51	$6.97	$6.77	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.11
037	Transport, Ambulance	15.14	19.03	19.03	$20.37	$19.80	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$20.79
040	Child and Teen Checkup	0.05	0.06	0.06	$0.06	$0.06	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.06
041	Anesthesia	4.82	6.05	6.05	$6.48	$6.30	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.62
043	Physician Services	107.29	138.88	131.60	$140.85	$132.68	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$139.31
045	Dental	11.88	14.94	14.94	$12.39	$12.04	1.050	$1.05	$0.00	$0.00	$0.00	$0.00	$0.00	$13.69
046	Mental Health	67.78	86.78	86.78	$92.88	$90.27	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$94.78
051	Physical Therapy	3.38	4.41	4.12	$4.41	$4.36	1.050	$0.00	$0.00	$0.04	$0.00	$0.00	$0.00	$4.61
053	Speech Therapy	0.77	1.00	0.93	$1.00	$0.99	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$1.05
054	Occupational Therapy	2.18	2.85	2.66	$2.85	$2.81	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$2.97
055	Podiatry	0.93	1.17	1.09	$1.17	$1.09	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.14
056	Ambulatory Surgery	1.20	1.51	1.44	$1.54	$1.50	1.050	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$1.59
057	Chiropractic	0.67	0.84	0.79	$0.85	$0.80	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.84
058	Audiology	0.20	0.26	0.24	$0.26	$0.24	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.25
062	Chemical Dependency	11.33	14.82	14.82	$15.86	$15.41	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.18
063	CD Extended Care / Halfway House	1.56	1.96	1.96	$2.10	$2.04	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.14
072	Hospice	6.78	8.53	8.53	$9.13	$8.87	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.31
074	Inpatient Hospital 45 Day Psych Contract	31.56	39.68	39.68	$42.47	$41.28	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$43.34
075	Eyeglasses / Contact Lenses	1.99	2.50	2.39	$2.56	$2.49	1.050	$0.00	$0.00	$0.02	$0.00	$0.00	$0.00	$2.63
076	Prosthetics and Orthotics	3.92	4.92	4.70	$5.03	$4.89	1.050	$0.00	$0.00	$0.04	$0.00	$0.00	$0.00	$5.18
077	Hearing Aids	0.40	0.50	0.49	$0.52	$0.51	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.54
078	Vision Care	1.11	1.39	1.30	$1.39	$1.29	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.35
079	Radiology, Technical Component	37.98	47.75	44.65	$47.79	$44.51	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$46.74
080	Laboratory	16.82	21.15	20.20	$21.62	$21.01	1.050	$0.00	$0.00	$0.17	$0.00	$0.00	$0.00	$22.24
082	Federal Qualified Health Contract Service	16.98	21.34	21.34	$22.84	$22.20	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$23.31
083	Rural Health Clinic Services	0.07	0.09	0.09	$0.10	$0.10	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.11
087	End-Stage Renal Dialysis	8.28	10.41	9.94	$10.64	$10.34	1.050	$0.00	$0.00	$0.09	$0.00	$0.00	$0.00	$10.94
088	Public Health Nursing	0.15	0.18	0.17	$0.18	$0.17	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.18
090	Nurse Midwife Services	0.12	0.15	0.14	$0.15	$0.15	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.16
091	Nurse Practitioner Services	1.65	2.08	2.00	$2.14	$2.03	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.13
999	Unable to Define	0.01	0.01	0.01	$0.01	$0.01	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01
	Dialectical Behavioral Therapy	0.67	0.68	0.68	$0.73	$0.71	1.050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.75
	Health Care Home Care Coordination	0.00	0.00	0.00	$2.51	$2.44	1.050	$0.00	$0.00	$0.00	$1.38	$0.00	$0.00	$3.94
	Total Acute Base Rate	$822.76	$1,151.65	$1,127.85	$1,204.92	$1,164.90								$1,216.62
	Prescription Drugs	$271.65	$387.86	$387.86	$429.99	$417.92	1.090	$0.00	$0.00	$0.00	$0.00	$0.02	$17.81	$473.36
	Spenddown	6.96	2.12	2.12	$2.12	$2.06	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.06
	Grand Total	$1,101.36	$1,541.63	$1,517.83	$1,637.03	$1,584.88	$96.91	$1.05	($11.26)	$1.26	$1.38	$0.02	$17.81	$1,692.05
	Mental Health Targeted Case Management	$332.35	$377.13	$377.13	$604.33	$586.20	1.000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$586.20
	NF Add-on													$15.36
	2005 Eligible Months	235,448												

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Appendix 3

SNBC PINs 2011 NF Add-On Rate Development

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Appendix 3

Special Needs BasicCare - Preferred Integrated Networks
100 Day Nursing Facility Add-On Rate Calculation
Calendar Year 2011
Single Eligible Population

	1/09 - 9/09	1/09 - 8/10
	$14.01	$15.29
	$172.09	$173.99
	0.125%	0.125%

	10/09 - 12/09	9/10 - 12/10	CY 2011
NF Add-On	$13.92	$14.82	$15.36
Per Diem	$171.06	$168.77	$169.61
Monthly Freq	0.125%	0.125%	0.125%

		(1)	(2)	(3)	NF Days for Admissions in Month by Contract Period			Health Plan Payments to NF for Admissions in Month by Contract Period		
Year	Month	Monthly Enrollment	Total NF Add-On Paid to Health Plans	Admissions	CY2009	CY2010	CY2011	CY 2009	CY 2010	CY 2011
2009	January	940	13,167	1.1750	72.0	0.0		14,559	0	
	February	947	13,265	1.1838	72.0	0.0		14,667	0	
	March	984	13,784	1.2300	72.0	0.0		15,240	0	
	April	1,027	14,386	1.2838	72.0	0.0		15,906	0	
	May	1,061	14,862	1.3263	72.0	0.0		16,433	0	
	June	1,079	15,114	1.3488	72.0	0.0		16,712	0	
	July	1,105	15,479	1.3813	72.0	0.0		17,114	0	
	August	1,173	16,431	1.4663	72.0	0.0		18,168	0	
	September	1,329	18,616	1.6613	72.0	0.0		20,584	0	
	October	1,400	19,488	1.7500	54.6	17.4		16,331	5,312	
	November	1,452	20,212	1.8150	35.0	37.0		10,858	11,693	
	December	1,440	20,045	1.8000	12.6	59.4		3,879	18,604	
Total 2009 Contract Period		13,937	$194,849		60.3	11.7		$180,451	$35,609	
2010	January	1,430	21,865	1.7875		72.0	0.0		22,393	0
	February	1,463	22,369	1.8288		72.0	0.0		22,909	0
	March	1,508	23,057	1.8850		72.0	0.0		23,614	0
	April	1,548	23,669	1.9350		72.0	0.0		24,240	0
	May	1,584	24,219	1.9800		72.0	0.0		24,804	0
	June	1,594	24,372	1.9925		72.0	0.0		24,961	0
	July	1,627	24,877	2.0338		72.0	0.0		25,477	0
	August	1,647	25,183	2.0588		72.0	0.0		25,791	0
	September	1,667	24,705	2.0838		72.0	0.0		25,321	0
	October	1,687	25,001	2.1088		54.6	17.4		19,416	6,239
	November	1,717	25,446	2.1463		35.0	37.0		12,667	13,480
	December	1,747	25,891	2.1838		12.6	59.4		4,643	22,002
Total 2010 Contract Period		19,219	$290,654			61.8	10.2		$256,235	$41,721
2011	January	1,547	23,762	1.9338			72.0			23,615
	February	1,570	24,109	1.9620			72.0			23,960
	March	1,589	24,411	1.9865			72.0			24,260
	April	1,606	24,671	2.0078			72.0			24,519
	May	1,621	24,892	2.0257			72.0			24,737
	June	1,632	25,071	2.0403			72.0			24,916
	July	1,643	25,239	2.0540			72.0			25,083
	August	1,654	25,407	2.0676			72.0			25,250
	September	1,668	25,627	2.0855			72.0			25,469
	October	1,686	25,894	2.1072			54.6			19,498
	November	1,702	26,137	2.1270			35.0			12,616
	December	1,717	26,369	2.1459			12.6			4,585
Total 2011 Contract Period		19,635	$301,589				62.1			$258,507
Grand Total								$203,118	$291,844	$300,228

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Appendix 3

Special Needs BasicCare - Preferred Integrated Networks
100 Day Nursing Facility Add-On Rate Calculation
Calendar Year 2011
Dual Eligible Population

	1/09 - 9/09	1/09 - 8/10
	$13.75	$13.35
	$172.09	$173.99
	0.125%	0.125%

	10/09 - 12/09	9/10 - 12/10	CY 2011
NF Add-On	$13.67	$12.95	$16.16
Per Diem	$171.06	$168.77	$169.61
Monthly Freq	0.125%	0.125%	0.125%

		(1)	(2)	(3)	NF Days for Admissions in Month by Contract Period *			Health Plan Payments to NF for Admissions in Month by Contract Period		
Year	Month	Monthly Enrollment	Total NF Add-On Paid to Health Plans	Admissions	CY2009	CY2010	CY2011	CY 2009	CY 2010	CY 2010
2009	January	1,849	25,428	2.3113	73.0	0.0		29,035	0	
	February	1,900	26,129	2.3750	73.0	0.0		29,836	0	
	March	1,956	26,899	2.4450	73.0	0.0		30,715	0	
	April	2,016	27,724	2.5200	73.0	0.0		31,658	0	
	May	2,101	28,893	2.6263	73.0	0.0		32,992	0	
	June	2,165	29,773	2.7063	73.0	0.0		33,997	0	
	July	2,218	30,502	2.7725	73.0	0.0		34,830	0	
	August	2,336	32,125	2.9200	73.0	0.0		36,683	0	
	September	2,509	34,504	3.1363	73.0	0.0		39,399	0	
	October	2,668	36,472	3.3350	55.3	17.7		31,555	10,263	
	November	2,735	37,387	3.4188	35.5	37.5		20,735	22,332	
	December	2,734	37,374	3.4175	12.8	60.2		7,467	35,812	
Total 2009 Contract Period		27,187	$373,212		61.4	11.6		$358,904	$68,407	
2010	January	2,747	36,672	3.4338		73.0	0.0		43,613	0
	February	2,778	37,086	3.4725		73.0	0.0		44,105	0
	March	2,804	37,433	3.5050		73.0	0.0		44,518	0
	April	2,835	37,847	3.5438		73.0	0.0		45,010	0
	May	2,856	38,128	3.5700		73.0	0.0		45,344	0
	June	2,861	38,194	3.5763		73.0	0.0		45,423	0
	July	2,892	38,608	3.6150		73.0	0.0		45,915	0
	August	2,924	39,035	3.6550		73.0	0.0		46,423	0
	September	2,912	37,710	3.6400		73.0	0.0		44,846	0
	October	2,916	37,762	3.6450		55.3	17.7		34,027	10,935
	November	2,922	37,840	3.6525		35.5	37.5		21,857	23,258
	December	2,925	37,879	3.6563		12.8	60.2		7,881	37,349
Total 2010 Contract Period		34,372	$454,196			63.2	9.8		$468,961	$71,542
2011	January	2,425	39,188	3.0313			73.0			37,532
	February	2,460	39,761	3.0756			73.0			38,080
	March	2,491	40,258	3.1140			73.0			38,556
	April	2,518	40,688	3.1473			73.0			38,968
	May	2,540	41,051	3.1753			73.0			39,316
	June	2,559	41,347	3.1983			73.0			39,599
	July	2,576	41,624	3.2197			73.0			39,865
	August	2,593	41,901	3.2411			73.0			40,130
	September	2,615	42,264	3.2692			73.0			40,478
	October	2,643	42,704	3.3032			55.3			30,989
	November	2,667	43,105	3.3342			35.5			20,051
	December	2,691	43,487	3.3638			12.8			7,287
Total 2011 Contract Period		30,778	$497,378				63.0			$410,851
Grand Total								$403,114	$537,368	$482,393

* Days that are 100% covered by Medicare are included.

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Appendix 3

Special Needs BasicCare - Preferred Integrated Networks
100 Day Nursing Facility Add-On Rate Calculation
Calendar Year 2011
Single Eligible Population

Rate Component	1/10 - 8/10	9/10 - 12/10	2011
Section A			
Monthly Claim Frequency (Rounded)	0.125%		0.125%
(x) Truncated Medicaid Length of Stay	61.8		62.1
(x) Charge per Day	$173.99		$169.61
= Initial Rate (1)	$13.43		$13.17
Section B			
2011 NF $ for 2010 Admits			$41,721
(/) 2011 Eligible Months			19,635
= Tail Rate (2)	$1.83		$2.12
Section C			
2010 NF Rates to Health Plans			($290,654)
2009 Enrollment Adjustment in 2010			$5,574
(+) 2010 NF $ for 2009 Admits			$35,609
(+) 2010 NF $ for 2010 Admits			$256,235
= Enrollment Adjustment Dollars			$6,763
(/) 2011 Eligible Months			19,635
= Enrollment Adjustment Rate (3)	$0.29		$0.34
Section D			
Initial Base Rate = (1)+(2)+(3)	$15.55	$15.08	$15.63
Disenrollment Fee Adjustment	0.983	0.983	0.983
Final Base Rate	$15.29	$14.82	$15.36

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Calendar Year 2011
Dual Eligible Population

Rate Component	1/10 - 8/10	9/10 - 12/10	2011
Section A			
Monthly Claim Frequency (Rounded)	0.125%		0.125%
(x) Truncated Medicaid Length of Stay	52.9		52.7
(x) Charge per Day	$173.99		$169.61
= Initial Rate (1)	$11.50		$11.16
Section B			
2011 NF $ for 2010 Admits			$71,542
(/) 2011 Eligible Months			30,778
= Tail Rate (2)	$1.85		$2.32
Section C			
2010 NF Rates to Health Plans			($454,196)
2009 Enrollment Adjustment in 2010			$7,906
(+) 2010 NF $ for 2009 Admits			$68,407
(+) 2010 NF $ for 2010 Admits			$468,961
= Enrollment Adjustment Dollars			$91,077
(/) 2011 Eligible Months			30,778
= Enrollment Adjustment Rate (3)	$0.23		$2.96
Section D			
Initial Base Rate = (1)+(2)+(3)	$13.58	$13.17	$16.44
Disenrollment Fee Adjustment	0.983	0.983	0.983
Final Base Rate	$13.35	$12.95	$16.16

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