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# RATE REPORT FOR THE DCHFP AND ALLIANCE PROGRAMS

DRAFT RATES FOR RFP

OCTOBER 1, 2020 — SEPTEMBER 30, 2021

JANUARY 7, 2020

District of Columbia

MAKE TOMORROW, TODAY



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# 1

## EXECUTIVE SUMMARY

The District of Columbia's (District's) Department of Health Care Finance (DHCF) has contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop the draft managed care capitation rates. Mercer has produced this Rate Report for DHCF as documentation of the development of the draft capitation rates effective October 1, 2020 through September 30, 2021, or Federal Fiscal Year (FFY) 2021, for the District of Columbia Healthy Families Program (DCHFP) and Alliance populations. These draft capitation rates are to be issued with the Request for Proposal (RFP). Moreover, the capitation rates are meant to provide a reimbursement structure that will match payment to the expected financial risk of the managed care program designed for the DCHFP and Alliance populations.

The District is working towards a more comprehensive Medicaid managed care program and has worked to redesign the DCHFP. This RFP aims to transform the managed care program into a more organized, accountable and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health. The program historically covered individuals who meet the eligibility requirements for the District's Temporary Assistance for Needy Families (TANF) program as well as their Children's Health Insurance program (CHIP). Eligible adults were able to opt-out of managed care and receive coverage through the District's fee-for-services (FFS) program. Effective October 1, 2020, the DCHFP will be mandatory for the entire TANF and CHIP populations. Additionally, non-dual Social Security Income (SSI) Adults ages 21+ currently served through the District's FFS program will be included in the program.

### BASE CAPITATION RATES

The base capitation rates were developed for DCHFP and Alliance programs. The capitation rates will be paid on a per member per month (PMPM) basis, along with one-time birth/maternity event payments.

The table below reflects the draft base capitation rates; detailed summaries by population and service category are provided in Section 7 of the Rate Report. The DCHFP base capitation rates will be risk adjusted to reflect the underlying health risk of the members enrolled in each managed care

organization (MCO). Risk adjustment differentiates capitation payments to MCOs and is budget-neutral to the District.

#### DRAFT FFY 2021 DCHFP CAPITATION RATES

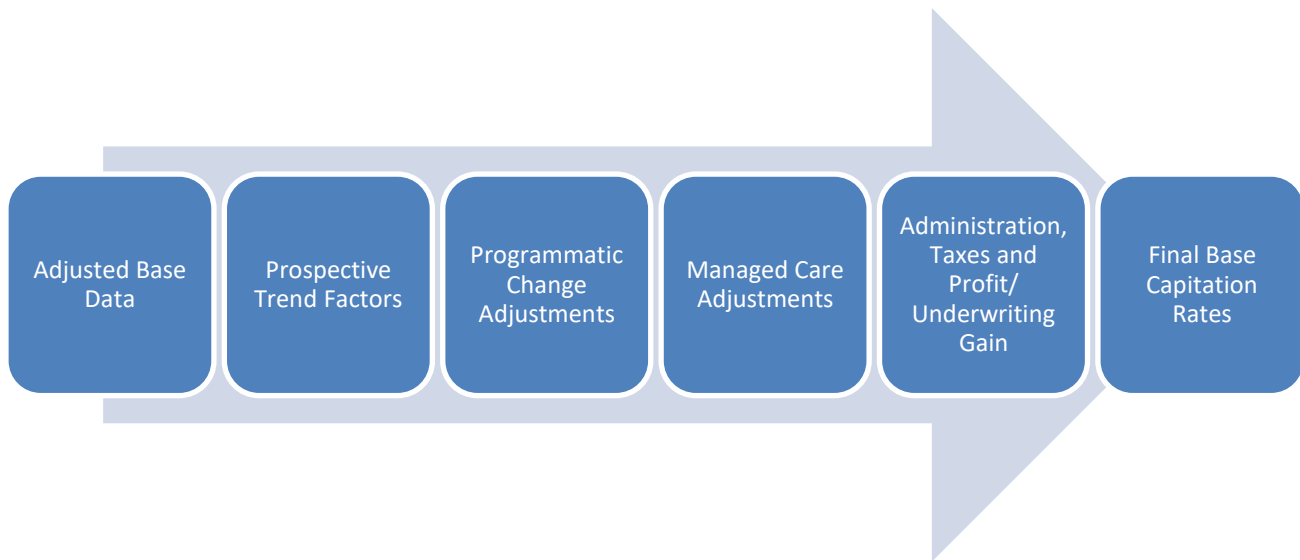
RATE CELL	BASE CAPITATION RATE
Male and Female <1	\$539.56
Children 1–18	\$236.44
TANF Adults 19+	\$437.09
SSI Adults 21+	\$1,808.69
Infant's Month of Birth	\$7,451.17
Mother's Month of Delivery	\$12,589.98
All Rate Cells	\$494.74

#### DRAFT FFY 2021 ALLIANCE CAPITATION RATES

RATE CELL	BASE CAPITATION RATE
19–36 Female	\$257.71
19–36 Male	\$213.10
37–49 Female	\$419.63
37–49 Male	\$346.93
50+ Female	\$881.65
50+ Male	\$975.02
All Rate Cells	\$455.14

#### CAPITATION RATE DEVELOPMENT METHODOLOGY

The rate-setting process is the means for determining the capitation payments DHCF will pay the MCOs for each beneficiary enrolled in the DCHFP or Alliance programs, regardless of the amount of future services that beneficiary receives. This process involves summarizing historical claims and eligibility data that represents the covered populations and services, and projecting future medical claims costs on a PMPM basis into the rating period.



Mercer leveraged historical FFS and encounter claims data from the District’s fiscal agent Conduent to summarize the cost and utilization information for the DCHFP and Alliance programs. Mercer used this information as the basis for capitation rate development. For service category detail, please see Section 5 of the Rate Report. Mercer also used member-level eligibility information to summarize the data and identify the DCHFP and Alliance populations.

The base data has been adjusted to account for historical program changes and consideration for the future managed care design. Detailed methodology and impact of base data adjustments are outlined in Section 6 of the Rate Report.

Prospective adjustments were applied to the base data to project the historical information to the future rating period. Medical trend was evaluated and unit cost and utilization trend factors were developed for each of the major service categories. Programmatic design changes were also considered to account for known design elements that are anticipated to impact projected claims expenditures; for example, hospital reimbursement considerations. Managed care adjustments were applied to capture assumed future changes in the unit cost and utilization of certain services as a result of MCO care management and provider contracting.

The final component of the capitation rate development is the application of the non-benefit expense load. This portion of the capitation rates accounts for expected MCO administration and care management costs to operate the managed care program. The non-benefit load considerations were developed to reflect the MCO contract requirements as defined by DHCF. The non-benefit expense load includes consideration for general administration (including program management, administrative operations and utilization management personnel), care management, profit/underwriting gain and premium taxes imposed on the MCOs. Section 12 of the Rate Report provides additional information on the non-benefit expense considerations.

## FINAL FFY 2021 RATE CONSIDERATIONS

The rates in this report are draft and will be updated to produce final FFY 2021 capitation rates. Below are components of the rate development process that are anticipated to change in the final rate development. Other updates outside of this list may be recognized. A final rate report will be issued to document the rate development and changes from the draft rates.

- The encounter data for the existing DCHFP and Alliance populations will be rebased to reflect base data period of FY 2018 and FY 2019. The draft rates are based on FY 2017 and FY 2018 data. With the updated data, all base data adjustments, program change adjustments and trend applied to the DCHFP and Alliance encounter data will be re-evaluated. Mercer is also evaluating reimbursement levels specific to Outpatient services that may be considered for final rates. Some adjustments may no longer be necessary; additionally, the updated base data may require new adjustments not discussed in this report.
- For the SSI and former Opt-out populations, the FFS retroactive Medicaid enrollment adjustment is draft and will be refined for final rates. The managed care adjustment for anticipated managed care pharmacy reimbursement is also undergoing review and may be refined for final rates.
- The New Population adjustment applied to TANF Adults 19+ accounts for the transition of the former Opt-out population that will be recalibrated after other rate updates are made.
- In 2019, the District received approval of an 1115 demonstration waiver related to services provided to individuals in Institutions for Mental Disease (IMDs). It is anticipated that most services covered through the waiver will be administered through FFS. Mercer is evaluating whether any managed care coverage requirements beyond those discussed in Sections 6 and 10 may necessitate a rate adjustment.
- The fixed/variable administrative allocation will be updated to reflect final cost distribution across rate cells.
- Other changes, as necessary, based on information not available at the issuance of this report.



# 2

## INTRODUCTION

Mercer has produced this Rate Report for the DHCF as documentation of the development of the draft capitation rates effective October 1, 2020 through September 30, 2021, or Federal Fiscal Year (FFY) 2021. Capitation rates were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). The capitation rates described in this Rate Report were developed for the covered services and populations as described in the Request for Proposal (RFP) for the DCHFP and Alliance managed care programs.

The intent of the Rate Report is to summarize historical data and outline key prospective rate considerations for the District of Columbia Healthy Families Program (DCHFP) and Alliance populations for purposes of providing transparency into the current program costs and utilization along with insight into the rate development process for the programs. This Rate Report documents the assumptions underlying the development of the draft capitation rates selected by DHCF at the lower bound of the rate ranges for the FFY 2021 rate period.

The rates included in this Rate Report are draft and will change for final rates. Anticipated changes are described in Section 1.

### PROGRAM OVERVIEW

The DHCF has been operating DCHFP and Alliance programs since 1994 and 2001, respectively. The District is working towards a more comprehensive Medicaid managed care program and has worked to redesign DCHFP. This RFP aims to transform the managed care program into a more organized, accountable and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health.

The DCHFP operates under 1932(a) State Plan Authority. The program historically covered individuals who meet the eligibility requirements for the District's Temporary Assistance for Needy Families (TANF) program as well as their Children's Health Insurance program (CHIP). Eligible adults were able to Opt-out of managed care and receive coverage through the District's fee-for-service (FFS) program. Effective October 1, 2020, the DCHFP will be mandatory for the entire TANF and CHIP populations. Additionally, non-dual Social Security Income (SSI) Adults ages 21+ will be included in the program. SSI Adults have historically been covered through the District's FFS program.

The Alliance program provides coverage to residents of the District with incomes at or below 200% of the federal poverty level (FPL) and who are ineligible for Medicaid. This program is not anticipated to change with the District's DCHFP redesign.

As described in the RFP, additional populations and services will be phased-in over a five-year period. Detailed cost and utilization information for populations and services transitioning after FFY 2021 are outside of the scope of this Rate Report. Please refer to the RFP for detailed program design information and requirements for the managed care organizations (MCOs) managing the program.

## CAVEATS

Please note that Mercer's rate analysis has relied upon enrollment, encounter and FFS claims, reimbursement level, benefit design, program descriptions, financial data and information supplied by the DHCF and its vendors. DHCF and its vendors are responsible for the validity and completeness of these supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion, they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this Rate Report may need to be revised accordingly.

*The rates in this document were developed for informational purposes for the MCO RFP and will change for final rates.*

Sections 3 through 7 provide information on the data summarization process including an outline of population and service groups, adjustments applied to the base data, and detailed summaries by rate cell and Category of Service (COS).

**The users of this Rate Report are cautioned against relying solely on the data contained herein. DHCF and Mercer provide no guarantee, either written or implied, that this report is 100% accurate or error-free. Furthermore, projections outlined in this Rate Report are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued**

**by DHCF and Mercer. DHCF and Mercer are not responsible for the consequences of any unauthorized use.<sup>1</sup>**

The authors of this document, listed below, are members of the American Academy of Actuaries and meet the qualification standards for issuing statements of actuarial opinion outlined in this document.

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<sup>1</sup> These disclosures are made in accordance with the Actuarial Standards of Practice (ASOP) on Actuarial Communications (ASOP 41).

# 3

## DATA SOURCES

Mercer used several data sources as the basis for rate development that included encounter and other data specific to the historical managed care populations. For the populations transitioning to managed care effective FFY 2021, Mercer utilized FFS data from the District's Medicaid management information systems. The data sources and time periods are described in detail below.

### ELIGIBILITY DATA

As a part of the data summarization process, Mercer analyzed eligibility information from the District's eligibility file provided by the District's fiscal agent, Conduent, which outlines enrollment segments for each member.

### ENCOUNTER DATA

The encounter data contains utilization information for the services and populations historically covered in the DCHFP and Alliance programs. Mercer used encounter data provided by Conduent in October 2018.

Pharmacy data was submitted directly from one MCO due to issues with the MCO's pharmacy encounter submissions to Conduent. The MCO provided a separate pharmacy data set in November 2018 that was merged with the encounter data. For base data development, the encounter data is summarized by FY:

- FY 2017 (May 1, 2016 through April 30, 2017)
- FY 2018 (May 1, 2017 through April 30, 2018)

*Note: The baseline encounter data utilized in the RFP rates will be updated to reflect FY 2018 and FY 2019 base data as of September 2019 for final rates.*

## FFS DATA

FFS claims data were provided by Conduent in August 2019. Mercer used FFS claims data to summarize experience for populations and benefits transitioning to DCHFP effective FFY 2021. For base data development, the FFS data is summarized by Calendar Year (CY):

- CY 2017 (January 1, 2017 through December 31, 2017)
- CY 2018 (January 1, 2018 through December 31, 2018)

*Note: The baseline FFS data utilized in the RFP rates will remain as the base data source for final rates with potential refinement to certain adjustments discussed later in this report.*

## OTHER DATA SOURCES

Several other data sources were used to inform adjustments, but are not summarized directly in the data summaries.

- Transportation Workbooks: A small subset of claims were submitted in an Excel workbook due to provider difficulties with the HIPAA 837 format of the encounter records. These claims included expenses for transportation services.
- Data provided by the District's Department of Behavioral Health (DBH) to support analysis of utilization of services provided in an institution for mental disease (IMD).
- Program Integrity Data: DHCF collects data quarterly from MCOs, which includes information related to claims identified as overpayments and the amounts recovered. Mercer utilized data reported from the July 2016 through June 2018 period for the DCHFP and Alliance programs, as this data best aligned with the base period.
- Federally qualified health centers (FQHC) wrap payment data to support an adjustment to account for required future payment at the District's Alternative Payment Methodology (APM) or Prospective Payment System (PPS) rates.
- MCO-Reported Financial Data: Mercer collected financial data from the MCOs for the historical DCHFP and Alliance program data. The financial data is not summarized directly in this Rate Report, but is used to inform base data adjustments as discussed in Section 6.

# 4

## COVERED POPULATIONS

This section describes the covered populations described in the RFP as they are reflected in this Rate Report.

### DCHFP

The DCHFP currently covers individuals who meet the eligibility requirements for the District's TANF program, including children ages 0 to 18 enrolled in CHIP, children eligible for the immigrant children program and childless adults up to the age of 64 with incomes at or below 210% of the FPL. The childless adults have been in DCHFP since 2010; individuals up to 133% of the FPL since July 2010 and individuals with incomes between 134%–210% of the FPL since December 2010.

Effective October 2020, the following populations will be added to the DCHFP:

- **Former Opt-out Adults:** Adults eligible for the DCHFP program are currently allowed to opt-out of managed care and receive coverage through the District's FFS program if they meet certain criteria. Effective October 2020, enrollment in the DCHFP is mandatory for all covered populations. Individuals who opted out will be included in the TANF Adult 19+ rate cell.
- **SSI Adults:** SSI Adults ages 21+ historically covered in the FFS program. The non-dual SSI Adults will transition to managed care in a separate SSI Adult 21+ rate cell.

### DCHFP Rate Structure

The base data sets are split into cohorts, as listed below, which inherently represent different levels of risk.

- Male and Female <1
- Children 1–18
- TANF Adults 19+
- SSI Adults 21+
- Infant's Month of Birth
- Mother's Month of Delivery

### **Birth/Maternity Events**

The Infant's Month of Birth and Mother's Month of Delivery represent one-time birth/maternity event (or "kick") payments that DHCF will pay to cover prenatal, delivery and postpartum care for each mother and newborn. The birth/maternity event payments are made in addition to the monthly per member capitation rates. Birth/Maternity event payments will be made for any delivery by an eligible adult in DCHFP.

Appendix A contains detailed coding logic used to define the new DCHFP populations (SSI Adults and former Opt-out Adults).

### **ALLIANCE**

The Alliance program covers residents of the District whose income is at or below 200% of the FPL, and who are ineligible for Medicaid. There are no population changes for Alliance in FFY 2021.

#### **Alliance Rate Structure**

The base data sets are split into cohorts that represent different age/gender bands, which inherently represent different levels of risk. The following is a list of the six rate cells for the Alliance program.

- Female 19–36
- Male 19–36
- Female 37–49
- Male 37–49
- Female 50+
- Male 50+

These rate cells were selected based on a review of the historical cost structures within these age/gender bands.

### **EXCLUDED POPULATIONS**

The following populations are excluded from the DCHFP and Alliance programs.

- Individuals residing in a long-term nursing facility, intermediate care facilities (ICF) or psychiatric residential treatment facility (PRTF);
- Individuals enrolled in the intellectually/developmentally disabled (ID/DD) and, elderly and persons with physical disabilities (EPD) waivers;
- Children with special health care needs;

- Foster care children; and
- Individuals eligible for both Medicare and Medicare with special health care needs.



## 5 COVERED SERVICES

The historical service costs are summarized into the following major service categories in the table below. In the program redesign, the District has made some modifications to the limits on covered benefits, but has not substantially changed the services covered.

### UNITS OF SERVICE BY COS

COS	DESCRIPTION	UNITS OF SERVICE
Inpatient Hospital	Acute care hospital services	Days
Inpatient Hospital — BH	Behavioral health inpatient services	Days
Outpatient Hospital	Outpatient hospital services	Visits
Outpatient Hospital — BH	Day treatment and outpatient mental health services	Visits
Emergency Room	Emergency room services	Visits
Physician	Primary care and specialist services	Visits
Physician — BH	Professional mental health claims	Visits
FQHC	Services rendered at an FQHC	Visits
Home Health	Home Health/State Plan PCA services	Visits
Nursing Facility	Nursing facility coverage reverts to FFS on the 1 <sup>st</sup> of the month following a beneficiary's 90 <sup>th</sup> day	Days
Pharmacy	Prescription drugs	Scripts
Dental	Dental services	Visits
DME/Supply	Durable Medical Equipment and medical supplies	Units
Transportation	Ambulance and non-emergent	Trips
Lab & Radiology	Lab and radiology services	Units
Other Services	Vision, Hearing and Hospice services	Units

For a complete list of covered and excluded services, please refer to the RFP. Additionally, Appendix B contains detailed coding logic used to define the categories noted above.

## EXCLUDED SERVICES

The following services are excluded from the DCHFP and Alliance programs.

- Long-term stays in nursing facilities, ICF and PRTF;
- Home health services (other than state plan PCA);
- HIV drugs with the exception of pre-exposure prophylaxis drugs (PrEP);
- Health Home services; and
- Certain behavioral health services.

The Alliance program includes additional exclusions and limitations on the following services:

- Inpatient stays and Emergency Room visits that meet the criteria for admission due to an emergency medical condition per DHCF Policy Number HCPRA-2013-02R
- Non-Emergent Medical Transportation
- Deliveries
- Vision services

Please refer to the RFP for additional information on excluded services.

# 6

## BASE DATA DEVELOPMENT

This section discusses the adjustments Mercer made to the encounter and FFS base data sources, organized by data type. These adjustments are made to reflect changes required for completeness of data. Note that the FFS and encounter data summarize data from populations in different delivery systems, and as such have inherent differences in the base data development. There are also some changes to the historical DCHFP coverage requirements. The rate development adjustments in Sections 8 through 11 include adjustments related to programmatic and pricing changes, as well as adjustments for new populations to reflect coverage under a managed care delivery system. Thus, direct comparisons of the FFS and encounter data pages in Section 7 may not be appropriate for all service categories.

These adjustments in this section are reflected in the summaries shown in Section 7.

### DATA VALIDATION

Mercer utilized MCO-submitted encounter and FFS data as the primary data sources in the rate-setting process. MCO-submitted financial data was utilized for validation and assumption setting purposes. The encounter data reflects the actual medical expense for the MCOs for the population enrolled in managed care. FFS data was used for populations and services that are being carved into managed care.

Mercer assessed the quality and completeness of the data per ASOP 23 (Data Quality) in order to deem the data sufficient to support rate-setting. This included a review of the data for changes year-over-year, errors in reporting including missing or repeating data, overall reasonableness and consistency across data sources. In Mercer's opinion, the data is reasonable and appropriate for use in rate-setting.

### ENCOUNTER DATA

Mercer evaluated the encounter data set to ensure the appropriate claims were included. A subset of encounter records was initially denied due to claim submission issues or differing payment arrangements between the MCOs and the FFS program. Mercer's encounter data team validated these encounters for covered services, which must be included in the analysis. Mercer adjusted the

status of these unique encounters to include in the final rate-setting analysis. The increase in base data for this adjustment is summarized below.

TIME PERIOD	DCHFP	ALLIANCE
FY 2017	1.9%	2.7%
FY 2018	1.7%	2.0%

Mercer cross-referenced the encounter data to the District's eligibility file to confirm Medicaid or Alliance program eligibility. Mercer excluded any encounters without a matching Medicaid or Alliance eligibility segment. Mercer also excluded encounters and associated eligibility if MCOs submitted encounters for individuals covered under FFS Medicaid. The adjustment is summarized below.

TIME PERIOD	DCHFP	ALLIANCE
FY 2017	-0.3%	-0.5%
FY 2018	-0.2%	-0.3%

Mercer understands the following items were not included in the encounter data, so no adjustment was made for:

- Disproportionate Share Hospital payments
- Copayments, Coinsurance and Deductibles

Mercer made adjustments to address the following considerations.

### Completion Factors

The encounter data in this Rate Report includes claims for dates of service from May 1, 2016 through April 30, 2018. Mercer developed completion factors to estimate incurred but not reported (IBNR) claims (those claims not yet adjudicated).

Due to dating conventions within the encounter data where the actual MCO payment date for an encounter is not available, Mercer relied on the financial lags as the data source to develop the completion factors. To determine the completion factors, Mercer estimated the incurred claims for each time period in the financial data and compared it to the total paid claims for each period through September 2018. The ratio of paid claims to incurred claims in the financial data resulted in the completion factor for the encounter data. This ratio was calculated by major COS separately for each MCO's data.

Completion factors were developed and applied by month of service. The factors below are applied to both dollars and utilization.

#### DCHFP ENCOUNTER COMPLETION FACTORS

MAJOR COS	FY 2017	FY 2018
Inpatient Hospital — Physical Health	1.0024	1.0297
Outpatient Hospital — Physical Health	1.0000	1.0119
Physician — Physical Health	1.0001	1.0098
Pharmacy	1.0000	1.0000
Mental Health	1.0003	1.0125
Other services	1.0000	1.0063
<b>Total</b>	<b>1.0008</b>	<b>1.0144</b>

#### ALLIANCE ENCOUNTER COMPLETION FACTORS

MAJOR COS	FY 2017	FY 2018
Inpatient Hospital — Physical Health	1.0032	1.0231
Outpatient Hospital — Physical Health	1.0000	1.0081
Physician — Physical Health	1.0000	1.0110
Pharmacy	1.0000	1.0000
Mental Health	1.0000	1.0080
Other services	1.0001	1.0083
<b>Total</b>	<b>1.0005</b>	<b>1.0099</b>

#### Encounter Data Underreporting Adjustment

After applying completion factors, Mercer reviewed the monthly incurred amounts captured in the encounter data to determine whether there were gaps in the encounter reporting. Mercer's analysis consisted of reviewing monthly encounter claims by major COS for consistency in addition to a monthly comparison of encounters to financial data. Mercer identified isolated gaps in reporting of a prior MCO and applied adjustments to the Inpatient, Outpatient, Pharmacy service categories to bring encounters to a more consistent level with the financial data and historical experience.

The tables below summarize the underreporting adjustment factors applied by major COS to the impacted rate cells. The Mother's Month of Delivery rate cell is assigned based on birth/maternity events identified in the encounter data. The level of membership and dollars do not appear to be impacted by underreporting based on a comparison to financial data, so no underreporting adjustment was applied to this rate cell.

#### DCHFP ENCOUNTER UNDERREPORTING FACTORS

MAJOR COS	FY 2017	FY 2018
Inpatient Hospital — Physical Health	1.0077	1.0000
Outpatient Hospital — Physical Health	1.0038	1.0000
Physician — Physical Health	1.0000	1.0000
Pharmacy	1.0000	1.0000
Mental Health	1.0000	1.0000
Other services	1.0000	1.0000
<b>Total</b>	<b>1.0030</b>	<b>1.0000</b>

#### ALLIANCE ENCOUNTER UNDERREPORTING FACTORS

MAJOR COS	FY 2017	FY 2018
Inpatient Hospital — Physical Health	1.0000	1.0000
Outpatient Hospital — Physical Health	1.0000	1.0000
Physician — Physical Health	1.0000	1.0000
Pharmacy	1.0497	1.0292
Mental Health	1.0000	1.0000
Other services	1.0000	1.0000
<b>Total</b>	<b>1.0089</b>	<b>1.0057</b>

#### Adjustments for Other Covered Expenses

Certain covered expenses were not captured in the encounter data due to reporting or data collection issues. Mercer reviewed the additional data and made adjustments to include all services covered under the contract.

#### Transportation Workbooks

A small subset of DCHFP claims were submitted in an Excel workbook due to provider difficulties with the HIPAA 837 format of the encounter records. These claims included expenses for transportation services. The supplemental files identified the recipient associated with the

encounter, so Mercer added these claims to the appropriate COS and rate cell. The Transportation Workbook adjustment is summarized below.

#### TRANSPORTATION WORKBOOK ADJUSTMENT

TIME PERIOD	SERVICE	DCHFP
FY 2017	Transportation	\$1.2 million
FY 2018	Transportation	\$0.7 million

#### Subcapitated Provider Data

Encounters for some of the subcapitated provider arrangements are submitted with an MCO paid amount equal to zero. The subcapitated encounters are captured in the professional claim type of the encounter data. In order to assign a value to these valid encounters for rate-setting purposes, Mercer shadow-priced the subcapitated encounters. For each MCO, Mercer calculated a ratio of the MCO paid amount to the Medicaid proxy amount (ACS\_Paid\_Amount) for the paid encounters by procedure code with positive MCO paid amounts. For the subcapitated encounters, this ratio is multiplied by the Medicaid proxy amount (ACS\_Paid\_Amount) to assign a value to the subcapitated encounter. Mercer identified encounter records related to the subcapitated services reported in each MCO's financial data and included only subcapitated encounters for the arrangements that aligned with financial reporting and did not have corresponding MCO paid dollars. There were no subcapitation arrangements for the Alliance program included in the encounter base. There are subcapitation arrangements for the DCHFP program and these arrangements include Physician services. The subcapitation pricing adjustment is summarized below.

#### SUBCAPITATION PRICING ADJUSTMENT

TIME PERIOD	SERVICE	DCHFP
FY 2017	Physician, Physician — BH; FQHC	\$4.5 million
FY 2018	Physician and Physician — BH	\$3.4 million

#### Pharmacy Rebates

For this Rate Report, Mercer incorporated an adjustment to account for historical pharmacy rebates collected outside the claims systems based on information captured in the financial data. Mercer developed separate assumptions for the DCHFP infant, child and adult populations, and for the Alliance program. The rebate adjustment is summarized below.

#### PHARMACY REBATE ADJUSTMENT

TIME PERIOD	SERVICE	DCHFP INFANTS	DCHFP CHILDREN	DCHFP ADULTS	ALLIANCE
FY 2017	Pharmacy	-2.6%	-5.3%	-9.0%	-3.2%
FY 2018	Pharmacy	-2.1%	-4.3%	-7.3%	-3.2%

### Net Reinsurance Costs

To the extent the MCOs have been purchasing reinsurance coverage for high-cost Inpatient claims, Mercer reviewed the historical experience from FY 2017 and FY 2018 to determine the average net reinsurance PMPM (premiums minus recoveries). Based on this review, Mercer applied reinsurance adjustment factors to the Inpatient Hospital COS. The reinsurance adjustment is summarized below.

#### NET REINSURANCE ADJUSTMENT

TIME PERIOD	SERVICE	DCHFP	ALLIANCE
FY 2017	Inpatient	0.7%	0.7%
FY 2018	Inpatient	0.2%	0.2%

### Covered Services Adjustment

#### Alliance Emergent Diagnosis Carve-out

Effective October 1, 2012, the District carved-out coverage for hospital-based services with a specified emergent diagnosis within the Alliance program. Effective April 1, 2018, the District carved out coverage for the physician component of hospital-based services with a specified emergent diagnosis. Mercer identified dollars in the encounter data meeting the criteria for emergent claims that should have been denied by the MCOs. Mercer applied downward adjustments by rate cell to the Emergency Room COS consideration for the carved out emergency services with emergent diagnoses. These services totaled approximately \$520,000 in FY 2017 and \$420,000 in FY 2018. The adjustments used to exclude these services by COS are provided in the table below.

#### ALLIANCE ER DIAGNOSIS CARVE-OUT ADJUSTMENT

SERVICE	FY 2017	FY 2018
Emergency Room	-38.5%	-23.6%

### Program Integrity Considerations

As part of the oversight of the managed care contracts, DHCF has engaged with MCOs to identify non-allowable costs, including those for overpayment or other instances of fraud, waste or abuse. DHCF collects data quarterly from MCOs, which includes information related to claims identified as overpayments and the amounts recovered. Mercer utilized data reported from the July 2016 through June 2018 period for the DCHFP and Alliance programs, as this data best aligned with the base period. The data needed to be annualized for one MCO that reported only seven quarters of experience for this two-year period; the MCO had consistent levels reported in other reported quarters so Mercer determined annualizing was appropriate.

Mercer observed a lag in the reporting of fraud, waste or abuse activity and, thus averaged two years of activity over the two years of base data. Mercer utilized the total DCHFP and Alliance



financial base as the denominator for the respective program adjustments and downward adjustments to the data to remove these claims. The following tables contain summaries of the adjustment development. The same adjustment was applied to both DCHFP and Alliance programs.

#### DCHFP AND ALLIANCE PROGRAM INTEGRITY ADJUSTMENT

MCO REPORTED DOLLARS	JULY 2016–JUNE 2018
Identified Overpayments	\$1,149,595
Recovered Overpayments	\$288,829
<b>Net Adjustment Amount</b>	<b>\$860,766</b>

TOTAL PROGRAM DOLLARS	JULY 2016–JUNE 2018
DCHFP	\$1,328,116,438
Alliance	\$126,125,419
<b>Total</b>	<b>\$1,454,241,857</b>

<b>ADJUSTMENT</b>	<b>-0.06%</b>
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Note:

1. One of the MCOs did not report for the quarter of July 2016–September 2016. This quarter was estimated using the average of the MCO's other quarterly data.
2. Total Program Dollars reflects totals reported by MCOs in financial lag October 2018, prior to any adjustments.

#### IMD

Effective January 1, 2020, the District's Behavioral Health Transformation IMD waiver was approved. This waives provision §438.6(e) of the Medicaid and CHIP Final Rule requiring "...the State may make a monthly capitation payment to an MCO or Prepaid Inpatient Health Plan (PIHP) for adults receiving inpatient treatment in an IMD, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short-term stay of no more than 15 days during the period of the monthly capitation payment." And that states "must price utilization at the cost of the same services through providers included under the State Plan." Therefore, no adjustment was made to remove stays of over 15 days, nor to reprice the IMD cost per diem. Additional consideration for the waiver implementation is discussed in Section 10.

#### Graduate Medical Education (GME)

In accordance with 42 CFR 438.60, DHCF reimburses in-District general hospitals directly for Direct Medical Expense (DME) add-on payments related to inpatient services covered under managed care. One MCO reported making the DME payments directly to certain providers. As DHCF will continue to make the DME payments directly to eligible hospitals, an adjustment was necessary to

remove the DME payments from the base data. Mercer utilized information from the MCO that made DME payments to determine the appropriate amount to remove from the base data for the affected hospital admissions. The GME adjustment is summarized below.

#### ENCOUNTER GME ADJUSTMENT

TIME PERIOD	SERVICE	DCHFP CHILDREN	DCHFP ADULTS	ALLIANCE
FY 2017	Inpatient — PH	-5.4%	-2.4%	-1.8%
	Inpatient — BH			
FY 2018	Inpatient — PH	-6.4%	-3.2%	-1.5%
	Inpatient — BH			

#### Other Encounter Data Considerations

##### Provider Settlements Outside of Encounter Data

Mercer included adjustments to the encounter data to reflect the cost of services covered under the contract, but not reflected in the encounter data submitted by the MCOs. This includes costs settled outside of the claims process for Outpatient hospital claims as summarized below.

#### PROVIDER SETTLEMENTS ADJUSTMENT

TIME PERIOD	SERVICE	DCHFP	ALLIANCE
FY 2017	Outpatient	\$500,000	\$65,000

#### Interest Payments

One MCO reported interest payments on services with late claims payments in the encounter data. Mercer utilized information from the MCO to determine the appropriate amount to remove from the base data. The interest payment adjustment is summarized below.

#### INTEREST PAYMENTS ADJUSTMENT

TIME PERIOD	SERVICE	DCHFP	ALLIANCE
FY 2017	All	-\$30,000	-\$5,000
FY 2018	All	-\$46,000	-\$3,000

#### Incorrect Fee Schedule Load

During FY 2018, DHCF inadvertently published an incorrect physician fee schedule on its website. As the MCOs have certain contracts indexed to the DHCF fee schedule, the incorrect fee schedule was utilized by the MCOs for a period of time which resulted in overpayments to providers which are not representative of future claims pricing. To evaluate the impact of the incorrect fee schedule reflected in the encounter data, Mercer solicited information from the MCOs. Mercer utilized this

information to determine the appropriate amount to remove from the base data. Based on this review, Mercer removed approximately \$520,000 in FY 2018.

#### INCORRECT FEE SCHEDULE ADJUSTMENT

TIME PERIOD	SERVICE	DCHFP	ALLIANCE
FY 2018	Physician	-\$520,000	-\$40,000

#### Overpayments for Vaccines

Children's National Medical Center reported receiving overpayments for vaccinations, for cases where the hospital received payment from the MCOs for both the vaccine and administration of the vaccine but should only have billed the MCOs for administration of the vaccine. Children's National Medical Center provided information to DHCF related to the amount of overpayments which Mercer used to determine the appropriate amount to remove from the base data. Based on this information, Mercer made the downward adjustments summarized below.

#### VACCINE OVERPAYMENT ADJUSTMENT

TIME PERIOD	SERVICE	DCHFP
FY 2017	Physician	-\$301,000
FY 2018	Physician	-\$587,000

#### FFS DATA

Mercer evaluated the FFS data set to ensure the appropriate claims were included. This included summarizing the data for the covered populations and covered services as noted in Section 4 and Section 5. Again, the FFS data represents the historical utilization and cost of services for populations who were not enrolled with the MCOs.

Mercer understands the following items were not included in the FFS data, so no adjustment was made for:

- Disproportionate Share Hospital payments
- Copayments, Coinsurance and Deductibles

#### Completion Factors

Mercer reviewed the remaining liability associated with IBNR claims in the FFS data. Mercer performed a claim lag analysis and developed completion factors for each month of service and high-level service grouping using the claims development method. The monthly IBNR was summarized for each service for application to the FFS data. The overall adjustments for CY 2017

and CY 2018 (using paid claims data through mid-August 2019) are reflected by service grouping in the table below. The factors are applied to both dollars and utilization.

#### FFS COMPLETION FACTORS

MAJOR COS	CY 2017	CY 2018
Inpatient Hospital — Physical Health	1.0000	1.0057
Outpatient Hospital — Physical Health	1.0007	1.0053
Physician — Physical Health	1.0000	1.0072
Home Health	1.0000	1.0020
Nursing Facility	1.0012	1.0181
Pharmacy	1.0000	1.0000
Dental	1.0000	1.0020
Other services	1.0003	1.0046
<b>Total</b>	<b>1.0001</b>	<b>1.0047</b>

#### Retroactive Medicaid eligibility periods

The retroactive eligibility period reflects a period of Medicaid coverage that provides retrospective coverage of claims prior to the Medicaid eligibility date. In these instances, the MCOs are not responsible for coverage per the RFP. In order to ensure the data summarization reflects only cost and utilization that will be the responsibility of the MCOs, an adjustment was applied to remove the cost, utilization and member months (MMs) associated with the retroactive eligibility period.

Mercer has developed a proxy for this adjustment based on a review of claims and eligibility in the FFS data. Mercer is working with DHCF to gather more information to specifically identify these retroactive segments in the FFS data. This analysis will likely require an update for the final rates. The initial adjustment applied to the FFS data is summarized below. As the PMPM costs in the retroactive period exceed the prospective coverage period, this results in a slight decrease to the FFS data.

#### RETROACTIVE MEDICAID ELIGIBILITY ADJUSTMENT

MAJOR COS	CY 2017				CY 2018			
	OPT-OUTS		SSI ADULTS		OPT-OUTS		SSI ADULTS	
	DOLLAR IMPACT	PMPM IMPACT	DOLLAR IMPACT	PMPM IMPACT	DOLLAR IMPACT	PMPM IMPACT	DOLLAR IMPACT	PMPM IMPACT
Inpatient Hospital	-13.8%	-9.1%	-1.5%	-0.8%	-13.9%	-9.1%	-1.7%	-1.1%

MAJOR COS	CY 2017				CY 2018			
	OPT-OUTS		SSI ADULTS		OPT-OUTS		SSI ADULTS	
	DOLLAR IMPACT	PMPM IMPACT	DOLLAR IMPACT	PMPM IMPACT	DOLLAR IMPACT	PMPM IMPACT	DOLLAR IMPACT	PMPM IMPACT
Inpatient Hospital — BH	-12.7%	-8.0%	-2.5%	-1.8%	-7.7%	-2.6%	-0.7%	-0.1%
Outpatient Hospital	-1.8%	3.5%	-0.4%	0.4%	-1.4%	4.1%	-0.2%	0.4%
Outpatient Hospital — BH	-0.3%	5.0%	-0.4%	0.3%	-2.6%	2.7%	-0.1%	0.6%
Emergency Room	-6.7%	-1.7%	-0.8%	-0.1%	-3.8%	1.5%	-0.8%	-0.2%
Physician	-7.7%	-2.7%	-0.7%	0.0%	-4.5%	0.8%	-0.6%	0.1%
Physician — BH	-3.3%	1.9%	-0.2%	0.6%	-1.0%	4.4%	0.0%	0.7%
FQHC	-3.3%	1.9%	-0.9%	-0.2%	-2.6%	2.8%	-0.8%	-0.1%
Home Health	-0.3%	5.1%	0.0%	0.7%	-0.8%	4.7%	0.0%	0.6%
Nursing Facility	-3.4%	1.9%	-1.1%	-0.4%	-8.2%	-3.2%	-1.1%	-0.4%
Pharmacy	-1.0%	4.3%	-0.1%	0.6%	-0.8%	4.7%	-0.1%	0.6%
Dental	-4.3%	0.8%	-0.9%	-0.2%	-4.0%	1.3%	-0.5%	0.1%
DME/Supply	-0.7%	4.6%	0.0%	0.7%	-0.5%	5.0%	-0.1%	0.6%
Transportation	-5.9%	-0.8%	-0.5%	0.2%	-3.6%	1.7%	-0.5%	0.2%
Lab & Radiology	-3.3%	1.9%	-0.6%	0.1%	-2.7%	2.7%	-0.4%	0.2%
Other Services	-1.5%	3.8%	-0.3%	0.4%	-3.2%	2.2%	-0.9%	-0.2%
<b>Total</b>	<b>-7.2%</b>	<b>-2.1%</b>	<b>-0.8%</b>	<b>-0.1%</b>	<b>-7.2%</b>	<b>-2.1%</b>	<b>-0.8%</b>	<b>-0.1%</b>

### GME Removal

In accordance with 42 CFR 438.60, DHCF will reimburse in-District general hospitals directly for DME add-on payments related to inpatient services covered under managed care. The FFS claims data reflect the DME payments, so an adjustment was necessary to remove the DME payments from the base data. Mercer utilized the District's APR-DRG fee schedules to determine the

appropriate amount to remove from the base data for the applicable hospital admissions. Mercer applied the following adjustments.

#### FFS GME ADJUSTMENT

TIME PERIOD	SERVICE	OPT-OUTS	SSI ADULTS
CY 2017	Inpatient Hospital	-5.7%	-5.4%
CY 2017	Inpatient Hospital — BH	-7.5%	-7.4%
CY 2018	Inpatient Hospital	-5.3%	-5.4%
CY 2018	Inpatient Hospital — BH	-7.5%	-6.9%

#### BASE DATA BLENDING

As part of the rate development process, Mercer reviewed data from multiple years of the program to arrive at the overall data source for rate setting. The goal of the blending process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially sound capitation rates. Mercer has applied credibility weighting, as appropriate, to blend data from the two FYs and CYs for encounters and FFS data, respectively, focusing on the most recent year of data.

Mercer trended the FY 2017 and CY 2017 data to FY 2018 and CY 2018 using historical trends to bring the cost to a FY 2018 and CY 2018 time period. Mercer weighted the more recent year of data approximately 80% and the earlier year of data 20% to smooth out fluctuation in costs from year to year. This enhanced the credibility of the data set and increased the stability of the rates.

# 7

## BASE DATA EXHIBITS

Mercer summarized the base data experience in the following exhibits. These summaries reflect the base data adjustments outlined in Section 6.

The top of each exhibit includes the following identifying information:

- **Time Period:** FY 2017–2018 for encounters and CY 2017–2018 for FFS data
- **Data Source:** Encounters or FFS
- **Program:** DCHFP or Alliance
- **Population:** DCHFP and Alliance rate cells including separate summary for the former Opt-out population FFS experience.

Below the population criteria is information on the following metrics associated with the population selections:

- **MMs/Deliveries:** MMs reflect a count of monthly eligibles for the historical time period; Deliveries represents the count of qualifying birth/maternity events related to the birth/maternity kick payments.
- **Category of Service:** As described in Section 5, each of the covered services is listed.
- **Incurred Claims:** Amount paid for each service line item based on the paid amount field included in both the FFS data and encounter data; these amounts are based on date of service and reflect the applicable data adjustments outlined in Section 6.
- **Utilization:** Utilization for each service line item. This represents the number of visits, days, services or scripts for each category as reported in the data after application of adjustments outlined in Section 6; see the unit of service table in Section 5 for the unit types used to define utilization for the various service categories.
- **Utilization per 1,000:** Annual utilization for each service divided by total MMs/deliveries multiplied by 12,000.
- **Unit Cost:** Average cost of each service line item; incurred claims divided by the utilization of services delivered.

- **PMPM/Payment:** PMPM is the incurred claims divided by total MMs; the Maternity kick payments reflect the incurred claims divided by the Deliveries.



<b>Time Period/Data Selections:</b>	
Time Period:	FY17
Data Source:	Encounters

<b>Population Selections:</b>	
Program:	DCHFP
Population:	Male and Female < 1

<b>Member Months/Deliveries:</b>	<b>57,751</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 9,272,437	2,299	478	\$ 4,032.97	\$ 160.56
Inpatient Hospital - BH	\$ 14,274	11	2	\$ 1,297.58	\$ 0.25
Outpatient Hospital	\$ 1,715,739	4,421	919	\$ 388.05	\$ 29.71
Outpatient Hospital - BH	\$ 2,813	11	2	\$ 255.65	\$ 0.05
Emergency Room	\$ 4,012,399	6,548	1,361	\$ 612.73	\$ 69.48
Physician	\$ 4,122,431	29,461	6,122	\$ 139.93	\$ 71.38
Physician - BH	\$ 143,197	749	156	\$ 191.14	\$ 2.48
FQHC	\$ 702,688	6,365	1,322	\$ 110.41	\$ 12.17
Home Health	\$ 25,267	81	17	\$ 311.93	\$ 0.44
Nursing Facility	\$ -	-	-	\$ -	\$ -
Pharmacy	\$ 446,085	13,448	2,794	\$ 33.17	\$ 7.72
Dental	\$ 19,442	238	49	\$ 81.69	\$ 0.34
DME/Supply	\$ 126,285	526	109	\$ 240.08	\$ 2.19
Transportation	\$ 182,975	2,555	531	\$ 71.61	\$ 3.17
Lab & Radiology	\$ 469,724	4,627	961	\$ 101.52	\$ 8.13
Other	\$ 264	4	1	\$ 66.11	\$ 0.00
<b>Total</b>	<b>\$ 21,256,020</b>	<b>71,345</b>			<b>\$ 368.06</b>

<b>Time Period/Data Selections:</b>	
Time Period:	FY18
Data Source:	Encounters

<b>Population Selections:</b>	
Program:	DCHFP
Population:	Male and Female < 1

<b>Member Months/Deliveries:</b>	<b>59,002</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 11,483,523	3,008	612	\$ 3,818.23	\$ 194.63
Inpatient Hospital - BH	\$ 37,831	57	12	\$ 663.72	\$ 0.64
Outpatient Hospital	\$ 1,887,037	5,545	1,128	\$ 340.34	\$ 31.98
Outpatient Hospital - BH	\$ 5,682	20	4	\$ 282.75	\$ 0.10
Emergency Room	\$ 4,196,900	6,623	1,347	\$ 633.73	\$ 71.13
Physician	\$ 3,983,883	24,836	5,051	\$ 160.41	\$ 67.52
Physician - BH	\$ 129,461	411	84	\$ 315.33	\$ 2.19
FQHC	\$ 1,295,704	12,383	2,518	\$ 104.64	\$ 21.96
Home Health	\$ 14,866	58	12	\$ 254.49	\$ 0.25
Nursing Facility	\$ -	-	-	\$ -	\$ -
Pharmacy	\$ 566,881	14,060	2,859	\$ 40.32	\$ 9.61
Dental	\$ 18,889	231	47	\$ 81.64	\$ 0.32
DME/Supply	\$ 144,479	681	138	\$ 212.26	\$ 2.45
Transportation	\$ 210,867	2,326	473	\$ 90.67	\$ 3.57
Lab & Radiology	\$ 596,188	5,222	1,062	\$ 114.16	\$ 10.10
Other	\$ 7,379	27	6	\$ 271.97	\$ 0.13
<b>Total</b>	<b>\$ 24,579,570</b>	<b>75,486</b>			<b>\$ 416.59</b>

Total may not equal sum of individual category of services due to rounding

<b>Time Period/Data Selections:</b>	
Time Period:	FY17
Data Source:	Encounters

<b>Population Selections:</b>	
Program:	DCHFP
Population:	Children 1-18

<b>Member Months/Deliveries:</b>	<b>762,714</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 17,698,661	4,662	73	\$ 3,796.10	\$ 23.20
Inpatient Hospital - BH	\$ 3,893,569	3,755	59	\$ 1,037.03	\$ 5.10
Outpatient Hospital	\$ 14,202,698	23,256	366	\$ 610.71	\$ 18.62
Outpatient Hospital - BH	\$ 332,997	1,506	24	\$ 221.05	\$ 0.44
Emergency Room	\$ 28,680,797	41,350	651	\$ 693.61	\$ 37.60
Physician	\$ 16,016,486	128,113	2,016	\$ 125.02	\$ 21.00
Physician - BH	\$ 6,142,709	38,889	612	\$ 157.95	\$ 8.05
FQHC	\$ 4,051,500	44,003	692	\$ 92.07	\$ 5.31
Home Health	\$ 317,982	1,994	31	\$ 159.47	\$ 0.42
Nursing Facility	\$ 14,029	36	1	\$ 384.43	\$ 0.02
Pharmacy	\$ 10,439,824	200,996	3,162	\$ 51.94	\$ 13.69
Dental	\$ 17,380,970	93,472	1,471	\$ 185.95	\$ 22.79
DME/Supply	\$ 537,240	4,284	67	\$ 125.41	\$ 0.70
Transportation	\$ 1,373,340	19,035	299	\$ 72.15	\$ 1.80
Lab & Radiology	\$ 6,114,104	50,089	788	\$ 122.06	\$ 8.02
Other	\$ 465,841	10,285	162	\$ 45.29	\$ 0.61
<b>Total</b>	<b>\$ 127,662,748</b>	<b>665,727</b>			<b>\$ 167.38</b>

<b>Time Period/Data Selections:</b>	
Time Period:	FY18
Data Source:	Encounters

<b>Population Selections:</b>	
Program:	DCHFP
Population:	Children 1-18

<b>Member Months/Deliveries:</b>	<b>839,124</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 23,097,561	5,478	78	\$ 4,216.18	\$ 27.53
Inpatient Hospital - BH	\$ 3,789,639	3,280	47	\$ 1,155.20	\$ 4.52
Outpatient Hospital	\$ 15,062,802	26,820	384	\$ 561.64	\$ 17.95
Outpatient Hospital - BH	\$ 545,496	2,232	32	\$ 244.40	\$ 0.65
Emergency Room	\$ 30,539,945	43,197	618	\$ 706.99	\$ 36.40
Physician	\$ 14,639,902	109,523	1,566	\$ 133.67	\$ 17.45
Physician - BH	\$ 6,998,297	44,624	638	\$ 156.83	\$ 8.34
FQHC	\$ 8,141,831	90,194	1,290	\$ 90.27	\$ 9.70
Home Health	\$ 187,836	789	11	\$ 238.11	\$ 0.22
Nursing Facility	\$ -	-	-	\$ -	\$ -
Pharmacy	\$ 11,048,574	211,065	3,018	\$ 52.35	\$ 13.17
Dental	\$ 17,803,318	94,636	1,353	\$ 188.12	\$ 21.22
DME/Supply	\$ 621,235	4,610	66	\$ 134.77	\$ 0.74
Transportation	\$ 1,351,035	18,050	258	\$ 74.85	\$ 1.61
Lab & Radiology	\$ 7,714,080	50,772	726	\$ 151.94	\$ 9.19
Other	\$ 430,382	8,683	124	\$ 49.57	\$ 0.51
<b>Total</b>	<b>\$ 141,971,932</b>	<b>713,953</b>			<b>\$ 169.19</b>

Total may not equal sum of individual category of services due to rounding

Time Period/Data Selections:	
Time Period:	FY17
Data Source:	Encounters

Population Selections:	
Program:	DCHFP
Population:	TANF Adult 19+

Member Months/Deliveries:	1,315,139
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 127,068,006	43,693	399	\$ 2,908.20	\$ 96.62
Inpatient Hospital - BH	\$ 14,104,066	14,829	135	\$ 951.13	\$ 10.72
Outpatient Hospital	\$ 31,855,869	48,870	446	\$ 651.85	\$ 24.22
Outpatient Hospital - BH	\$ 1,032,146	1,986	18	\$ 519.69	\$ 0.78
Emergency Room	\$ 46,931,513	88,601	808	\$ 529.70	\$ 35.69
Physician	\$ 56,172,535	373,193	3,405	\$ 150.52	\$ 42.71
Physician - BH	\$ 7,459,067	65,670	599	\$ 113.58	\$ 5.67
FQHC	\$ 8,100,617	90,782	828	\$ 89.23	\$ 6.16
Home Health	\$ 1,200,634	4,982	45	\$ 240.99	\$ 0.91
Nursing Facility	\$ 4,972,003	8,490	77	\$ 585.64	\$ 3.78
Pharmacy	\$ 73,154,796	1,273,754	11,622	\$ 57.43	\$ 55.63
Dental	\$ 26,304,680	99,293	906	\$ 264.92	\$ 20.00
DME/Supply	\$ 2,691,718	14,491	132	\$ 185.75	\$ 2.05
Transportation	\$ 8,381,305	153,980	1,405	\$ 54.43	\$ 6.37
Lab & Radiology	\$ 38,253,188	287,572	2,624	\$ 133.02	\$ 29.09
Other	\$ 1,503,570	20,408	186	\$ 73.67	\$ 1.14
<b>Total</b>	<b>\$ 449,185,714</b>	<b>2,590,593</b>			<b>\$ 341.55</b>

Time Period/Data Selections:	
Time Period:	FY18
Data Source:	Encounters

Population Selections:	
Program:	DCHFP
Population:	TANF Adult 19+

Member Months/Deliveries:	1,395,430
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 111,587,463	38,649	332	\$ 2,887.20	\$ 79.97
Inpatient Hospital - BH	\$ 15,334,150	15,479	133	\$ 990.64	\$ 10.99
Outpatient Hospital	\$ 36,410,374	42,656	367	\$ 853.59	\$ 26.09
Outpatient Hospital - BH	\$ 750,956	1,237	11	\$ 607.09	\$ 0.54
Emergency Room	\$ 53,421,410	91,581	788	\$ 583.33	\$ 38.28
Physician	\$ 52,866,617	321,249	2,763	\$ 164.57	\$ 37.89
Physician - BH	\$ 8,538,820	66,065	568	\$ 129.25	\$ 6.12
FQHC	\$ 15,818,313	177,195	1,524	\$ 89.27	\$ 11.34
Home Health	\$ 874,192	3,231	28	\$ 270.61	\$ 0.63
Nursing Facility	\$ 4,556,777	10,098	87	\$ 451.27	\$ 3.27
Pharmacy	\$ 69,886,310	1,256,782	10,808	\$ 55.61	\$ 50.08
Dental	\$ 26,595,792	95,471	821	\$ 278.58	\$ 19.06
DME/Supply	\$ 3,072,970	16,607	143	\$ 185.04	\$ 2.20
Transportation	\$ 7,189,105	130,375	1,121	\$ 55.14	\$ 5.15
Lab & Radiology	\$ 38,849,638	290,374	2,497	\$ 133.79	\$ 27.84
Other	\$ 1,272,851	17,050	147	\$ 74.66	\$ 0.91
<b>Total</b>	<b>\$ 447,025,738</b>	<b>2,574,097</b>			<b>\$ 320.35</b>

Total may not equal sum of individual category of services due to rounding

<b>Time Period/Data Selections:</b>	
Time Period:	CY17
Data Source:	FFS

<b>Population Selections:</b>	
Program:	DCHFP
Population:	Opt Out Adults 19+

<b>Member Months/Deliveries:</b>	<b>43,340</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 8,012,994	3,304	915	\$ 2,425.24	\$ 184.89
Inpatient Hospital - BH	\$ 1,561,079	1,077	298	\$ 1,449.47	\$ 36.02
Outpatient Hospital	\$ 1,179,944	2,424	671	\$ 486.85	\$ 27.23
Outpatient Hospital - BH	\$ 55,210	101	28	\$ 546.27	\$ 1.27
Emergency Room	\$ 1,758,028	3,733	1,033	\$ 471.00	\$ 40.56
Physician	\$ 1,743,547	13,022	3,606	\$ 133.89	\$ 40.23
Physician - BH	\$ 35,668	194	54	\$ 183.86	\$ 0.82
FQHC	\$ 2,424,852	10,205	2,826	\$ 237.61	\$ 55.95
Home Health	\$ 446,214	507	140	\$ 880.11	\$ 10.30
Nursing Facility	\$ 536,951	1,212	335	\$ 443.21	\$ 12.39
Pharmacy	\$ 6,563,399	41,347	11,448	\$ 158.74	\$ 151.44
Dental	\$ 993,489	2,078	575	\$ 478.10	\$ 22.92
DME/Supply	\$ 131,539	661	183	\$ 198.95	\$ 3.04
Transportation	\$ 265,658	7,550	2,090	\$ 35.19	\$ 6.13
Lab & Radiology	\$ 1,685,791	12,464	3,451	\$ 135.25	\$ 38.90
Other	\$ 226,948	405	112	\$ 560.21	\$ 5.24
<b>Total</b>	<b>\$ 27,621,310</b>	<b>100,283</b>			<b>\$ 637.32</b>

<b>Time Period/Data Selections:</b>	
Time Period:	CY18
Data Source:	FFS

<b>Population Selections:</b>	
Program:	DCHFP
Population:	Opt Out Adults 19+

<b>Member Months/Deliveries:</b>	<b>53,968</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 11,076,376	4,491	998	\$ 2,466.62	\$ 205.24
Inpatient Hospital - BH	\$ 1,768,151	1,172	261	\$ 1,509.11	\$ 32.76
Outpatient Hospital	\$ 1,609,556	3,115	693	\$ 516.64	\$ 29.82
Outpatient Hospital - BH	\$ 107,180	193	43	\$ 555.29	\$ 1.99
Emergency Room	\$ 2,274,163	4,745	1,055	\$ 479.28	\$ 42.14
Physician	\$ 2,635,781	16,882	3,754	\$ 156.13	\$ 48.84
Physician - BH	\$ 60,261	163	36	\$ 369.33	\$ 1.12
FQHC	\$ 2,681,861	8,751	1,946	\$ 306.45	\$ 49.69
Home Health	\$ 462,516	678	151	\$ 681.82	\$ 8.57
Nursing Facility	\$ 1,687,078	2,331	518	\$ 723.61	\$ 31.26
Pharmacy	\$ 5,074,830	42,427	9,434	\$ 119.61	\$ 94.03
Dental	\$ 1,107,923	2,332	518	\$ 475.17	\$ 20.53
DME/Supply	\$ 111,332	680	151	\$ 163.70	\$ 2.06
Transportation	\$ 442,174	7,678	1,707	\$ 57.59	\$ 8.19
Lab & Radiology	\$ 2,013,007	15,306	3,403	\$ 131.52	\$ 37.30
Other	\$ 226,479	510	113	\$ 443.79	\$ 4.20
<b>Total</b>	<b>\$ 33,338,668</b>	<b>111,455</b>			<b>\$ 617.75</b>

Total may not equal sum of individual category of services due to rounding.

<b>Time Period/Data Selections:</b>	
Time Period:	CY17
Data Source:	FFS

<b>Population Selections:</b>	
Program:	DCHFP
Population:	SSI Adults 21+

<b>Member Months/Deliveries:</b>	<b>202,907</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 96,446,915	42,040	2,486	\$ 2,294.17	\$ 475.33
Inpatient Hospital - BH	\$ 14,196,809	11,667	690	\$ 1,216.83	\$ 69.97
Outpatient Hospital	\$ 16,961,112	37,609	2,224	\$ 450.98	\$ 83.59
Outpatient Hospital - BH	\$ 982,779	3,051	180	\$ 322.11	\$ 4.84
Emergency Room	\$ 13,899,080	26,626	1,575	\$ 522.01	\$ 68.50
Physician	\$ 26,704,271	182,397	10,787	\$ 146.41	\$ 131.61
Physician - BH	\$ 4,260,259	9,907	586	\$ 430.03	\$ 21.00
FQHC	\$ 7,432,995	37,963	2,245	\$ 195.80	\$ 36.63
Home Health	\$ 34,614,578	45,807	2,709	\$ 755.66	\$ 170.59
Nursing Facility	\$ 9,385,452	17,012	1,006	\$ 551.69	\$ 46.25
Pharmacy	\$ 61,267,191	549,362	32,489	\$ 111.52	\$ 301.95
Dental	\$ 7,303,192	15,402	911	\$ 474.17	\$ 35.99
DME/Supply	\$ 4,707,243	18,319	1,083	\$ 256.96	\$ 23.20
Transportation	\$ 4,509,901	250,911	14,839	\$ 17.97	\$ 22.23
Lab & Radiology	\$ 9,838,908	101,296	5,991	\$ 97.13	\$ 48.49
Other	\$ 1,869,919	4,068	241	\$ 459.65	\$ 9.22
<b>Total</b>	<b>\$ 314,380,603</b>	<b>1,353,438</b>			<b>\$ 1,549.38</b>

<b>Time Period/Data Selections:</b>	
Time Period:	CY18
Data Source:	FFS

<b>Population Selections:</b>	
Program:	DCHFP
Population:	SSI Adults 21+

<b>Member Months/Deliveries:</b>	<b>187,788</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 87,473,813	39,629	2,532	\$ 2,207.31	\$ 465.81
Inpatient Hospital - BH	\$ 12,294,388	9,676	618	\$ 1,270.61	\$ 65.47
Outpatient Hospital	\$ 16,288,838	33,049	2,112	\$ 492.87	\$ 86.74
Outpatient Hospital - BH	\$ 975,119	2,642	169	\$ 369.10	\$ 5.19
Emergency Room	\$ 13,553,686	25,304	1,617	\$ 535.63	\$ 72.18
Physician	\$ 26,516,162	166,332	10,629	\$ 159.42	\$ 141.20
Physician - BH	\$ 3,551,281	6,074	388	\$ 584.64	\$ 18.91
FQHC	\$ 7,364,781	28,445	1,818	\$ 258.92	\$ 39.22
Home Health	\$ 34,587,284	45,674	2,919	\$ 757.26	\$ 184.18
Nursing Facility	\$ 9,271,491	15,892	1,016	\$ 583.42	\$ 49.37
Pharmacy	\$ 55,617,873	512,323	32,738	\$ 108.56	\$ 296.17
Dental	\$ 6,056,036	13,431	858	\$ 450.91	\$ 32.25
DME/Supply	\$ 4,904,618	16,142	1,031	\$ 303.85	\$ 26.12
Transportation	\$ 4,242,921	212,264	13,564	\$ 19.99	\$ 22.59
Lab & Radiology	\$ 9,593,094	99,486	6,357	\$ 96.43	\$ 51.08
Other	\$ 1,697,459	4,583	293	\$ 370.39	\$ 9.04
<b>Total</b>	<b>\$ 293,988,845</b>	<b>1,230,945</b>			<b>\$ 1,565.54</b>

Total may not equal sum of individual category of services due to rounding.

<b>Time Period/Data Selections:</b>	
Time Period:	FY17
Data Source:	Encounters

<b>Population Selections:</b>	
Program:	DCHFP
Population:	Infant's Month of Birth

<b>Member Months/Deliveries:</b>	<b>3,304</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 18,548,953	11,865	43,093	\$ 1,563.33	\$ 5,614.09
Inpatient Hospital - BH	\$ -	-	-	\$ -	\$ -
Outpatient Hospital	\$ 142,909	403	1,463	\$ 354.71	\$ 43.25
Outpatient Hospital - BH	\$ -	-	-	\$ -	\$ -
Emergency Room	\$ 115,857	180	653	\$ 644.46	\$ 35.07
Physician	\$ 1,426,556	7,056	25,628	\$ 202.17	\$ 431.77
Physician - BH	\$ 1,797	19	69	\$ 94.59	\$ 0.54
FQHC	\$ 56,350	608	2,208	\$ 92.68	\$ 17.06
Home Health	\$ 5,370	40	145	\$ 134.25	\$ 1.63
Nursing Facility	\$ -	-	-	\$ -	\$ -
Pharmacy	\$ 67	10	36	\$ 6.68	\$ 0.02
Dental	\$ -	-	-	\$ -	\$ -
DME/Supply	\$ 1,007	5	18	\$ 201.38	\$ 0.30
Transportation	\$ 4,425	27	98	\$ 163.88	\$ 1.34
Lab & Radiology	\$ 44,912	471	1,711	\$ 95.35	\$ 13.59
Other	\$ 2,832	35	127	\$ 80.90	\$ 0.86
<b>Total</b>	<b>\$ 20,351,034</b>	<b>20,719</b>			<b>\$ 6,159.51</b>

<b>Time Period/Data Selections:</b>	
Time Period:	FY18
Data Source:	Encounters

<b>Population Selections:</b>	
Program:	DCHFP
Population:	Infant's Month of Birth

<b>Member Months/Deliveries:</b>	<b>3,225</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 17,895,049	13,212	49,161	\$ 1,354.46	\$ 5,548.85
Inpatient Hospital - BH	\$ -	-	-	\$ -	\$ -
Outpatient Hospital	\$ 159,043	429	1,598	\$ 370.36	\$ 49.32
Outpatient Hospital - BH	\$ 68	1	4	\$ 65.76	\$ 0.02
Emergency Room	\$ 118,259	157	582	\$ 755.62	\$ 36.67
Physician	\$ 1,588,604	7,506	27,928	\$ 211.66	\$ 492.59
Physician - BH	\$ 116	1	4	\$ 115.36	\$ 0.04
FQHC	\$ 87,609	924	3,438	\$ 94.82	\$ 27.17
Home Health	\$ 84	1	4	\$ 83.95	\$ 0.03
Nursing Facility	\$ -	-	-	\$ -	\$ -
Pharmacy	\$ 277	30	112	\$ 9.22	\$ 0.09
Dental	\$ -	-	-	\$ -	\$ -
DME/Supply	\$ 289	2	7	\$ 143.73	\$ 0.09
Transportation	\$ 4,571	15	56	\$ 304.51	\$ 1.42
Lab & Radiology	\$ 46,822	670	2,495	\$ 69.83	\$ 14.52
Other	\$ 341	2	7	\$ 169.90	\$ 0.11
<b>Total</b>	<b>\$ 19,901,131</b>	<b>22,950</b>			<b>\$ 6,170.89</b>

Total may not equal sum of individual category of services due to rounding

Time Period/Data Selections:	
Time Period:	FY17
Data Source:	Encounters

Population Selections:	
Program:	DCHFP
Population:	Mother's Month of Delivery

Member Months/Deliveries:	3,399
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 23,159,769	13,206	46,625	\$ 1,753.68	\$ 6,813.70
Inpatient Hospital - BH	\$ 61,104	43	152	\$ 1,420.99	\$ 17.98
Outpatient Hospital	\$ 736,998	1,624	5,734	\$ 453.80	\$ 216.83
Outpatient Hospital - BH	\$ 25	1	4	\$ 24.51	\$ 0.01
Emergency Room	\$ 195,424	265	936	\$ 737.41	\$ 57.49
Physician	\$ 5,047,936	14,154	49,969	\$ 356.65	\$ 1,485.12
Physician - BH	\$ 29,793	202	713	\$ 147.45	\$ 8.77
FQHC	\$ 142,871	1,124	3,968	\$ 127.10	\$ 42.03
Home Health	\$ 17,370	79	279	\$ 219.88	\$ 5.11
Nursing Facility	\$ -	-	-	\$ -	\$ -
Pharmacy	\$ 187,992	8,059	28,452	\$ 23.33	\$ 55.31
Dental	\$ 20,899	88	311	\$ 237.49	\$ 6.15
DME/Supply	\$ 163,083	975	3,442	\$ 167.26	\$ 47.98
Transportation	\$ 250,079	1,933	6,823	\$ 129.40	\$ 73.57
Lab & Radiology	\$ 858,372	6,193	21,864	\$ 138.60	\$ 252.54
Other	\$ 2,332	38	134	\$ 61.38	\$ 0.69
<b>Total</b>	<b>\$ 30,874,048</b>	<b>47,984</b>			<b>\$ 9,083.27</b>

Time Period/Data Selections:	
Time Period:	FY18
Data Source:	Encounters

Population Selections:	
Program:	DCHFP
Population:	Mother's Month of Delivery

Member Months/Deliveries:	3,311
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 26,948,893	12,237	44,350	\$ 2,202.26	\$ 8,139.20
Inpatient Hospital - BH	\$ 12,751	13	48	\$ 969.11	\$ 3.85
Outpatient Hospital	\$ 617,364	1,396	5,058	\$ 442.34	\$ 186.46
Outpatient Hospital - BH	\$ 195	1	4	\$ 189.38	\$ 0.06
Emergency Room	\$ 271,235	311	1,128	\$ 871.51	\$ 81.92
Physician	\$ 5,074,115	14,228	51,565	\$ 356.64	\$ 1,532.50
Physician - BH	\$ 18,868	130	473	\$ 144.70	\$ 5.70
FQHC	\$ 164,740	2,026	7,342	\$ 81.32	\$ 49.76
Home Health	\$ 18,596	40	146	\$ 462.10	\$ 5.62
Nursing Facility	\$ 9,926	34	124	\$ 289.48	\$ 3.00
Pharmacy	\$ 163,050	7,698	27,900	\$ 21.18	\$ 49.24
Dental	\$ 25,861	111	402	\$ 233.41	\$ 7.81
DME/Supply	\$ 190,923	1,103	3,997	\$ 173.10	\$ 57.66
Transportation	\$ 246,769	1,907	6,912	\$ 129.39	\$ 74.53
Lab & Radiology	\$ 924,127	6,264	22,701	\$ 147.54	\$ 279.11
Other	\$ 1,362	24	87	\$ 56.50	\$ 0.41
<b>Total</b>	<b>\$ 34,688,776</b>	<b>47,523</b>			<b>\$ 10,476.83</b>

Total may not equal sum of individual category of services due to rounding

Time Period/Data Selections:	
Time Period:	FY17
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	19-36 Female

Member Months/Deliveries:	51,387
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 587,746	323	75	\$ 1,820.36	\$ 11.44
Inpatient Hospital - BH	\$ -	-	-	\$ -	\$ -
Outpatient Hospital	\$ 804,725	1,602	374	\$ 502.31	\$ 15.66
Outpatient Hospital - BH	\$ 843	3	1	\$ 280.85	\$ 0.02
Emergency Room	\$ 178,375	198	46	\$ 899.60	\$ 3.47
Physician	\$ 1,738,396	12,002	2,803	\$ 144.84	\$ 33.83
Physician - BH	\$ 101,491	862	201	\$ 117.74	\$ 1.98
FQHC	\$ 1,548,290	13,309	3,108	\$ 116.33	\$ 30.13
Home Health	\$ 31,554	56	13	\$ 563.40	\$ 0.61
Nursing Facility	\$ 1,199	4	1	\$ 295.95	\$ 0.02
Pharmacy	\$ 830,370	17,589	4,107	\$ 47.21	\$ 16.16
Dental	\$ 719,374	5,501	1,285	\$ 130.76	\$ 14.00
DME/Supply	\$ 58,045	262	61	\$ 221.53	\$ 1.13
Transportation	\$ 48,078	1,786	417	\$ 26.92	\$ 0.94
Lab & Radiology	\$ 1,966,591	17,134	4,001	\$ 114.78	\$ 38.27
Other	\$ 1,668	22	5	\$ 75.80	\$ 0.03
<b>Total</b>	<b>\$ 8,616,745</b>	<b>70,654</b>			<b>\$ 167.68</b>

Time Period/Data Selections:	
Time Period:	FY18
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	19-36 Female

Member Months/Deliveries:	51,767
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 1,194,087	327	76	\$ 3,655.16	\$ 23.07
Inpatient Hospital - BH	\$ -	-	-	\$ -	\$ -
Outpatient Hospital	\$ 958,746	1,395	323	\$ 687.32	\$ 18.52
Outpatient Hospital - BH	\$ -	-	-	\$ -	\$ -
Emergency Room	\$ 287,972	310	72	\$ 927.89	\$ 5.56
Physician	\$ 1,493,239	8,111	1,880	\$ 184.11	\$ 28.85
Physician - BH	\$ 5,207	29	7	\$ 178.09	\$ 0.10
FQHC	\$ 2,651,390	23,322	5,406	\$ 113.68	\$ 51.22
Home Health	\$ 21,290	46	11	\$ 460.62	\$ 0.41
Nursing Facility	\$ 51,988	102	24	\$ 509.58	\$ 1.00
Pharmacy	\$ 995,014	25,791	5,978	\$ 38.58	\$ 19.22
Dental	\$ 627,053	4,102	951	\$ 152.86	\$ 12.11
DME/Supply	\$ 67,415	439	102	\$ 153.53	\$ 1.30
Transportation	\$ 56,612	2,167	502	\$ 26.12	\$ 1.09
Lab & Radiology	\$ 2,598,232	19,302	4,474	\$ 134.61	\$ 50.19
Other	\$ 890	17	4	\$ 52.08	\$ 0.02
<b>Total</b>	<b>\$ 11,009,133</b>	<b>85,461</b>			<b>\$ 212.67</b>

Total may not equal sum of individual category of services due to rounding



Time Period/Data Selections:	
Time Period:	FY17
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	19-36 Male

<b>Member Months/Deliveries:</b>	<b>34,380</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 388,670	170	59	\$ 2,281.31	\$ 11.31
Inpatient Hospital - BH	\$ 32,134	13	5	\$ 2,471.87	\$ 0.93
Outpatient Hospital	\$ 591,934	611	213	\$ 968.76	\$ 17.22
Outpatient Hospital - BH	\$ 5,128	4	1	\$ 1,282.02	\$ 0.15
Emergency Room	\$ 96,566	136	47	\$ 710.15	\$ 2.81
Physician	\$ 1,202,974	4,522	1,578	\$ 266.03	\$ 34.99
Physician - BH	\$ 25,687	271	95	\$ 94.79	\$ 0.75
FQHC	\$ 395,569	3,783	1,320	\$ 104.56	\$ 11.51
Home Health	\$ 4,051	14	5	\$ 289.33	\$ 0.12
Nursing Facility	\$ -	-	-	\$ -	\$ -
Pharmacy	\$ 981,373	7,785	2,717	\$ 126.06	\$ 28.54
Dental	\$ 516,144	3,668	1,280	\$ 140.71	\$ 15.01
DME/Supply	\$ 45,799	88	31	\$ 520.41	\$ 1.33
Transportation	\$ 56,356	817	285	\$ 68.97	\$ 1.64
Lab & Radiology	\$ 445,560	4,477	1,563	\$ 99.52	\$ 12.96
Other	\$ 6,619	12	4	\$ 551.56	\$ 0.19
<b>Total</b>	<b>\$ 4,794,564</b>	<b>26,372</b>			<b>\$ 139.46</b>

Time Period/Data Selections:	
Time Period:	FY18
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	19-36 Male

<b>Member Months/Deliveries:</b>	<b>33,642</b>
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 503,285	159	57	\$ 3,155.53	\$ 14.96
Inpatient Hospital - BH	\$ 94,630	33	12	\$ 2,854.93	\$ 2.81
Outpatient Hospital	\$ 808,314	683	244	\$ 1,184.01	\$ 24.03
Outpatient Hospital - BH	\$ 4,534	3	1	\$ 1,471.38	\$ 0.13
Emergency Room	\$ 139,341	168	60	\$ 831.45	\$ 4.14
Physician	\$ 1,227,728	3,900	1,391	\$ 314.77	\$ 36.49
Physician - BH	\$ 17,711	116	41	\$ 152.72	\$ 0.53
FQHC	\$ 670,086	6,533	2,330	\$ 102.58	\$ 19.92
Home Health	\$ 6,122	16	6	\$ 374.90	\$ 0.18
Nursing Facility	\$ 5,248	14	5	\$ 371.21	\$ 0.16
Pharmacy	\$ 985,453	10,619	3,788	\$ 92.80	\$ 29.29
Dental	\$ 442,929	2,751	981	\$ 160.98	\$ 13.17
DME/Supply	\$ 14,246	93	33	\$ 153.52	\$ 0.42
Transportation	\$ 41,115	825	294	\$ 49.82	\$ 1.22
Lab & Radiology	\$ 557,296	5,166	1,843	\$ 107.89	\$ 16.57
Other	\$ 1,934	19	7	\$ 101.41	\$ 0.06
<b>Total</b>	<b>\$ 5,519,972</b>	<b>31,098</b>			<b>\$ 164.08</b>

Total may not equal sum of individual category of services due to rounding

Time Period/Data Selections:	
Time Period:	FY17
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	37-49 Female

Member Months/Deliveries:	32,895
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 881,170	369	135	\$ 2,388.20	\$ 26.79
Inpatient Hospital - BH	\$ 12,804	8	3	\$ 1,600.52	\$ 0.39
Outpatient Hospital	\$ 1,082,172	1,730	631	\$ 625.52	\$ 32.90
Outpatient Hospital - BH	\$ 414	3	1	\$ 137.87	\$ 0.01
Emergency Room	\$ 186,019	206	75	\$ 904.13	\$ 5.65
Physician	\$ 2,290,898	10,295	3,756	\$ 222.53	\$ 69.64
Physician - BH	\$ 38,996	378	138	\$ 103.16	\$ 1.19
FQHC	\$ 940,558	7,706	2,811	\$ 122.06	\$ 28.59
Home Health	\$ 4,556	11	4	\$ 414.12	\$ 0.14
Nursing Facility	\$ -	-	-	\$ -	\$ -
Pharmacy	\$ 1,621,155	25,812	9,416	\$ 62.81	\$ 49.28
Dental	\$ 479,865	3,758	1,371	\$ 127.68	\$ 14.59
DME/Supply	\$ 42,782	280	102	\$ 152.78	\$ 1.30
Transportation	\$ 47,788	2,178	795	\$ 21.94	\$ 1.45
Lab & Radiology	\$ 1,397,708	11,798	4,304	\$ 118.47	\$ 42.49
Other	\$ 31,831	27	10	\$ 1,178.89	\$ 0.97
<b>Total</b>	<b>\$ 9,058,716</b>	<b>64,559</b>			<b>\$ 275.38</b>

Time Period/Data Selections:	
Time Period:	FY18
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	37-49 Female

Member Months/Deliveries:	34,832
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 1,426,010	391	135	\$ 3,649.30	\$ 40.94
Inpatient Hospital - BH	\$ 3,286	5	2	\$ 652.60	\$ 0.09
Outpatient Hospital	\$ 1,423,949	1,648	568	\$ 863.90	\$ 40.88
Outpatient Hospital - BH	\$ 1,086	7	2	\$ 153.84	\$ 0.03
Emergency Room	\$ 296,519	329	113	\$ 900.06	\$ 8.51
Physician	\$ 2,141,823	8,448	2,910	\$ 253.53	\$ 61.49
Physician - BH	\$ 14,693	111	38	\$ 132.51	\$ 0.42
FQHC	\$ 1,642,933	13,601	4,686	\$ 120.79	\$ 47.17
Home Health	\$ 20,843	50	17	\$ 415.28	\$ 0.60
Nursing Facility	\$ 67,175	83	29	\$ 805.07	\$ 1.93
Pharmacy	\$ 2,227,824	34,800	11,989	\$ 64.02	\$ 63.96
Dental	\$ 458,392	3,136	1,080	\$ 146.19	\$ 13.16
DME/Supply	\$ 115,755	472	163	\$ 244.99	\$ 3.32
Transportation	\$ 59,800	3,116	1,074	\$ 19.19	\$ 1.72
Lab & Radiology	\$ 1,791,275	13,240	4,561	\$ 135.29	\$ 51.43
Other	\$ 6,537	32	11	\$ 203.15	\$ 0.19
<b>Total</b>	<b>\$ 11,697,900</b>	<b>79,471</b>			<b>\$ 335.84</b>

Total may not equal sum of individual category of services due to rounding

Time Period/Data Selections:	
Time Period:	FY17
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	37-49 Male

Member Months/Deliveries:	23,305
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 943,998	480	247	\$ 1,967.61	\$ 40.51
Inpatient Hospital - BH	\$ 46,602	24	12	\$ 1,941.76	\$ 2.00
Outpatient Hospital	\$ 343,824	587	302	\$ 585.72	\$ 14.75
Outpatient Hospital - BH	\$ 858	7	4	\$ 122.60	\$ 0.04
Emergency Room	\$ 98,024	109	56	\$ 901.37	\$ 4.21
Physician	\$ 1,972,470	5,556	2,861	\$ 355.02	\$ 84.64
Physician - BH	\$ 22,637	261	134	\$ 86.73	\$ 0.97
FQHC	\$ 370,818	3,253	1,675	\$ 113.99	\$ 15.91
Home Health	\$ 8,190	19	10	\$ 431.02	\$ 0.35
Nursing Facility	\$ -	-	-	\$ -	\$ -
Pharmacy	\$ 1,028,860	13,068	6,729	\$ 78.73	\$ 44.15
Dental	\$ 332,943	2,416	1,244	\$ 137.80	\$ 14.29
DME/Supply	\$ 49,486	152	78	\$ 325.55	\$ 2.12
Transportation	\$ 56,025	930	479	\$ 60.24	\$ 2.40
Lab & Radiology	\$ 403,957	4,433	2,283	\$ 91.12	\$ 17.33
Other	\$ 3,625	9	5	\$ 402.80	\$ 0.16
<b>Total</b>	<b>\$ 5,682,318</b>	<b>31,304</b>			<b>\$ 243.82</b>

Time Period/Data Selections:	
Time Period:	FY18
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	37-49 Male

Member Months/Deliveries:	25,087
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 902,195	333	159	\$ 2,712.32	\$ 35.96
Inpatient Hospital - BH	\$ 38,602	25	12	\$ 1,522.98	\$ 1.54
Outpatient Hospital	\$ 577,314	580	277	\$ 996.22	\$ 23.01
Outpatient Hospital - BH	\$ 441	3	1	\$ 146.91	\$ 0.02
Emergency Room	\$ 162,591	177	85	\$ 918.41	\$ 6.48
Physician	\$ 2,066,290	4,903	2,345	\$ 421.47	\$ 82.36
Physician - BH	\$ 15,943	125	60	\$ 127.07	\$ 0.64
FQHC	\$ 611,442	5,852	2,799	\$ 104.48	\$ 24.37
Home Health	\$ 1,823	4	2	\$ 454.69	\$ 0.07
Nursing Facility	\$ 28,048	74	35	\$ 379.19	\$ 1.12
Pharmacy	\$ 1,253,029	17,328	8,289	\$ 72.31	\$ 49.95
Dental	\$ 308,833	1,963	939	\$ 157.31	\$ 12.31
DME/Supply	\$ 89,281	153	73	\$ 585.40	\$ 3.56
Transportation	\$ 42,712	910	435	\$ 46.95	\$ 1.70
Lab & Radiology	\$ 520,180	5,175	2,475	\$ 100.53	\$ 20.74
Other	\$ 24,000	17	8	\$ 1,400.08	\$ 0.96
<b>Total</b>	<b>\$ 6,642,723</b>	<b>37,621</b>			<b>\$ 264.79</b>

Total may not equal sum of individual category of services due to rounding

Time Period/Data Selections:	
Time Period:	FY17
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	50+ Female

Member Months/Deliveries:	26,550
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 2,522,494	995	450	\$ 2,535.84	\$ 95.01
Inpatient Hospital - BH	\$ 18,212	10	5	\$ 1,821.16	\$ 0.69
Outpatient Hospital	\$ 1,716,882	3,079	1,392	\$ 557.59	\$ 64.67
Outpatient Hospital - BH	\$ 294	2	1	\$ 146.91	\$ 0.01
Emergency Room	\$ 177,535	195	88	\$ 909.55	\$ 6.69
Physician	\$ 3,774,661	16,204	7,324	\$ 232.95	\$ 142.17
Physician - BH	\$ 27,199	288	130	\$ 94.44	\$ 1.02
FQHC	\$ 719,309	5,626	2,543	\$ 127.85	\$ 27.09
Home Health	\$ 51,968	86	39	\$ 604.24	\$ 1.96
Nursing Facility	\$ 225,108	514	233	\$ 437.54	\$ 8.48
Pharmacy	\$ 2,842,411	51,188	23,136	\$ 55.53	\$ 107.06
Dental	\$ 297,372	2,087	943	\$ 142.48	\$ 11.20
DME/Supply	\$ 117,553	556	251	\$ 211.41	\$ 4.43
Transportation	\$ 59,407	2,376	1,074	\$ 25.00	\$ 2.24
Lab & Radiology	\$ 1,431,570	13,624	6,158	\$ 105.08	\$ 53.92
Other	\$ 38,769	44	20	\$ 881.05	\$ 1.46
<b>Total</b>	<b>\$ 14,020,743</b>	<b>96,875</b>			<b>\$ 528.09</b>

Time Period/Data Selections:	
Time Period:	FY18
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	50+ Female

Member Months/Deliveries:	29,267
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 3,853,755	1,007	413	\$ 3,828.77	\$ 131.68
Inpatient Hospital - BH	\$ 22,256	10	4	\$ 2,210.07	\$ 0.76
Outpatient Hospital	\$ 2,930,428	3,254	1,334	\$ 900.56	\$ 100.13
Outpatient Hospital - BH	\$ 147	1	0	\$ 146.91	\$ 0.01
Emergency Room	\$ 285,201	284	116	\$ 1,004.20	\$ 9.74
Physician	\$ 4,225,308	15,487	6,350	\$ 272.84	\$ 144.37
Physician - BH	\$ 8,929	96	39	\$ 93.09	\$ 0.31
FQHC	\$ 1,292,647	10,467	4,292	\$ 123.49	\$ 44.17
Home Health	\$ 33,930	75	31	\$ 450.50	\$ 1.16
Nursing Facility	\$ 262,898	574	235	\$ 458.18	\$ 8.98
Pharmacy	\$ 5,074,751	69,058	28,315	\$ 73.49	\$ 173.39
Dental	\$ 253,630	1,542	632	\$ 164.47	\$ 8.67
DME/Supply	\$ 201,176	708	290	\$ 284.19	\$ 6.87
Transportation	\$ 80,122	3,496	1,434	\$ 22.92	\$ 2.74
Lab & Radiology	\$ 2,097,817	16,425	6,735	\$ 127.72	\$ 71.68
Other	\$ 47,686	72	29	\$ 666.39	\$ 1.63
<b>Total</b>	<b>\$ 20,670,682</b>	<b>122,555</b>			<b>\$ 706.28</b>

Total may not equal sum of individual category of services due to rounding

Time Period/Data Selections:	
Time Period:	FY17
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	50+ Male

Member Months/Deliveries:	15,924
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 1,888,422	942	710	\$ 2,005.50	\$ 118.59
Inpatient Hospital - BH	\$ 5,877	4	3	\$ 1,469.20	\$ 0.37
Outpatient Hospital	\$ 1,035,530	1,687	1,271	\$ 613.82	\$ 65.03
Outpatient Hospital - BH	\$ 588	4	3	\$ 146.91	\$ 0.04
Emergency Room	\$ 100,254	88	67	\$ 1,134.71	\$ 6.30
Physician	\$ 3,220,298	10,577	7,971	\$ 304.46	\$ 202.23
Physician - BH	\$ 16,074	170	128	\$ 94.55	\$ 1.01
FQHC	\$ 376,570	3,233	2,436	\$ 116.48	\$ 23.65
Home Health	\$ 84,326	82	62	\$ 1,028.30	\$ 5.30
Nursing Facility	\$ 141,033	481	362	\$ 293.20	\$ 8.86
Pharmacy	\$ 2,290,772	31,710	23,896	\$ 72.24	\$ 143.86
Dental	\$ 197,544	1,391	1,048	\$ 142.01	\$ 12.41
DME/Supply	\$ 92,930	296	223	\$ 313.93	\$ 5.84
Transportation	\$ 53,714	1,024	772	\$ 52.45	\$ 3.37
Lab & Radiology	\$ 618,647	6,689	5,041	\$ 92.48	\$ 38.85
Other	\$ 50,188	36	27	\$ 1,394.02	\$ 3.15
<b>Total</b>	<b>\$ 10,172,767</b>	<b>58,414</b>			<b>\$ 638.83</b>

Time Period/Data Selections:	
Time Period:	FY18
Data Source:	Encounters

Population Selections:	
Program:	Alliance
Population:	50+ Male

Member Months/Deliveries:	16,890
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Category of Service	Incurred Claims	Utilization	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient Hospital	\$ 2,545,956	901	640	\$ 2,826.62	\$ 150.74
Inpatient Hospital - BH	\$ 20,538	18	13	\$ 1,133.08	\$ 1.22
Outpatient Hospital	\$ 1,752,226	1,782	1,266	\$ 983.20	\$ 103.74
Outpatient Hospital - BH	\$ 384	1	1	\$ 381.12	\$ 0.02
Emergency Room	\$ 194,732	183	130	\$ 1,063.25	\$ 11.53
Physician	\$ 3,228,832	10,678	7,587	\$ 302.37	\$ 191.17
Physician - BH	\$ 21,943	124	88	\$ 177.59	\$ 1.30
FQHC	\$ 671,113	5,867	4,168	\$ 114.39	\$ 39.73
Home Health	\$ 90,746	111	79	\$ 820.61	\$ 5.37
Nursing Facility	\$ 369,979	763	542	\$ 484.84	\$ 21.91
Pharmacy	\$ 2,926,855	43,096	30,619	\$ 67.91	\$ 173.29
Dental	\$ 175,752	1,071	761	\$ 164.13	\$ 10.41
DME/Supply	\$ 93,712	289	206	\$ 323.93	\$ 5.55
Transportation	\$ 54,413	1,372	975	\$ 39.66	\$ 3.22
Lab & Radiology	\$ 1,025,469	8,290	5,890	\$ 123.70	\$ 60.71
Other	\$ 41,564	45	32	\$ 915.23	\$ 2.46
<b>Total</b>	<b>\$ 13,214,216</b>	<b>74,591</b>			<b>\$ 782.37</b>

Total may not equal sum of individual category of services due to rounding

# 8

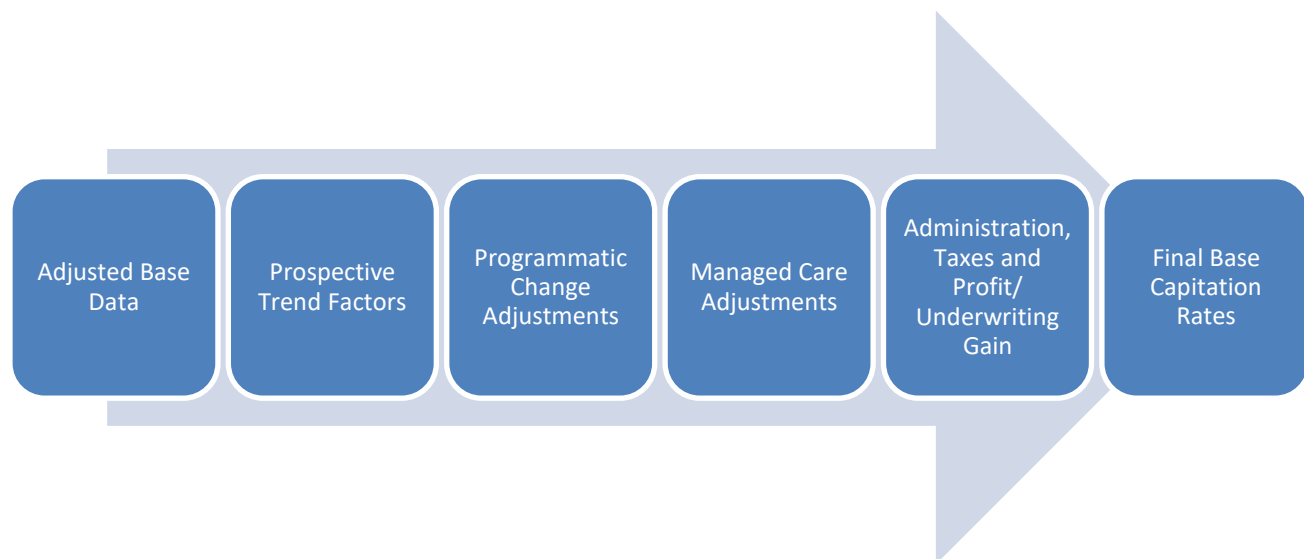
## CAPITATION RATE DEVELOPMENT

The rate-setting methodology is based on generally accepted actuarial principles and best practices. The rate-setting process and related documentation comply with the CMS regulations outlined in 42 CFR 438.4 and were developed in accordance with applicable law and regulations, including the ASOPs.

The capitation rates are meant to provide a reimbursement structure that will match payment to the expected financial risk of the managed care. Under managed care, the capitation payments will be made by DHCF to the MCOs who will administer the contractually-required services to the populations covered under the program.

The rate-setting process is the means for determining the PMPM capitation payments DHCF will pay to the MCOs for each beneficiary enrolled in the program, regardless of the amount of future services that beneficiary receives. Generally, this process involves summarizing historical claims and eligibility data that represent the covered populations and services (Sections 3 through 7) and projecting future medical claims costs on a PMPM basis into the rating period. Consideration for administrative allowances and profit/underwriting gain or risk margin will be added to the expected medical costs to arrive at the base capitation rates for each rate cell.

The overall rate-setting approach is based on the foundational steps outlined below.



# 9

## TREND ASSUMPTIONS

Medical trend is the projection of utilization and unit cost changes over time. A trend factor is necessary to estimate the expenses of providing health care services in the FFY 2021 rating period.

### TREND DEVELOPMENT METHODOLOGY

Mercer reviewed the historic FFS and encounter data from 2016 through mid-CY 2019 for the DCHFP and Alliance populations. The data was analyzed on a rolling average basis (12-month, 9-month, 3-month and 1-month average) to evaluate changes in historical cost and utilization patterns while smoothing the influence of significant outliers and seasonality. Regression models were also created to fit the historical data to a linear equation by service category. For pharmacy trends, Mercer's trend review also included a market analysis of prescription drugs. As a secondary source, Mercer reviewed actuarial reports from CMS Office of the Actuary, Consumer Price Indices and trend information from other state Medicaid programs.

Unit cost and utilization trend factors were developed to form an overall PMPM trend for each of the major COS. Similar service categories were aggregated and reviewed by population and program. Since each rate cell has a different distribution of services, the trend assumption percentages translate to a different total PMPM impact by rate cell. The trend assumptions were applied from the midpoint of the base data period to the midpoint of the contract period. For the SSI and Opt-out populations, this is a total of 33 months and for the historical DCHFP and Alliance populations, 41 months.

We reviewed the data by category of service separately for each population. Based on this review, Mercer developed separate trend assumptions for the TANF Child, TANF Adult, Opt-out, SSI Adult and Alliance populations.

### ENCOUNTER TREND

COS	DCHFP CHILDREN			DCHFP ADULTS			ALLIANCE ADULTS		
	UNIT COST	UTIL/ 1000	PMPM	UNIT COST	UTIL/ 1000	PMPM	UNIT COST	UTIL/ 1000	PMPM
Inpatient Hospital	1.5%	0.0%	1.5%	1.5%	0.0%	1.5%	0.0%	1.0%	1.0%
Inpatient Hospital — BH	-1.0%	7.1%	6.0%	1.0%	2.0%	3.0%	1.0%	0.0%	1.0%
Outpatient Hospital	1.0%	1.0%	2.0%	1.0%	0.5%	1.5%	1.0%	0.0%	1.0%

COS	DCHFP CHILDREN			DCHFP ADULTS			ALLIANCE ADULTS		
	UNIT COST	UTIL/ 1000	PMPM	UNIT COST	UTIL/ 1000	PMPM	UNIT COST	UTIL/ 1000	PMPM
Outpatient Hospital — BH	-1.0%	7.1%	6.0%	1.0%	2.0%	3.0%	1.0%	0.0%	1.0%
Emergency Room	1.0%	1.0%	2.0%	1.0%	0.5%	1.5%	1.0%	0.0%	1.0%
Physician	1.5%	0.5%	2.0%	1.5%	1.5%	3.0%	-1.0%	3.0%	2.0%
Physician — BH	-1.0%	7.1%	6.0%	1.0%	2.0%	3.0%	1.0%	0.0%	1.0%
FQHC	1.5%	0.5%	2.0%	1.5%	1.5%	3.0%	-1.0%	3.0%	2.0%
Home Health	1.5%	0.0%	1.5%	1.5%	0.0%	1.5%	0.0%	1.0%	1.0%
Nursing Facility	0.0%	2.0%	2.0%	0.0%	2.0%	2.0%	0.0%	0.0%	0.0%
Pharmacy	3.0%	0.5%	3.5%	1.5%	1.5%	3.0%	7.0%	2.8%	10.0%
Dental	0.0%	2.0%	2.0%	0.0%	2.0%	2.0%	0.0%	0.0%	0.0%
DME/Supply	0.0%	2.0%	2.0%	0.0%	2.0%	2.0%	0.0%	0.0%	0.0%
Transportation	0.0%	2.0%	2.0%	0.0%	2.0%	2.0%	0.0%	0.0%	0.0%
Lab & Radiology	0.0%	2.0%	2.0%	0.0%	2.0%	2.0%	0.0%	0.0%	0.0%
Other	0.0%	2.0%	2.0%	0.0%	2.0%	2.0%	0.0%	0.0%	0.0%
<b>Total</b>	<b>0.9%</b>	<b>1.3%</b>	<b>2.2%</b>	<b>0.6%</b>	<b>1.5%</b>	<b>2.1%</b>	<b>0.9%</b>	<b>2.2%</b>	<b>3.1%</b>

#### FFS TREND

COS	OPT-OUT ADULTS			SSI ADULTS 21+		
	UNIT COST	UTIL/ 1000	PMPM	UNIT COST	UTIL/ 1000	PMPM
Inpatient Hospital	1.5%	0.5%	2.0%	1.5%	0.5%	2.0%
Inpatient Hospital — BH	1.5%	0.5%	2.0%	1.5%	0.5%	2.0%
Outpatient Hospital	4.0%	1.0%	5.0%	4.0%	1.0%	5.0%
Outpatient Hospital — BH	4.0%	1.0%	5.0%	4.0%	1.0%	5.0%
Emergency Room	4.0%	1.0%	5.0%	4.0%	1.0%	5.0%
Physician	0.0%	0.5%	0.5%	0.0%	0.5%	0.5%
Physician — BH	0.0%	0.5%	0.5%	0.0%	0.5%	0.5%



COS	OPT-OUT ADULTS			SSI ADULTS 21+		
	UNIT COST	UTIL/ 1000	PMPM	UNIT COST	UTIL/ 1000	PMPM
FQHC	1.6%	0.4%	2.0%	1.6%	0.4%	2.0%
Home Health	0.0%	0.0%	0.0%	1.0%	0.0%	1.0%
Nursing Facility	1.6%	0.4%	2.0%	1.6%	0.4%	2.0%
Pharmacy	1.0%	2.0%	3.0%	2.0%	2.0%	4.0%
Dental	0.5%	0.0%	0.5%	0.5%	0.0%	0.5%
DME/Supply	0.5%	0.5%	1.0%	0.5%	0.0%	0.5%
Transportation	0.5%	0.5%	1.0%	0.5%	0.0%	0.5%
Lab & Radiology	0.5%	0.5%	1.0%	0.5%	0.0%	0.5%
Other	0.5%	0.5%	1.0%	0.5%	0.0%	0.5%
<b>Total</b>	<b>1.2%</b>	<b>1.1%</b>	<b>2.2%</b>	<b>1.3%</b>	<b>1.0%</b>	<b>2.3%</b>

### Inpatient Hospital Services

Specific to Inpatient Hospital services, DHCF is requiring MCOs to reimburse hospitals at a minimum of the APR DRG fee schedule rates. Consideration for these reimbursement requirements was considered as part of rate development. DHCF will increase the APR DRG base rate annually based on the methodology outlined in the District's Medicaid State Plan. DHCF updated the APR DRG fee schedule for FFY 2020. Mercer evaluated the known changes in fee schedules from the base period through FFY 2020 and assumed inflationary changes from FFY 2020 to FFY 2021, for both FFS and encounter data.

### Outpatient Hospital Services

Specific to Outpatient Hospital services, DHCF is requiring MCOs to reimburse hospitals at a minimum of 130% of the FFS fee schedule rates. Consideration for these reimbursement requirements is discussed in Section 10. DHCF will increase the EAPG base rate annually based on the methodology outlined in the District's Medicaid State Plan. DHCF updated the EAPG fee schedule for FFY 2020. Mercer evaluated the known changes in fee schedules from the base period through FFY 2020 and assumed inflationary changes from FFY 2020 to FFY 2021, for both FFS and encounter data.

### FQHC Services

The District is requiring MCOs reimburse FQHC services at the District's APM fee schedule for the DCHFP, discussed further in Section 10. Similar to Inpatient services, the APM fee schedule is rebased every three years and adjusted based on MEI in other years. The APM was last updated in

CY 2018. Mercer used MEI to develop the unit cost trend to FFY 2021, for both FFS and encounter data.

### Prescription Drugs

It is important to note pharmacy trends require special consideration in rate-setting. Recently, pharmacy trends have been higher than other services covered under Medicaid programs driven by large trends in specialty medications. Mercer has performed a trend analysis that reviews considerations for changes that occurred during the base data period as well as projections for specialty and traditional pharmacy trends by rate cell to account for the varying impact of prescription drugs for each population. These trends assume that the MCOs will retain the flexibility to develop their own preferred drug lists and negotiate terms of pharmacy reimbursement.

Pipeline drugs, which are drugs that are still under development or discovery but are not yet available in the marketplace, are not generally reflected in the historical claims data, but are expected to impact utilization and cost within therapeutic categories during the rate year. Pipeline drugs were evaluated and accounted for in the pharmacy trend development based on the information available at the time rates were developed.

Significant growth is anticipated in drug classes such as diabetes (traditional), asthma (traditional), substance abuse and dependence (traditional), rheumatoid arthritis and other inflammatory conditions (specialty), oncology (specialty), HIV PrEP (specialty) as well as other new and emerging therapeutic drugs and categories. Some recent examples of emerging drugs that have impacted expected pharmacy costs are treatments for hemophilia, enzyme deficiency, oncology, cystic fibrosis and hepatitis C. Specific to hepatitis C, Mercer included consideration for the emergence of new lower cost hepatitis C products in the development of the pharmacy trends. For PrEP, Mercer considered the District's city-wide effort to increase knowledge of and access to HIV PrEP medications. DHCF is implementing a uniform PrEP coverage policy effective January 6, 2020, to align prior authorization requirements for PrEP across the managed care and the FFS program.

### Overall

The DCHFP has experienced low-to-moderate growth in the past few years. For TANF adults, prescription drugs have lower trends than Alliance due to drug mix. TANF children have moderate growth across most service categories. Trends in FFS for SSI Adults and Opt-outs are relatively low year to year, with emerging experience indicating modest growth for most non-pharmacy services.

The Alliance program has had significant growth in costs across most service categories in the past several years. Higher trends continue to be observed for prescription drugs. However, cost and utilization growth for other services has leveled out in more recent experience.

*Note: The trends in the draft rates will be revisited for final rates.*

# 10

## PROGRAM DESIGN CONSIDERATIONS

Mercer has adjusted the data for known programmatic design elements that are anticipated to impact the projected claims expenditures. Mercer has utilized information in the FFS and encounter data as well as information provided by DHCF to assess the impact of known programmatic changes to the capitation rates.

### BENEFIT CHANGES

#### Day Treatment Carve-out

DHCF reviewed the behavioral health coverage provisions of the DCHFP contract and provided clarification on coverage of day treatment services. Effective October 1, 2018, day treatment services are covered through the DBH rather than through managed care contract. Mercer reviewed the historical DCHFP encounter data and identified utilization of day treatment services in the encounter data using procedure code H0025 without any modifiers. This service was utilized by DCHFP eligibles in the TANF Child 1–18 and TANF Adult 19+ rate cells. To align with the coverage change, Mercer evaluated the adjustment by rate cell and applied a downward adjustment as summarized below.

#### DAY TREATMENT CARVE-OUT ADJUSTMENT

SERVICE	TANF CHILD	TANF ADULT
Physician – BH	-0.2%	-7.5%

*Note: The FFS data excludes Day Treatment services, so no adjustment was made to the FFS data.*

#### Nursing Facility (NF) Coverage

The MCOs will be responsible for short-term stays in nursing facilities. Historically, individuals were disenrolled from managed care the first of the month following a NF stay reaching 30 consecutive days. In order to limit disruption in coverage, the managed care coverage period is being extended to the end of the month when the 90<sup>th</sup> day is reached effective in FFY 2021. Mercer reviewed data for individuals enrolled in DCHFP who were disenrolled during a NF stay and added their experience to the base data. This adjustment considers all services incurred by these individuals in the applicable months, which fall primarily in the nursing facility COS. The adjustments below reflect adjustments for service categories with impacts that round to 0.1% or more.

#### NURSING FACILITY COVERAGE ADJUSTMENT

COS	TANF ADULTS
Inpatient Hospital	0.1%
Nursing Facility	9.4%

*Note: The FFS base data reflects the month following day 90, so no adjustment was needed to the FFS data.*

### IMD Waiver Considerations

Effective January 1, 2020, the District's Behavioral Health Transformation IMD waiver was approved. As a part of the waiver demonstration, IMD stays for the populations transitioning from FFS will become covered services by the MCOs. Currently, any IMD stays that are not covered by the MCOs are managed by the District's DBH. DHCF provided data from the DBH related to additional IMD Detox stays that will now be the responsibility of the MCOs. The DBH does not submit claims through Conduent, so a separate data set was used. Mercer evaluated the data for use and determined that a uniform percent adjustment to the Opt-out and SSI Adult populations was appropriate.

No other adjustments to behavioral health services have been made to the managed care program due to the waiver's implementation, as it is anticipated that most of the services covered through the waiver will be administered through FFS. Mercer is evaluating whether any managed care coverage requirements may necessitate a rate adjustment for final rates.

### IMD WAIVER ADJUSTMENT

SERVICE	OPT-OUTS	SSI
Inpatient – BH	5.5%	5.5%

### PRICING ADJUSTMENTS

As a part of the DCHFP program design, DHCF has included reimbursement requirements that meet the federal definition of directed payments in 42 CFR 438.6(c) for certain provider types. This sub-section includes information related to pricing adjustments

#### Inpatient Hospital Pricing

As described in the RFP, MCOs will be required to contract at a minimum of the District's APR-DRG fee schedule. Mercer evaluated the encounter data, in addition to hospital contracting information provided by the MCOs, to determine if adjustments were necessary to reflect the APR-DRG payment levels. The majority of MCO hospital arrangements are contracted at or above the fee schedule, but for those that are not, Mercer shadow-priced field the encounter data up to the FFS fee schedule for applicable hospital arrangements. This resulted in a higher adjustment to the Infant and TANF Child rate cells due to repricing of certain Children's Hospital contracts.

### INPATIENT HOSPITAL PRICING ADJUSTMENT

RATE CELL	INPATIENT – PH	INPATIENT – BH
Male and Female <1	8.0%	9.0%
Children 1-18	9.1%	16.6%

RATE CELL	INPATIENT – PH	INPATIENT – BH
TANF Adults 19+	1.2%	0.3%
Infant's Month of Birth	1.8%	0.0%
Mother's Month of Delivery	0.6%	0.0%

*Note: The FFS data reflects payments at the APR-DRG levels, so no adjustment was needed to the FFS data.*

### Outpatient Hospital Pricing Adjustment

As described in the RFP, MCOs will be required to contract at a minimum of 130% of the District's Outpatient EAPG fee schedule. Currently, the District reimburses hospitals for outpatient services at a mix of fee-for-service payments and supplemental payments. The District has required this reimbursement level in order to fund outpatient payments in managed care at levels consistent with current hospital payments. Mercer modeled an adjustment using historical supplemental payment data provided by the District. This data indicated supplemental payments are approximately 35% of total fee schedule costs. Mercer applied adjustments to the FFS data by hospital consistent with each hospital's supplemental payment levels. The impacts by COS are in the table below.

#### OUTPATIENT HOSPITAL PRICING ADJUSTMENT

COS	OPT-OUTS	SSI
Outpatient	35.2%	35.2%
Outpatient – BH	34.3%	34.3%
Emergency Room	23.4%	23.4%
Lab	11.0%	11.0%

*Note: Mercer is evaluating the current MCO reimbursement compared to the RFP requirements. No adjustment was made to the encounter data in the draft rates, but an adjustment may be considered in final rates rate development.*

### FQHC Pricing Adjustment

As described in the RFP, MCOs will be required to contract with FQHC providers at the APM/PPS rate for the DCHFP. Historically, the MCOs were required to pay FQHCs comparable rates to similar providers and the District made a wraparound payment as required in federal law for any difference between the MCO payment and the APM/FFS. In the future, this requirement will change and essentially eliminate the 'wraparound' payment to providers.

As noted, the encounter data reflect each MCO's negotiated rates with FQHC providers during the historical period. Mercer developed an adjustment to reflect the cost of the APM/PPS. The wrap

around payments are paid to FQHCs and captured in the FFS claims data. Mercer collected the wrap around claims data by month and rate cell and compared this to the total wraparound payments provided by the District. Mercer applied an adjustment to the claims data for completeness to reflect the total wraparound payments made. This resulted in an increase to the FQHC COS as follows.

#### FQHC PRICING ADJUSTMENT

RATE CELL	FQHC ADJUSTMENT
Male and Female <1	86.4%
Children 1-18	116.4%
TANF Adults 19+	135.7%
Infant's Month of Birth	106.9%
Mother's Month of Birth	126.9%

*Note: Since the FFS data reflects payments at the APM/PPS levels, no adjustment was needed to the FFS data.*

#### NEW POPULATION ADJUSTMENT

The TANF Adults 19+ rate cell has a new population adjustment to account for the transition of the former "Opt-out" population into the DCHFP. Mercer developed project medical expenditures for the Opt-out population, including applicable program changes, trend and managed care adjustments. Adjustments specific to the Opt-out population are discussed in Sections 9 through 11. The new population adjustment is included in the TANF Adult 19+ as an adjustment to the medical PMPM. To determine the adjustment, Mercer developed a weighted average PMPM of the existing TANF Adult population and the Opt-outs. Mercer used historical member months for each population. For the existing TANF Adult population, this is July 2018 through June 2019 membership.

The build-up of the adjustment PMPM is included in Section 13.

# 11

## MANAGED CARE ASSUMPTIONS

For the populations transitioning for FFS to managed care in FFY 2021, Mercer considered adjustments to reflect differences in service utilization and reimbursement once the populations are transitioned to a managed care program. These managed care adjustments are intended to capture future changes in the utilization and cost of certain services as a result of care management initiatives by the MCOs. Mercer analyzed the CY 2018 experience for the SSI and Opt-out populations. Specifically, Mercer reviewed the following:

- Comparison of DC FFS statistics to the DCHFP managed care experience.
- Comparison of DC FFS statistics to other state managed care experience.
- Research regarding other state program initial managed care expectations and experience operating under managed care.
- Pharmacy considerations under managed care.

More detail on each analysis is included in the remainder of this section.

### OVERALL MANAGED CARE FINDINGS

Mercer applied managed care assumptions FFY 2021 rate development for the SSI and Opt-out populations. These assumptions were developed based on a review of current program experience coupled with other data sources which includes specific data analyses such as clinical efficiency analyses and pharmacy clinical edits analysis. Assumed reductions in provider services spend are offset by non-benefit expenses incorporated into capitation rates as outlined in Section 12.

Mercer assumes it will take approximately three years for each population under managed care to realize the full extent of expected utilization savings. For development of the RFP draft capitation rates, Mercer assumed approximately 75% of managed care utilization savings to be realized in the first 12 months given a period of continuity of care and an implementation period for plans to realize results from their care management strategies and utilization management procedures. This ramp-up assumption was considered for all adjustments except for pricing considerations.

The tables below illustrate the overall impact of the FFY 2021 managed care assumptions by population and service.

## MANAGED CARE ADJUSTMENT

COS	OPT OUT ADULTS 19+			SSI ADULTS 21+		
	UNIT COST	UTIL/1000	PMPM	UNIT COST	UTIL/1000	PMPM
Inpatient Hospital	10.0%	-18.8%	-10.6%	10.0%	-18.8%	-10.6%
Inpatient Hospital — BH	5.0%	-9.4%	-4.8%	5.0%	-9.4%	-4.8%
Outpatient Hospital	0.0%	-3.8%	-3.8%	0.0%	-3.8%	-3.8%
Outpatient Hospital — BH	0.0%	-1.9%	-1.9%	0.0%	-1.9%	-1.9%
Emergency Room	0.0%	-7.5%	-7.5%	0.0%	-18.8%	-18.8%
Physician	0.0%	-1.6%	-1.6%	0.0%	-1.1%	-1.1%
Physician — BH	0.0%	-0.8%	-0.8%	0.0%	-0.5%	-0.5%
FQHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Home Health	0.0%	-1.5%	-1.5%	0.0%	-3.7%	-3.8%
Nursing Facility	0.0%	-3.8%	-3.8%	0.0%	-3.8%	-3.8%
Pharmacy	-9.3%	0.0%	-9.3%	-12.6%	0.0%	-12.6%
Dental	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
DME/Supply	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Transportation	0.0%	-3.8%	-3.8%	0.0%	-3.8%	-3.8%
Lab & Radiology	0.0%	-3.8%	-3.8%	0.0%	-3.8%	-3.8%
Other	0.0%	-3.8%	-3.8%	0.0%	-3.8%	-3.8%
<b>Total</b>			<b>-6.5%</b>			<b>-7.9%</b>

## NON-PHARMACY BENEFITS

Mercer reviewed a number of data sources in order to arrive at reasonable managed care expectations for the SSI and Opt-out populations. These reviews largely focused on a comparison to other state Medicaid managed care experience, a review of other state Medicaid managed care assumptions, and DCHFP experience.



In general, MCOs are expected to impact the current levels of medical cost and utilization through care management. The overall managed care savings may be achieved through a reduction to utilization of high-cost and high-intensity services as a result of activities such as, but not limited to:

1. Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the Emergency Room or hospitalization.
2. Reducing non-emergent use of the Emergency Room through member education and viable alternatives (e.g., extended hours for doctor's offices, after-hours urgent care clinics or even nurse advice lines).
3. Hospital discharge planning to ensure a smooth transition from facility-based care to community resources, and minimize readmissions.

Mercer also reviewed the historical utilization of physician services in the FFS program. Mercer evaluated physician claims summarized by primary care and specialist visits. For office visits, Mercer evaluated the impact on utilization for both primary care and specialty Physician visits. Mercer assumed decreases on Physician specialty visits, assuming MCOs would increase provider network management to better manage services provided by specialists and specialty facilities. For primary care office visits, Mercer assumed increased utilization as a result of MCO preventative care efforts coupled with beneficiaries being diverted from more high-cost and high-intensity services.

Mercer evaluated reimbursement differences between FFS and managed care for the DCHFP. For Inpatient and Outpatient services the RFP stipulates minimum payments. In the DCHFP, MCO reimbursement has historically been higher than the required payment levels for inpatient hospital services. Mercer included consideration for contracting based on a comparison of reimbursement levels between FFS and managed care, with a unit cost increase of 10% for Inpatient – PH and 5% for Inpatient – BH. Mercer is continuing to evaluate the outpatient reimbursement between the required minimum payments and current MCO reimbursement and will include an adjustment for Outpatient services in final rates if appropriate. For other services, the managed care reimbursement levels have been generally consistent with FFS so no reimbursement adjustments were made.

## PHARMACY BENEFITS

Reimbursement and utilization management strategies play an important role in controlling pharmacy costs. Mercer evaluated changes expected to pharmacy pricing levels in the transition to managed care. Mercer assumed these pricing levels will be achieved at 100% for the FFY 2021 period with no ramp-up adjustment.

Under managed care, the MCO is expected to negotiate for rebates on prescription drugs. These rebates are separate and distinct from rebates received by DHCF. Mercer evaluated expected

pharmacy PBM rebate levels for the SSI and Opt-out populations. Mercer reviewed the drugs by class and brand/generic in the FFS base data, assuming only brand drugs receive rebates. We determined the expected percent of rebates for each drug class. Top rebating drug classes include blood modifying drugs (traditional), Diabetes and Diabetic supplies (traditional), anti-psychotic injectables (specialty) and Rheumatoid arthritis and other inflammatory conditions (specialty). Mercer applied rebate assumptions of -4.9% for Opt-outs and -7.5% for SSI Adults.

Mercer considered changes in reimbursement levels between FFS and managed care including lower dispensing fees and higher ingredient costs. In DCHFP and other state programs, MCO reimbursement is typically 4–6% lower than FFS, based on a lower dispensing fee and higher ingredient cost. In FFS, the District pays pharmacies a dispensing fee of \$11.15. Mercer adjusted the pharmacy data to reflect an assumed dispensing fee of \$1.25 based on a review of DCHFP and other state data. Mercer assumed a higher ingredient cost of approximately 4% above FFS. In total, the pricing adjustment is -4.6% for Opt-outs and -5.5% for SSI adults. Further analysis is being conducted and this assumption may be refined for final rates.

# 12

## NON-BENEFIT EXPENSE CONSIDERATIONS

This section describes the components of the rate that are not directly related to benefit costs, which include the following:

- General Administration
- Care Management
- Underwriting Gain
- MCO Assessments
- Health Benefit Exchange (HBX) Tax
- HIPF

### GENERAL ADMINISTRATION

Mercer developed an administrative model that calculates the expected cost to operate a Medicaid managed care program for the combined DCHFP and Alliance programs, including new populations. The model includes personnel costs for program management and general administrative operations as well as non-personnel costs necessary to run the program. Mercer prepared an additional model that established cost expectations for the anticipated personnel required to achieve the RFP's care management requirements. Mercer also evaluated the administrative expenses reported by MCOs for the current DCHFP and Alliance programs, through September 2019, for a basis of the current costs of administering the programs.

### PROGRAM MANAGEMENT AND ADMINISTRATIVE OPERATIONS PERSONNEL

The general administration and utilization management model addresses the expected staffing needs to operate and administer a Medicaid program. The capitation rates assume each MCO will have program management staff that is further delineated by key personnel, financial, clinical operations, legal (general counsel), human resources and information technology. Key personnel include the 16 required positions in the RFP, including the Chief Executive, Chief Financial, Chief Compliance, Chief Medical and Chief Operating Officers. Financial staff includes accountants, financial analysts and actuarial staff. Clinical operations include a Pharmacy Director and utilization management staff. Information technology staff includes reporting and monitoring as well as IT specialists and support.

The capitation rates also include consideration for general administrative operations staff, delineated by customer service, compliance, network, and claims processing. Operations staff reflects customer service representatives, program integrity team, and provider specialists.

Assumptions for the number of Full-Time Equivalents (FTEs) vary by staffing position. Salaries for each personnel component were developed based on the median salary levels in the BLS data for each staff type in the District of Columbia. In addition to the BLS salary data, Mercer included an assumption for fringe benefits and payroll taxes.

## CARE MANAGEMENT

The general care management model addresses both beneficiary care management and care coordination as a part of the approach to ensure efficient, coordinated and quality care. Care coordination is more administratively focused and as such, it is available to all beneficiaries and is often administered by a non-licensed individual. Care management is a team-based, person-centered approach to effectively manage patients' medical, social and behavioral conditions.

The base care management modeling assumes that 100% of beneficiaries will have access to care coordination whereas care management will be focused on low to high-needs beneficiaries which are assumed to comprise around 12% of the total program population, which assumes 100% of SSI Adults and 5% of other populations receive care management services. The care management modeling includes consideration for care management FTEs based on a beneficiary to staff ratio.

## ADMINISTRATIVE EXPENSE ALLOCATION

Each component within program management and administrative operations personnel, care management personnel and non-personnel modeling is classified as either a fixed or variable cost. This approach recognizes that certain administrative costs will be incurred regardless of population size or magnitude of medical claims (fixed costs) while others are a function of the size of the population served or services provided to members (variable costs). The capitation rates aggregated across all rate cells illustrate a split of approximately 55% fixed and 45% variable.

The fixed PMPM is applied uniformly to all rate cells (other than the Infant's Month of Birth and Mother's Month of Delivery kick payments), such that each rate cell receives the same fixed PMPM. The kick payments do not include the fixed portion of the administrative expense PMPM as each infant/pregnant woman's rate cell capitation payment (concurrent with the kick payment) for non-delivery related services will include fixed administrative costs. The remaining portion of the administrative PMPM pertains to variable costs. The program-wide non-benefit expense PMPM prior to the application of profit/underwriting gain and premium taxes is \$42.48.

DHCF operates two health home programs that may serve DCHFP members with certain chronic conditions or with Serious Mental Illness. Health Home services may replace the case management

services some of the members in each plan receive. As such, the administrative load is set assuming that any impact of the health homes will be offset by repurposing MCO staff for coordination with the health home or other MCO activities. No adjustment has been made to the MCO administration assumption in these rates. As further information becomes available, changes to the administration level in these rates may be revisited.

### UNDERWRITING GAIN

Per ASOP 49, underwriting gain (or profit) provides compensation for the risk assumed by the MCO. Underwriting gain includes consideration for cost of capital and margin for risk contingency. Risks include insurance, investment, inflation and regulatory risks as well as risk associated with social, economic and legal environments. An overall profit/underwriting gain assumption of 1.75% has been included, comprised of 1.25% for cost of capital and 0.5% for margin for risk.

### MCO ASSESSMENT

For many years, the Department of Insurance, Securities and Banking (DISB) in the District has imposed an assessment on health management organizations (HMOs) and preferred provider organizations (PPOs) for the privilege of operating in the District, to cover insurance department costs. This HMO/PPO assessment had traditionally been waived for Medicaid contracting insurers. In May 2010, the commissioner of insurance extended the application of this assessment to the Medicaid MCOs operating in the District and licensed by the DISB as HMOs. This is a uniform, broad-based fee imposed on all HMOs and PPOs and all lines of business. The assessment amounts to 2.0% of premiums. This is an acceptable rate consideration per item 5.B.ii of the May 2018 CMS Rate Development Guide.

This assessment is a legitimate cost of doing business in the District for Medicaid MCOs, and reasonable to include in the consideration of actuarially sound capitation rates. Since this is a cost of doing business in the District, Mercer included consideration for this assessment in the rate development. The assessment is expressed as a percentage of the gross capitation rate (i.e., premium). Mercer applied a 2.0% adjustment consistent with the assessment that will apply to the MCOs.

### HBX TAX

In addition to the premium tax, the MCOs are subject to an assessment to fund the HBX in the District. The HBX Authority Financial Sustainability Act of 2014 was passed by the District City Council in April 2014. Under this law, all health insurance providers that have \$50,000 or more in DC-based gross premium receipts per year would be subject to the assessment. The gross receipts of the Medicaid MCOs are subject to the assessment. In the first year, the Authority has estimated the assessment at 1.0% of gross receipts. Mercer incorporated consideration of the 1.0% HBX assessment into the development of the rates.

## HEALTH INSURANCE PROVIDERS FEE

The Health Insurer Provider Fee (HIPF) is a federal fee that applies to certain health insurers. The HIPF has been repealed for fee years CY 2021 and thereafter. As such, no adjustment has been included in the draft capitation rates for the HIPF. To the extent this changes, DHCF will reimburse MCOs for these fees and will determine the appropriate approach as more information becomes available.

# 13

## CAPITATION RATE DEVELOPMENT EXHIBITS

The following exhibits are detailed summaries illustrating the full rate development process for each rate cell, from the adjusted base data to the prospective adjustments. Additionally, the non-medical expense considerations are outlined in each summary in accordance with the methodology in Section 12 of this Rate Report. The last exhibit in this section summarizes the development of the new population PMPM add-on for the Opt-out population.

Program:	DCHFP
Rate Cell:	Male and Female < 1

Member Months:	54,914
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 188.08	\$ 3,857.76	585	1.5%	1.5%	0.0%	8.0%	0.0%	\$ 213.70	\$ 4,383.26	585
Inpatient Hospital - BH	\$ 0.56	\$ 693.95	10	6.0%	-1.0%	7.1%	9.0%	0.0%	\$ 0.75	\$ 730.89	12
Outpatient Hospital	\$ 31.65	\$ 348.35	1,090	2.0%	1.0%	1.0%	0.0%	0.0%	\$ 33.86	\$ 360.39	1,128
Outpatient Hospital - BH	\$ 0.09	\$ 279.60	4	6.0%	-1.0%	7.1%	0.0%	0.0%	\$ 0.11	\$ 270.16	5
Emergency Room	\$ 71.08	\$ 628.99	1,356	2.0%	1.0%	1.0%	0.0%	0.0%	\$ 76.06	\$ 650.74	1,403
Physician	\$ 68.67	\$ 156.04	5,281	2.0%	1.5%	0.5%	0.0%	0.0%	\$ 73.48	\$ 164.18	5,371
Physician - BH	\$ 2.28	\$ 275.08	100	6.0%	-1.0%	7.1%	0.0%	0.0%	\$ 2.79	\$ 265.79	126
FQHC	\$ 20.07	\$ 105.49	2,283	2.0%	1.5%	0.5%	86.4%	0.0%	\$ 40.03	\$ 206.94	2,321
Home Health	\$ 0.29	\$ 270.88	13	1.5%	1.5%	0.0%	0.0%	0.0%	\$ 0.31	\$ 285.01	13
Nursing Facility	\$ -	\$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	\$ -	\$ -	-
Pharmacy	\$ 9.30	\$ 38.87	2,872	3.5%	3.0%	0.5%	0.0%	0.0%	\$ 10.46	\$ 43.00	2,920
Dental	\$ 0.32	\$ 81.94	48	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 0.35	\$ 81.94	51
DME/Supply	\$ 2.40	\$ 217.51	133	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 2.57	\$ 217.51	142
Transportation	\$ 3.50	\$ 86.75	485	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 3.75	\$ 86.75	519
Lab & Radiology	\$ 9.74	\$ 112.14	1,042	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 10.42	\$ 112.14	1,115
Other	\$ 0.10	\$ 264.54	5	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 0.11	\$ 264.54	5
<b>Total</b>	\$ 408.15	N/A	15,304	1.8%	1.1%	0.8%	7.9%	0.0%	\$ 468.74	N/A	15,714

New Populations Add on Adjustment: \$ -

Gross Medical PMPM/Payment: \$ 468.74

Non-Benefit Expense PMPM/Payment:

General Administration (5%)	\$ 26.16
Care Management (3.7%)	\$ 19.31
Underwriting Gain (1.75%)	\$ 9.16

Total Service Cost and Non-Benefit Load PMPM/Payment:

\$ 523.37	
MCO Tax (3.0%)	\$ 16.19

Total Capitation Rate: \$ 539.56



Program:	DCHFP
Rate Cell:	Children 1-18

Member Months:	869,993
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 26.70	\$ 4,141.20	77	1.5%	1.5%	0.0%	9.1%	0.0%	\$ 30.66	\$ 4,755.71	77
Inpatient Hospital - BH	\$ 4.64	\$ 1,128.53	49	6.0%	-1.0%	7.1%	16.6%	0.0%	\$ 6.60	\$ 1,271.20	62
Outpatient Hospital	\$ 18.16	\$ 570.87	382	2.0%	1.0%	1.0%	0.0%	0.0%	\$ 19.43	\$ 590.61	395
Outpatient Hospital - BH	\$ 0.61	\$ 240.95	31	6.0%	-1.0%	7.1%	0.0%	0.0%	\$ 0.75	\$ 232.81	39
Emergency Room	\$ 36.79	\$ 703.66	627	2.0%	1.0%	1.0%	0.0%	0.0%	\$ 39.36	\$ 727.99	649
Physician	\$ 18.27	\$ 131.95	1,661	2.0%	1.5%	0.5%	0.0%	0.0%	\$ 19.55	\$ 138.84	1,690
Physician - BH	\$ 8.38	\$ 157.37	639	6.0%	-1.0%	7.1%	-0.2%	0.0%	\$ 10.21	\$ 152.06	806
FQHC	\$ 8.85	\$ 90.63	1,172	2.0%	1.5%	0.5%	116.4%	0.0%	\$ 20.50	\$ 206.39	1,192
Home Health	\$ 0.26	\$ 206.95	15	1.5%	1.5%	0.0%	0.0%	0.0%	\$ 0.28	\$ 217.75	15
Nursing Facility	\$ 0.00	\$ 386.99	0	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 0.00	\$ 386.99	0
Pharmacy	\$ 13.39	\$ 52.26	3,076	3.5%	3.0%	0.5%	0.0%	0.0%	\$ 15.06	\$ 57.81	3,127
Dental	\$ 21.61	\$ 188.32	1,377	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 23.12	\$ 188.32	1,473
DME/Supply	\$ 0.74	\$ 133.29	66	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 0.79	\$ 133.29	71
Transportation	\$ 1.65	\$ 74.51	266	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 1.77	\$ 74.51	285
Lab & Radiology	\$ 8.98	\$ 145.99	739	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 9.61	\$ 145.99	790
Other	\$ 0.53	\$ 48.70	132	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 0.57	\$ 48.70	141
<b>Total</b>	\$ 169.59	N/A	10,310	2.4%	1.0%	1.4%	7.9%	0.0%	\$ 198.28	N/A	10,812

New Populations Add on Adjustment: \$ -

Gross Medical PMPM/Payment: \$ 198.28

Non-Benefit Expense PMPM/Payment:

General Administration (8.2%)	\$ 18.89
Care Management (3.6%)	\$ 8.17
Underwriting Gain (1.75%)	\$ 4.01

Total Service Cost and Non-Benefit Load PMPM/Payment:

\$ 229.34	
MCO Tax (3.0%)	\$ 7.09

Total Capitation Rate: \$ 236.44

Program:	DCHFP
Rate Cell:	TANF Adults 19+

Member Months:	1,390,482
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 83.30	\$ 2,892.04	346	1.5%	1.5%	0.0%	1.3%	0.0%	\$ 88.79	\$ 3,078.22	346
Inpatient Hospital - BH	\$ 10.96	\$ 982.55	134	3.0%	1.0%	2.0%	0.3%	0.0%	\$ 12.16	\$ 1,019.46	143
Outpatient Hospital	\$ 25.88	\$ 809.16	384	1.5%	1.0%	0.5%	0.0%	0.0%	\$ 27.24	\$ 837.09	390
Outpatient Hospital - BH	\$ 0.60	\$ 583.41	12	3.0%	1.0%	2.0%	0.0%	0.0%	\$ 0.66	\$ 603.37	13
Emergency Room	\$ 38.00	\$ 574.44	794	1.5%	1.0%	0.5%	0.0%	0.0%	\$ 39.99	\$ 594.30	807
Physician	\$ 39.08	\$ 161.95	2,896	3.0%	1.5%	1.5%	0.0%	0.0%	\$ 43.25	\$ 170.37	3,046
Physician - BH	\$ 6.10	\$ 126.36	579	3.0%	1.0%	2.0%	-7.5%	0.0%	\$ 6.24	\$ 130.73	573
FQHC	\$ 10.33	\$ 89.48	1,386	3.0%	1.5%	1.5%	135.7%	0.0%	\$ 26.94	\$ 221.88	1,457
Home Health	\$ 0.69	\$ 261.89	31	1.5%	1.5%	0.0%	0.0%	0.0%	\$ 0.72	\$ 275.55	31
Nursing Facility	\$ 3.37	\$ 475.77	85	2.0%	0.0%	2.0%	9.4%	0.0%	\$ 3.94	\$ 455.03	104
Pharmacy	\$ 51.19	\$ 55.99	10,971	3.0%	1.5%	1.5%	0.0%	0.0%	\$ 56.64	\$ 58.90	11,539
Dental	\$ 19.33	\$ 275.58	842	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 20.69	\$ 275.62	901
DME/Supply	\$ 2.18	\$ 185.18	141	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 2.33	\$ 185.20	151
Transportation	\$ 5.42	\$ 54.97	1,184	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 5.80	\$ 54.95	1,267
Lab & Radiology	\$ 28.21	\$ 133.63	2,533	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 30.18	\$ 133.62	2,711
Other	\$ 0.96	\$ 74.42	155	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 1.03	\$ 74.42	166
<b>Total</b>	\$ 325.60	N/A	22,472	2.1%	0.6%	1.5%	4.7%	0.0%	\$ 366.62	N/A	23,647

New Populations Add on Adjustment: **\$ 10.69**

Gross Medical PMPM/Payment: **\$ 377.31**

Non-Benefit Expense PMPM/Payment:

General Administration (5.6%)	\$ 23.70
Care Management (3.7%)	\$ 15.54
Underwriting Gain (1.75%)	\$ 7.42

Total Service Cost and Non-Benefit Load PMPM/Payment:

	\$ 423.97
MCO Tax (3.0%)	\$ 13.11

Total Capitation Rate: **\$ 437.09**

Program:	DCHFP
Rate Cell:	SSI Adult

Member Months:	183,133
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Base Period:	January 1, 2018 - December 31, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	33

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 470.10	\$ 2,229.21	2,531	2.0%	1.5%	0.5%	0.0%	-10.6%	\$ 443.67	\$ 2,554.62	2,084
Inpatient Hospital - BH	\$ 66.72	\$ 1,261.43	635	2.0%	1.5%	0.5%	5.5%	-4.8%	\$ 70.75	\$ 1,456.23	583
Outpatient Hospital	\$ 86.47	\$ 485.01	2,139	5.0%	4.0%	1.0%	35.2%	-3.8%	\$ 128.65	\$ 730.25	2,114
Outpatient Hospital - BH	\$ 5.14	\$ 359.79	172	5.0%	4.0%	1.0%	34.3%	-1.9%	\$ 7.75	\$ 538.41	173
Emergency Room	\$ 71.73	\$ 533.97	1,612	5.0%	4.0%	1.0%	23.4%	-18.8%	\$ 82.26	\$ 734.09	1,345
Physician	\$ 139.75	\$ 157.07	10,677	0.5%	0.0%	0.5%	0.0%	-1.1%	\$ 140.12	\$ 157.07	10,705
Physician - BH	\$ 19.40	\$ 543.24	429	0.5%	0.0%	0.5%	0.0%	-0.5%	\$ 19.56	\$ 543.24	432
FQHC	\$ 38.89	\$ 244.32	1,910	2.0%	1.6%	0.4%	0.0%	0.0%	\$ 41.06	\$ 254.90	1,933
Home Health	\$ 182.45	\$ 758.40	2,887	1.0%	1.0%	0.0%	0.0%	-3.7%	\$ 180.48	\$ 779.44	2,779
Nursing Facility	\$ 48.98	\$ 578.15	1,017	2.0%	1.6%	0.4%	0.0%	-3.8%	\$ 49.78	\$ 604.54	988
Pharmacy	\$ 299.52	\$ 109.39	32,858	4.0%	2.0%	2.0%	0.0%	-12.6%	\$ 291.69	\$ 100.99	34,661
Dental	\$ 33.10	\$ 456.80	869	0.5%	0.5%	0.0%	0.0%	0.0%	\$ 33.55	\$ 463.11	869
DME/Supply	\$ 25.60	\$ 294.60	1,043	0.5%	0.5%	0.0%	0.0%	0.0%	\$ 25.95	\$ 298.67	1,043
Transportation	\$ 22.58	\$ 19.59	13,830	0.5%	0.5%	0.0%	0.0%	-3.8%	\$ 22.04	\$ 19.86	13,312
Lab & Radiology	\$ 50.70	\$ 96.75	6,289	0.5%	0.5%	0.0%	11.0%	-3.7%	\$ 54.93	\$ 108.91	6,053
Other	\$ 9.10	\$ 386.43	283	0.5%	0.5%	0.0%	0.0%	-3.7%	\$ 8.88	\$ 391.77	272
<b>Total</b>	\$ 1,570.24	N/A	79,179	2.3%	1.3%	1.0%	3.9%	-7.9%	\$ 1,601.14	N/A	79,345

New Populations Add on Adjustment:

\$ -

Gross Medical PMPM/Payment:

\$ 1,601.14

Non-Benefit Expense PMPM/Payment:

General Administration (3.2%)

\$ 56.64

Care Management (3.8%)

\$ 65.94

Underwriting Gain (1.75%)

\$ 30.70

Total Service Cost and Non-Benefit Load PMPM/Payment:

\$ 1,754.43

Premium Taxes (3.0%)

\$ 54.26

Total Capitation Rate:

\$ 1,808.69

Program:	DCHFP
Rate Cell:	Infant's Month of Birth

Member Months:	3,011
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 5,571.31	\$ 1,393.94	47,962	1.5%	1.5%	0.0%	1.8%	0.0%	\$ 5,967.35	\$ 1,493.03	47,962
Inpatient Hospital - BH	\$ -	\$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	\$ -	\$ -	-
Outpatient Hospital	\$ 48.28	\$ 367.16	1,578	2.0%	1.0%	1.0%	0.0%	0.0%	\$ 51.66	\$ 379.86	1,632
Outpatient Hospital - BH	\$ 0.02	\$ 65.76	3	6.0%	-1.0%	7.1%	0.0%	0.0%	\$ 0.02	\$ 63.54	4
Emergency Room	\$ 36.49	\$ 730.36	600	2.0%	1.0%	1.0%	0.0%	0.0%	\$ 39.04	\$ 755.62	620
Physician	\$ 482.73	\$ 210.38	27,535	2.0%	1.5%	0.5%	0.0%	0.0%	\$ 516.52	\$ 221.35	28,002
Physician - BH	\$ 0.14	\$ 98.93	18	6.0%	-1.0%	7.1%	0.0%	0.0%	\$ 0.18	\$ 95.59	22
FQHC	\$ 25.23	\$ 94.69	3,198	2.0%	1.5%	0.5%	106.9%	0.0%	\$ 55.86	\$ 206.14	3,252
Home Health	\$ 0.35	\$ 131.59	32	1.5%	1.5%	0.0%	0.0%	0.0%	\$ 0.37	\$ 138.46	32
Nursing Facility	\$ -	\$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	\$ -	\$ -	-
Pharmacy	\$ 0.07	\$ 9.02	97	3.5%	3.0%	0.5%	0.0%	0.0%	\$ 0.08	\$ 9.98	99
Dental	\$ -	\$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	\$ -	\$ -	-
DME/Supply	\$ 0.13	\$ 166.77	10	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 0.14	\$ 166.77	10
Transportation	\$ 1.41	\$ 262.44	64	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 1.50	\$ 262.44	69
Lab & Radiology	\$ 14.38	\$ 73.80	2,338	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 15.39	\$ 73.80	2,502
Other	\$ 0.26	\$ 98.92	31	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 0.28	\$ 98.92	34
<b>Total</b>	\$ 6,180.80	N/A	83,465	1.5%	1.3%	0.3%	2.1%	0.0%	\$ 6,648.40	N/A	84,238

New Populations Add on Adjustment: \$ -

Gross Medical PMPM/Payment: \$ 6,648.40

Non-Benefit Expense PMPM/Payment:

General Administration (2.5%)	\$ 178.94
Care Management (3.8%)	\$ 273.81
Underwriting Gain (1.75%)	\$ 126.48

Total Service Cost and Non-Benefit Load PMPM/Payment:

\$ 7,227.63
\$ 223.54

Total Capitation Rate: \$ 7,451.17

Program:	DCHFP
Rate Cell:	Mother's Month of Delivery

Member Months:	3,127
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 8,139.20	\$ 2,202.26	44,350	1.5%	1.5%	0.0%	0.6%	0.0%	\$ 8,611.72	\$ 2,330.11	44,350
Inpatient Hospital - BH	\$ 6.72	\$ 1,170.85	69	3.0%	1.0%	2.0%	0.0%	0.0%	\$ 7.44	\$ 1,211.34	74
Outpatient Hospital	\$ 193.99	\$ 446.92	5,209	1.5%	1.0%	0.5%	0.0%	0.0%	\$ 204.12	\$ 462.38	5,297
Outpatient Hospital - BH	\$ 0.05	\$ 156.89	4	3.0%	1.0%	2.0%	0.0%	0.0%	\$ 0.05	\$ 162.32	4
Emergency Room	\$ 77.42	\$ 850.78	1,092	1.5%	1.0%	0.5%	0.0%	0.0%	\$ 81.46	\$ 880.20	1,111
Physician	\$ 1,530.95	\$ 358.04	51,311	3.0%	1.5%	1.5%	0.0%	0.0%	\$ 1,693.64	\$ 376.72	53,949
Physician - BH	\$ 6.42	\$ 146.31	527	3.0%	1.0%	2.0%	0.0%	0.0%	\$ 7.11	\$ 151.37	563
FQHC	\$ 48.44	\$ 87.11	6,672	3.0%	1.5%	1.5%	126.9%	0.0%	\$ 121.56	\$ 207.94	7,015
Home Health	\$ 5.54	\$ 382.70	174	1.5%	1.5%	0.0%	0.0%	0.0%	\$ 5.82	\$ 402.67	174
Nursing Facility	\$ 2.40	\$ 289.48	99	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 2.57	\$ 289.48	106
Pharmacy	\$ 50.46	\$ 21.62	28,010	3.0%	1.5%	1.5%	0.0%	0.0%	\$ 55.82	\$ 22.74	29,450
Dental	\$ 7.50	\$ 234.09	385	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 8.03	\$ 234.09	412
DME/Supply	\$ 55.92	\$ 172.05	3,900	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 59.83	\$ 172.05	4,173
Transportation	\$ 74.63	\$ 129.40	6,921	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 79.86	\$ 129.40	7,406
Lab & Radiology	\$ 274.80	\$ 145.78	22,621	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 294.04	\$ 145.78	24,204
Other	\$ 0.47	\$ 57.87	97	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 0.50	\$ 57.87	104
<b>Total</b>	\$ 10,474.91	N/A	171,442	1.8%	0.6%	1.2%	1.0%	0.0%	\$ 11,233.57	N/A	178,392

New Populations Add on Adjustment:	\$ -
Gross Medical PMPM/Payment:	\$ 11,233.57
Non-Benefit Expense PMPM/Payment:	
General Administration (2.5%)	\$ 302.34
Care Management (3.8%)	\$ 462.65
Underwriting Gain (1.75%)	\$ 213.71
Total Service Cost and Non-Benefit Load PMPM/Payment:	\$ 12,212.28
MCO Tax (3.0%)	\$ 377.70
Total Capitation Rate:	\$ 12,589.98

Program:	Alliance
Rate Cell:	19-36 Female

Member Months:	48,670
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 17.71	\$ 2,812.42	76	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 18.32	\$ 2,812.42	78
Inpatient Hospital - BH	\$ -	\$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	\$ -	\$ -	-
Outpatient Hospital	\$ 18.52	\$ 687.32	323	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 19.16	\$ 711.09	323
Outpatient Hospital - BH	\$ 0.00	\$ 284.59	0	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.00	\$ 294.43	0
Emergency Room	\$ 5.20	\$ 931.49	67	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 5.38	\$ 963.71	67
Physician	\$ 30.15	\$ 173.43	2,086	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 32.26	\$ 167.57	2,310
Physician - BH	\$ 0.49	\$ 126.92	46	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.50	\$ 131.31	46
FQHC	\$ 47.27	\$ 114.13	4,970	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 50.58	\$ 110.28	5,504
Home Health	\$ 0.46	\$ 488.58	11	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 0.47	\$ 488.58	12
Nursing Facility	\$ 0.81	\$ 507.70	19	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 0.81	\$ 507.70	19
Pharmacy	\$ 19.22	\$ 38.58	5,978	10.0%	7.0%	2.8%	0.0%	0.0%	\$ 26.62	\$ 48.61	6,571
Dental	\$ 12.62	\$ 148.09	1,023	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 12.62	\$ 148.09	1,023
DME/Supply	\$ 1.28	\$ 163.35	94	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 1.28	\$ 163.35	94
Transportation	\$ 1.07	\$ 26.38	487	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 1.07	\$ 26.38	487
Lab & Radiology	\$ 48.16	\$ 131.50	4,395	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 48.16	\$ 131.50	4,395
Other	\$ 0.02	\$ 58.47	4	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 0.02	\$ 58.47	4
<b>Total</b>	\$ 202.98	N/A	19,580	2.0%	0.0%	2.0%	0.0%	0.0%	\$ 217.26	N/A	20,933

New Populations Add on Adjustment:	\$ -
Gross Medical PMPM/Payment:	\$ 217.26
Non-Benefit Expense PMPM/Payment:	
General Administration (7.8%)	\$ 19.40
Care Management (3.6%)	\$ 8.95
Underwriting Gain (1.75%)	\$ 4.37
Total Service Cost and Non-Benefit Load PMPM/Payment:	\$ 249.98
MCO Tax (3.0%)	\$ 7.73
Total Capitation Rate:	\$ 257.71

Program:	Alliance
Rate Cell:	19-36 Male

Member Months:	29,617
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 13.58	\$ 2,802.02	58	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 14.05	\$ 2,802.02	60
Inpatient Hospital - BH	\$ 2.44	\$ 2,826.43	10	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 2.53	\$ 2,924.17	10
Outpatient Hospital	\$ 24.03	\$ 1,184.01	244	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 24.86	\$ 1,224.95	244
Outpatient Hospital - BH	\$ 0.14	\$ 1,429.86	1	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.14	\$ 1,479.31	1
Emergency Room	\$ 3.92	\$ 818.25	57	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 4.05	\$ 846.55	57
Physician	\$ 36.51	\$ 304.09	1,441	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 39.06	\$ 293.82	1,595
Physician - BH	\$ 0.58	\$ 132.21	52	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.59	\$ 136.78	52
FQHC	\$ 18.34	\$ 102.92	2,138	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 19.62	\$ 99.45	2,368
Home Health	\$ 0.17	\$ 361.19	6	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 0.18	\$ 361.19	6
Nursing Facility	\$ 0.12	\$ 371.21	4	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 0.12	\$ 371.21	4
Pharmacy	\$ 29.29	\$ 92.80	3,788	10.0%	7.0%	2.8%	0.0%	0.0%	\$ 40.57	\$ 116.94	4,163
Dental	\$ 13.68	\$ 156.86	1,046	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 13.68	\$ 156.86	1,046
DME/Supply	\$ 0.62	\$ 226.36	33	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 0.62	\$ 226.36	33
Transportation	\$ 1.32	\$ 53.98	294	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 1.32	\$ 53.98	294
Lab & Radiology	\$ 15.97	\$ 106.87	1,793	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 15.97	\$ 106.87	1,793
Other	\$ 0.09	\$ 164.46	6	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 0.09	\$ 164.46	6
<b>Total</b>	\$ 160.79	N/A	10,971	2.9%	0.9%	2.0%	0.0%	0.0%	\$ 177.45	N/A	11,733

New Populations Add on Adjustment:	\$ -
Gross Medical PMPM/Payment:	\$ 177.45
Non-Benefit Expense PMPM/Payment:	
General Administration (8.9%)	\$ 18.33
Care Management (3.5%)	\$ 7.31
Underwriting Gain (1.75%)	\$ 3.62
Total Service Cost and Non-Benefit Load PMPM/Payment:	\$ 206.70
MCO Tax (3.0%)	\$ 6.39
Total Capitation Rate:	\$ 213.10

Program:	Alliance
Rate Cell:	37-49 Female

Member Months:	35,399
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 34.94	\$ 3,114.33	135	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 36.14	\$ 3,114.33	139
Inpatient Hospital - BH	\$ 0.16	\$ 948.12	2	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.16	\$ 980.90	2
Outpatient Hospital	\$ 40.88	\$ 863.90	568	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 42.29	\$ 893.78	568
Outpatient Hospital - BH	\$ 0.03	\$ 152.41	2	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.03	\$ 157.69	2
Emergency Room	\$ 8.03	\$ 908.44	106	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 8.31	\$ 939.85	106
Physician	\$ 63.75	\$ 246.12	3,108	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 68.21	\$ 237.81	3,442
Physician - BH	\$ 0.58	\$ 119.50	58	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.60	\$ 123.63	58
FQHC	\$ 43.71	\$ 121.07	4,332	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 46.77	\$ 116.99	4,797
Home Health	\$ 0.51	\$ 415.83	15	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 0.53	\$ 415.83	15
Nursing Facility	\$ 1.54	\$ 805.07	23	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 1.54	\$ 805.07	23
Pharmacy	\$ 63.96	\$ 64.02	11,989	10.0%	7.0%	2.8%	0.0%	0.0%	\$ 88.58	\$ 80.67	13,177
Dental	\$ 13.58	\$ 142.50	1,144	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 13.58	\$ 142.50	1,144
DME/Supply	\$ 2.93	\$ 232.84	151	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 2.93	\$ 232.84	151
Transportation	\$ 1.68	\$ 19.72	1,021	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 1.68	\$ 19.72	1,021
Lab & Radiology	\$ 50.04	\$ 132.64	4,527	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 50.04	\$ 132.64	4,527
Other	\$ 0.35	\$ 389.11	11	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 0.35	\$ 389.11	11
<b>Total</b>	\$ 326.65	N/A	27,191	3.0%	0.9%	2.1%	0.0%	0.0%	\$ 361.74	N/A	29,183

New Populations Add on Adjustment:	\$ -
Gross Medical PMPM/Payment:	\$ 361.74
Non-Benefit Expense PMPM/Payment:	
General Administration (5.7%)	\$ 23.29
Care Management (3.7%)	\$ 14.90
Underwriting Gain (1.75%)	\$ 7.12
Total Service Cost and Non-Benefit Load PMPM/Payment:	\$ 407.05
MCO Tax (3.0%)	\$ 12.59
Total Capitation Rate:	\$ 419.63



Program:	Alliance
Rate Cell:	37-49 Male

Member Months:	25,124
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 39.85	\$ 2,355.09	203	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 41.23	\$ 2,355.09	210
Inpatient Hospital - BH	\$ 1.65	\$ 1,618.99	12	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 1.70	\$ 1,674.98	12
Outpatient Hospital	\$ 23.01	\$ 996.22	277	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 23.81	\$ 1,030.67	277
Outpatient Hospital - BH	\$ 0.02	\$ 138.17	2	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.02	\$ 142.94	2
Emergency Room	\$ 6.09	\$ 923.74	79	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 6.30	\$ 955.68	79
Physician	\$ 83.58	\$ 406.06	2,470	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 89.43	\$ 392.35	2,735
Physician - BH	\$ 0.71	\$ 113.13	75	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.73	\$ 117.04	75
FQHC	\$ 22.82	\$ 105.86	2,587	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 24.42	\$ 102.29	2,865
Home Health	\$ 0.13	\$ 447.81	4	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 0.14	\$ 447.81	4
Nursing Facility	\$ 0.89	\$ 379.19	28	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 0.89	\$ 379.19	28
Pharmacy	\$ 49.95	\$ 72.31	8,289	10.0%	7.0%	2.8%	0.0%	0.0%	\$ 69.17	\$ 91.12	9,110
Dental	\$ 12.84	\$ 153.31	1,005	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 12.84	\$ 153.31	1,005
DME/Supply	\$ 3.29	\$ 531.46	74	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 3.29	\$ 531.46	74
Transportation	\$ 1.87	\$ 50.21	446	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 1.87	\$ 50.21	446
Lab & Radiology	\$ 20.22	\$ 99.20	2,446	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 20.22	\$ 99.20	2,446
Other	\$ 0.80	\$ 1,275.86	8	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 0.80	\$ 1,275.86	8
<b>Total</b>	\$ 267.72	N/A	18,004	3.1%	0.9%	2.2%	0.0%	0.0%	\$ 296.87	N/A	19,376

New Populations Add on Adjustment:	\$ -
Gross Medical PMPM/Payment:	\$ 296.87
Non-Benefit Expense PMPM/Payment:	
General Administration (6.4%)	\$ 21.54
Care Management (3.6%)	\$ 12.23
Underwriting Gain (1.75%)	\$ 5.89
Total Service Cost and Non-Benefit Load PMPM/Payment:	\$ 336.52
MCO Tax (3.0%)	\$ 10.41
Total Capitation Rate:	\$ 346.93

Program:	Alliance
Rate Cell:	50+ Female

Member Months:	28,576
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 117.14	\$ 3,260.41	431	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 121.19	\$ 3,260.41	446
Inpatient Hospital - BH	\$ 0.75	\$ 2,135.44	4	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.78	\$ 2,209.29	4
Outpatient Hospital	\$ 100.13	\$ 900.56	1,334	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 103.59	\$ 931.70	1,334
Outpatient Hospital - BH	\$ 0.01	\$ 147.61	1	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.01	\$ 152.71	1
Emergency Room	\$ 9.24	\$ 997.73	111	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 9.55	\$ 1,032.24	111
Physician	\$ 145.21	\$ 264.01	6,600	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 155.38	\$ 255.09	7,309
Physician - BH	\$ 0.46	\$ 94.56	58	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.47	\$ 97.83	58
FQHC	\$ 41.00	\$ 124.19	3,961	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 43.87	\$ 120.00	4,387
Home Health	\$ 1.34	\$ 491.76	33	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 1.38	\$ 491.76	34
Nursing Facility	\$ 9.02	\$ 461.02	235	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 9.02	\$ 461.02	235
Pharmacy	\$ 173.39	\$ 73.49	28,315	10.0%	7.0%	2.8%	0.0%	0.0%	\$ 240.14	\$ 92.60	31,121
Dental	\$ 9.28	\$ 159.46	698	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 9.28	\$ 159.46	698
DME/Supply	\$ 6.43	\$ 272.05	283	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 6.43	\$ 272.05	283
Transportation	\$ 2.66	\$ 23.36	1,366	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 2.66	\$ 23.36	1,366
Lab & Radiology	\$ 68.63	\$ 123.97	6,643	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 68.63	\$ 123.97	6,643
Other	\$ 1.61	\$ 701.47	28	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 1.61	\$ 701.47	28
<b>Total</b>	\$ 686.28	N/A	50,101	3.6%	1.3%	2.2%	0.0%	0.0%	\$ 773.97	N/A	54,057

New Populations Add on Adjustment:	\$ -
Gross Medical PMPM/Payment:	\$ 773.97
Non-Benefit Expense PMPM/Payment:	
General Administration (4%)	\$ 34.38
Care Management (3.7%)	\$ 31.88
Underwriting Gain (1.75%)	\$ 14.97
Total Service Cost and Non-Benefit Load PMPM/Payment:	\$ 855.20
MCO Tax (3.0%)	\$ 26.45
Total Capitation Rate:	\$ 881.65

Program:	Alliance
Rate Cell:	50+ Male

Member Months:	16,476
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Base Period:	May 1, 2017 to April 30, 2018
Contract Period:	October 1, 2020 to September 30, 2021
Trend Months:	41

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Category of Service	Base Data			Trend			Program Changes	Managed Care	Total Medical		
	PMPM	Unit Cost	Util/1000	PMPM	Unit Cost	Util/1000	PMPM	PMPM	PMPM	Unit Cost	Util/1000
Inpatient Hospital	\$ 139.41	\$ 2,479.23	675	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 144.23	\$ 2,479.23	698
Inpatient Hospital - BH	\$ 1.05	\$ 1,153.98	11	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 1.09	\$ 1,193.88	11
Outpatient Hospital	\$ 103.74	\$ 983.20	1,266	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 107.33	\$ 1,017.20	1,266
Outpatient Hospital - BH	\$ 0.03	\$ 261.99	1	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 0.03	\$ 271.05	1
Emergency Room	\$ 10.58	\$ 1,079.29	118	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 10.94	\$ 1,116.62	118
Physician	\$ 195.20	\$ 303.25	7,724	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 208.86	\$ 293.02	8,554
Physician - BH	\$ 1.25	\$ 155.75	96	1.0%	1.0%	0.0%	0.0%	0.0%	\$ 1.29	\$ 161.13	96
FQHC	\$ 36.73	\$ 114.77	3,840	2.0%	-1.0%	3.0%	0.0%	0.0%	\$ 39.30	\$ 110.90	4,253
Home Health	\$ 5.41	\$ 859.88	75	1.0%	0.0%	1.0%	0.0%	0.0%	\$ 5.59	\$ 859.88	78
Nursing Facility	\$ 19.44	\$ 460.75	506	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 19.44	\$ 460.75	506
Pharmacy	\$ 173.29	\$ 67.91	30,619	10.0%	7.0%	2.8%	0.0%	0.0%	\$ 239.99	\$ 85.58	33,653
Dental	\$ 10.92	\$ 159.36	822	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 10.92	\$ 159.36	822
DME/Supply	\$ 5.66	\$ 323.58	210	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 5.66	\$ 323.58	210
Transportation	\$ 3.28	\$ 42.04	937	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 3.28	\$ 42.04	937
Lab & Radiology	\$ 56.70	\$ 118.55	5,740	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 56.70	\$ 118.55	5,740
Other	\$ 2.63	\$ 1,006.29	31	0.0%	0.0%	0.0%	0.0%	0.0%	\$ 2.63	\$ 1,006.29	31
<b>Total</b>	\$ 765.31	N/A	52,672	3.4%	1.0%	2.3%	0.0%	0.0%	\$ 857.29	N/A	56,974

New Populations Add on Adjustment:	\$ -
Gross Medical PMPM/Payment:	\$ 857.29
Non-Benefit Expense PMPM/Payment:	
General Administration (3.9%)	\$ 36.62
Care Management (3.7%)	\$ 35.31
Underwriting Gain (1.75%)	\$ 16.55
Total Service Cost and Non-Benefit Load PMPM/Payment:	\$ 945.77
MCO Tax (3.0%)	\$ 29.25
Total Capitation Rate:	\$ 975.02

Rate Component	Opt-Outs	TANF Adults 19+
Projected MMs	53,968	1,336,514
Blended Base PMPM	\$ 617.82	\$ 325.60
Trend	\$ 38.96	\$ 24.45
Program Changes	\$ 30.09	\$ 16.57
Managed Care Adjustment	\$ (44.78)	\$ -
<b>Projected Medical PMPM</b>	<b>\$ 642.09</b>	<b>\$ 366.62</b>

**Overall TANF 19+ PMPM with New Populations:**

<b>\$ 377.31</b>
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**New Populations Add on Adjustment:**

<b>\$ 10.69</b>
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## OTHER CONSIDERATIONS

### RISK ADJUSTMENT

For the DCHFP, DHCF intends to utilize risk adjustment to differentiate rates by MCO based on the relative health cost risk of each MCOs covered population. The risk adjustment process scores individuals for their relative health cost risk, including a demographic factor to account for the age differentials within the rate cells. MCO-specific risk scores are developed for the following rate cells only:

- Children 1–18
- TANF Adults 19+
- SSI Adults 21+

DHCF intends to determine final capitation rates by adjusting the base capitation rates described in this memo using a budget-neutral risk score by rate cell and MCO. The anticipated risk adjustment model is the CDPS +Rx model. DHCF will evaluate risk scores at least quarterly for the FFY 2021 contract period.

Appendix C contains the prior risk adjustment methodology document for reference.

### PERFORMANCE WITHHOLDS

Providing incentives to Contractors for high quality performance is an important component of DHCF's overall strategy to improve the quality of care received by enrollees. DHCF intends to utilize financial performance-based incentives to encourage CQI and, therefore, improvement in quality of care received by enrollees. Currently, the Performance-Based Incentive Program is under design by DHCF. Final rates will include consideration as appropriate when the specifications of the program are determined.

### MEDICAL LOSS RATIO (MLR)

From a rate-setting standpoint, 42 CFR 438.4(b)(9) stipulates that rates must be established in such a way that a MCO would reasonably achieve a MLR of at least 85%. From a financial reporting perspective, CMS prescribes the MLR calculation methodology in 42 CFR 438.8 for states and their contractors including how to classify various incurred costs and how to develop the numerator and denominator included in the ratio. The capitation rates are developed independent of the MLR implications and are based on anticipated, reasonable expenditures required to meet the obligations put forth in the RFP.

The capitation rates have not been developed based on a target MLR, nor are they influenced by any potential remittance process to be implemented by the District. DHCF will collect data to support the calculation of each MCO's MLR and will require remittance of payments for MLR under 85%.

# APPENDIX A

## NEW POPULATION PROGRAM CODE MAPPING

### FORMER OPT-OUTS:

PROGRAM CODE	PROGRAM CODE
320	242
330	242T
720	271
730	271P
820	420
960	470
221	774
221B	774D
221Q	774F
221T	774P
222	820C
222P	921
231	931
231Q	931Q
241	938G
241P	

### SSI ADULTS 21+:

PROGRAM CODE	PROGRAM CODE
850	740
110	740T
140	750
150	910
710	941
710T	950

# APPENDIX B

## CATEGORY OF SERVICE LOGIC

The table below outlines the logic used in the summarization of the FFS and encounter data to map the data by COS assigned by Conduent into the service categories for this Rate Report.

### COS CODING LOGIC

COS	LOGIC
Inpatient Hospital	01, 26, 40 + unknown COS with inpatient claim type
Inpatient Hospital — BH	04, 08, 19, 20 + inpatient hospital claims meeting the mental health indicator (see note below)
Outpatient Hospital	02, 29, 30, 34, 41 + unknown COS with outpatient claim type
Outpatient Hospital — BH	14 + unknown COS with outpatient hospital claims meeting the mental health indicator (see note below)
Emergency Room	Any claims meeting the emergency room logic (see note below)
Physician	05, 10, 11, 22, 23, 25, 28, 32, 35, 42 + unknown COS with all other professional services claim types
Physician — BH	09 or; 07, 31, and other physician claims meeting the mental health indicator (see note below)
FQHC	Provider type X05
Home Health	06, 07, + unknown COS with home health claim type
Nursing Facility	04, 18, 19
Pharmacy	Based on pharmacy claims submitted directly by the MCO
Dental	12
DME/Supplies	24 + unknown COS with Medical Supply (DME) claim type
Transportation	Encounter logic: 37, 38, 39, 43, 56 FFS logic: Based on transportation claims submitted directly by the MCO
Lab & Radiology	03 + unknown COS with Lab claim type



COS	LOGIC
Other Services	13, 17,18, 31, 33 + unknown COS with vision and hearing claim type

### Mental Health Codes and Descriptions

Mercer categorized any claims with a primary diagnosis of mental health into the corresponding mental health service category. For example, if an inpatient hospital claim with COS '01' was identified as being primarily mental health, the claim was summarized as Inpatient Hospital — BH rather than Inpatient Hospital – PH. Mental health services are defined using the appropriate International Classification of Diseases (ICD)-10 diagnosis code, in addition to All Patient Refined Diagnosis Related Group (APR-DRG) codes

Mercer separated mental health services from other acute care encounters and FFS claims using the following logic:

- APR-DRG codes 740, 750–760, 770, 772–776 and ICD-10 diagnosis of F01–F99

### Emergency Room Logic

Mercer separated Emergency Room services from other outpatient hospital encounters using the following logic:

- Physician Component: Health Insurance Portability and Accountability Act (HIPAA) Place of Service Code “23” and Procedure Code 99281–99285
- Facility Component: Revenue Code 450–459 and Procedure Code 99281–99285

# APPENDIX C

## RISK ADJUSTMENT METHODOLOGY DOCUMENT

## **DISTRICT OF COLUMBIA HEALTHY FAMILIES PROGRAM RISK ADJUSTMENT METHODOLOGY RATE UPDATE EFFECTIVE OCTOBER 1, 2019-DECEMBER 31, 2019**

The District of Columbia (District) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop a risk adjustment methodology that will be applied to actuarially sound capitation rates effective during the October 1, 2019 to September 30, 2020 (Federal Fiscal Year [FFY] 2020) contract period. The managed care organization (MCO) specific risk scores will be recalculated every three months during the contract period. The risk adjustment methodology outlined in this document is applicable to the risk adjustment factors that will be used to adjust the capitation rates from October 1, 2019 to December 31, 2019.

This document and attachments provide the following information:

- An overview of the FFY 2020 risk adjustment methodology:
  - Appendix A (Chronic Illness and Disability Payment System [CDPS]+ Prescription [Rx] Background)
- FFY 2020 Risk Adjustment Review results for the October 1, 2019 to December 31, 2019 period including:
  - Exhibit 1 (MCO Risk Score Distribution)
  - Exhibit 2 (Final Risk Adjusted Rates)
  - Exhibit 3 (Contract Rate Exhibit)
  - Exhibit 4 (CDPS+Rx Model Category Distribution)

### **RISK ADJUSTMENT METHODOLOGY**

The risk adjustment results will be applied to a component of the base capitation rates for the District of Columbia Healthy Families Program (DCHFP) by the following consolidated rate cells:

- Children 1-18
- Legacy Adults 19+
- 271 Adults 21+

The rate structure for maternity, month of birth and Children < 1 will not be risk adjusted. Therefore, costs associated with these payments are not included within the risk adjustment model development. While the delivery costs are not reflected within the cost structure of the model (since there is a maternity supplemental payment), pregnant women are still included in the risk adjustment process and are evaluated in the same manner as all other eligible recipients.

In general, payments to MCOs are determined by multiplying a base capitation rate for the risk adjusted populations by each MCO's normalized risk score and by their enrollment. Each MCO risk score was derived from the average of the risk scores of enrollees for each population group in that MCO. Enrollees with at least six months of Medicaid eligibility in the 12-month study period were assigned a risk score using diagnostic, pharmaceutical and demographic information.

The FFY 2020 base capitation rates for DCHFP have been split into two distinct components for purposes of risk adjustment. A component of the rates associated with the fixed administrative expenses for contractually-required staff positions will not be risk adjusted. The remainder of the base rate, including all medical expenses and the majority of the administrative load, is risk adjusted. The components of the rates are illustrated in Exhibit 2.

To measure the risk associated with each MCO, the District evaluated possible risk adjustment models that could measure risk using demographic indicators in addition to disease history. While many risk adjustment models exist, the District applied a risk adjustment model that was specifically designed for medical assistance populations. The District chose the CDPS+Rx model to risk adjust the DCHFP capitation rates. As discussed below, the CDPS+Rx model was calibrated for use in the DCHFP program.

## CDPS+RX MODEL BACKGROUND

The CDPS model was designed by the University of California, San Diego (UCSD) in conjunction with clinical consultants who assisted in the disease classification process. In 2008, UCSD updated the CDPS model and disease classifications. As part of this update, UCSD created a diagnostic and pharmacy combined model. This model uses the diagnostic classification from the CDPS model in conjunction with select pharmacy categories from the MedRx model (restricted version). The combined diagnostic and pharmacy based model is referred to as CDPS+Rx. Through the years since the original release, UCSD has made updates to the CDPS+Rx model to include newly introduced drugs and refine the disease classification process for some historical drugs, as well as data time period updates. None of the model updates have changed the demographic or disease condition categories. The most recently available version of the CDPS+Rx model, Version 6.3 was used for DCHFP.

The encounter and pharmacy data are used in conjunction with member demographics (age and gender categories) to measure each population's anticipated health risk. The model assigns each member to one of 11 age/gender categories and to one or more (if applicable) of 56 medical condition categories based on the diagnosis information contained in the encounter data as well as 15 medical condition categories based on the prescription drugs usage of each member. Each of the age/gender and medical condition categories are assigned a numerical value, referred to as cost weights, which can be interpreted as relative

risk values for members classified into the age/gender or medical condition category. A member's risk score is calculated by summing all applicable cost weights based on the member's age/gender demographic category and medical condition categories as identified using the medical and pharmacy data.

Additional details on the application of the CDPS+Rx model are included in Appendix A.

#### DISTRICT SPECIFIC CDPS+RX MODEL

The CDPS+Rx model offers two methods for assessing health risk. The first approach is referred to as the “prospective method”, which measures existing conditions and their ability to predict future health care costs. The second approach is referred to as the “concurrent method”, which measures existing conditions and their ability to measure existing or past risk. Because the prospective application methodology (that uses existing conditions to predict future health care intensity) is consistent with the current prospective capitation rate range development process, the prospective method is used to adjust capitation payments.

In Mercer's development of a District-specific model, the national model weights were tailored to align with the DCHFP benefit package. Mercer worked with the model developers at UCSD to adjust the cost weights developed from the national data set for use in the District. While the CDPS+Rx framework utilized to classify claims into disease categories remains unchanged, the weights within the model were adjusted to match the covered benefits within the DCHFP program. Since HIV/AIDS-related pharmacy drugs are not part of the MCO-covered benefits, the model cost weight for the applicable categories were adjusted accordingly. As mentioned previously, adjustments were made to the model to account for the removal of maternity services that are captured within the separate supplemental maternity payment rate. Behavioral health (BH) services were removed from the cost weight development, since the majority of these services are not a managed care covered benefit.

Because of the distinct differences in treatment and relative costs among the unique population groups covered by Medicaid, the model developers at UCSD have created separate cost weight structures for multiple populations. The table below shows each population group that will be risk adjusted, along with the corresponding model weights that will be applied.

CDPS+RX COST WEIGHT	DCHFP POPULATION
TANF Children (adjusted for BH)	Children 1-18
TANF Adults (adjusted for BH)	Legacy Adults 19+
TANF Adults (adjusted for BH)	271 Adults 21+

(TANF = temporary assistance to needy families)

Using the adjusted District-specific version of the CDPS+Rx model, the most recent and complete data available is used to evaluate the underlying risk of the MCOs participating in the DCHFP. Below are the high-level steps that were used in assessing the population's risk for payments and will be covered in more detail in the remainder of this document:

- Collect encounter, pharmacy and eligibility data
- Select the appropriate CDPS+Rx model based on each recipient rate cell as of the enrollment snapshot month
- Calculate the individual risk scores for those with sufficient historical experience within the 12-month measurement period
- Assign recipients to a rate cell and MCO
- Assign assumed risk scores to recipients who did not receive a score (unscored recipients)
- Combine risk scores for scored and unscored recipients and calculate raw risk scores by rate cell and MCO
- Adjust combined risk scores for each risk adjusted rate cell to maintain budget neutrality
- Apply final risk scores to the applicable portion of the base capitation rates

## DATA COLLECTION

The cornerstone of any risk adjustment process is the data used to identify member demographics in order to classify members into diagnostic-related conditions. A 12-month data time period was used to measure the anticipated health risk for each recipient; this 12-month time period is referred to as the study period. Mercer collected encounter, pharmacy and eligibility data from the District's fiscal agent (Conduent) to support this analysis. These data include MCO-reported encounter claims and pharmacy data and fee-for-service (FFS) pharmacy claims with dates of service from October 1, 2017 through September 30, 2018 and include claims reported to the District through March 2019 for encounter claims and May 2019 for all pharmacy data. The eligibility information used in the data analysis is summarized from the District's eligibility file provided by Conduent, which outlines the MCO enrollment segments for each member as of June 2019. Although the MCOs are not at risk for claims paid by FFS (and the risk adjustment model was adjusted accordingly), for MCO-enrolled members, claims paid for non-managed care covered benefits (e.g., HIV/AIDS drugs) were also included in the analysis for disease condition flagging.

## INDIVIDUAL RISK SCORE DEVELOPMENT

Using data in the study period, each recipient was processed through the CDPS+Rx model. This step resulted in recipients being assigned to demographic categories and disease conditions, specific to the model. For demographic classifications, each recipient's age was calculated at the end of the study period. This information was then combined with the cost weight values associated with the CDPS+Rx model categories. The combination of the appropriate cost weights produced a risk score for each recipient.

For the diagnosis indicators, the presence of a single diagnosis, regardless of position on the claim (primary, secondary, tertiary, etc.), or a single national drug code is sufficient to support a classification into a CDPS+Rx diagnostic category. To be consistent with the most current risk adjustment protocol, the diagnoses on claims/encounter records that do not involve an encounter with a professional medical provider, such as laboratory and diagnostic radiology claims, have been excluded from the disease classification process, since such data is often a "rule-out" diagnosis. An exception to this protocol is inpatient laboratory and radiology claims/encounters, which are submitted in a consolidated (header) format; they are not excluded from the analysis. Due to the use of some radiology services as therapeutic radiology for specified disease conditions, these encounters are included in the risk assessment process.

Risk scores are only developed for recipients with at least six months of Medicaid eligibility within the 12-month study period (referred to as the six-month scoring criteria). Medicaid eligibility includes FFS and managed care enrollment segments. The six-month scoring criteria do not require continuous eligibility. Only recipients with six or more months of eligibility from October 1, 2017 through September 30, 2018 were assigned a risk score.

## MCO RISK SCORE DEVELOPMENT

Each recipient is assigned to an MCO and a consolidated risk adjustment rate cell based upon the recipient's enrollment status as of June 2019. Each recipient's risk adjustment rate cell as of June 2019 was used to determine which corresponding cost weights were appropriate to be used to measure that recipient's health risk.

The raw MCO risk scores are developed by aggregating the risk scores by rate cell, where each scored individual enrolled during the point-in-time estimate is equally weighted (straight average). Members that did not meet the six-month scoring criteria (i.e., unscored) receive the average of the scored individual's aggregate factor for their corresponding demographic cohort. The aggregated factors for the scored members within each demographic cohort are calculated using District-wide member risk scores. To arrive at the final unadjusted MCO risk score for each MCO and rate cell, the average risk scores for the scored population is weighted with the assumed risk scores for the unscored population.

## BUDGET NEUTRALITY

To ensure that the risk adjustment application does not result in unintended reductions or increases in total capitation payments, the unadjusted MCO risk scores are adjusted by the total population's average risk score by rate cell. This produces the MCOs' relative risk scores. The intent of this adjustment is to recalibrate all of the MCO risk scores to yield a population average of 1.0, thereby maintaining the budget neutrality of the managed care program. To calculate the population average used within the budget

neutrality calculation, each MCO's unadjusted risk score was weighted by the number of total enrolled members, including scored and unscored recipients. Budget neutrality calculations are performed separately for each rate cell. Please refer to Exhibit 1 for a table of the budget-neutral risk scores by rate cell.

### RISK-ADJUSTED CAPITATION RATES

To calculate the final risk-adjusted capitation rates, the MCO adjusted risk scores are applied to the risk adjusted portion of the capitation rates. The non-risk adjusted administrative component of the rate is added to produce the final MCO risk-adjusted capitation rates.

The risk adjustment process described above was developed in accordance with the CDPS+Rx model, a generally accepted risk adjustment grouper, and meets the requirements of the Centers for Medicare & Medicaid Services (CMS) regulations 42 CFR § 438.5 and 42 CFR § 438.7 and follows the guidelines established by Actuarial Standard of Practice No. 45 (the use of health status based risk adjustment methodologies). The use of the CDPS+Rx model has been CMS approved to risk adjust payments for other Medicaid programs.

### QUARTERLY UPDATES TO RISK-ADJUSTED CAPITATION RATES

The FFY 2020 capitation rates will be updated periodically to reflect emerging data so that the MCO risk scores capture changes in the relative risk of each MCO's covered population. The MCO risk scores and risk adjusted rates will be updated quarterly as outlined below:

- **Capitation rate effective January 1, 2020 - March 31, 2020:** Updated eligibility data will be used to reflect changes in enrollment within the MCOs. The individual risk scores calculated in the development of the October 1, 2019 - December 31, 2019 rates will remain unchanged, but the MCO risk scores will reflect updated enrollment data.
- **Capitation rate effective April 1, 2020 - June 30, 2020:** Updated eligibility, encounter and pharmacy data will be analyzed to capture changes in individual risk scores. The individual risk scores will be re-calculated for each recipient based on claims incurred from April 1, 2018 to March 31, 2019. The MCO risk scores will be calculated using the updated individual data and the updated MCO enrollment data.
- **Capitation rate effective July 1, 2020 - September 30, 2020:** Updated eligibility data will be used to reflect changes in enrollment within the MCOs. The individual risk scores calculated in the development of the April 1, 2020 - June 30, 2020 rates will remain unchanged, but the MCO risk scores will reflect updated enrollment data.

### CAVEATS

In preparing the risk scores for both the members and the MCOs, Mercer has used and relied upon enrollment, eligibility, encounter and other information supplied by the Department of Health Care Finance (DHCF) and its vendors. DHCF and its vendors are solely responsible for the validity and completeness of these supplied data and information. Mercer has reviewed the data and information for internal consistency



and reasonableness, but we did not audit them. In our opinion it is appropriate for the intended risk adjustment purpose. However, if the data and information are incomplete/inaccurate, the values and observations noted in this report may differ significantly from values and observations that would be obtained with accurate and complete information; this may require a later revision to this report.

The final MCO risk scores developed from the methodology described above are projections of estimated relative risk. Actual relative risk may differ from the estimated levels. The District will use the final MCO factors to adjust the variable component of the base capitation rates in effect for the October 1, 2019 through December 31, 2019 period as a means of matching MCO payments to their relative risks. Use of the risk adjustment results for any purpose beyond that stated may not be appropriate, and Mercer and the District are not responsible for the consequences for any unauthorized use.

All estimates are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any purpose than for which it was issued. Mercer and the District are not responsible for the consequences of any unauthorized use.

The risk adjustment model produces precise adjustment factors that are applied to the variable portion of the base capitation rates. However, acceptable variation exists within the calculated results due to the specific risk adjustment model chosen, the various assumptions applied and the availability and accuracy of the source data utilized. While health-based risk adjustment is not a perfect system that predicts all variation in individual and MCO costs, published results have shown that using health status as a predictor of costs is a significant improvement over age/gender rating alone. The risk adjustment model has been developed using an objective set of assumptions that are not intended to provide an advantage or disadvantage to any specific MCO. Per CMS guidelines, these final risk adjustment factors have been normalized to produce "budget neutral" results. If any material changes to these final results become necessary, all factors would need to be renormalized and payments should be reallocated across the MCOs in order to maintain budget neutrality.

This letter assumes the reader is familiar with DCHFP, Medicaid eligibility rules, risk adjustment and actuarial rating techniques. It has been prepared exclusively for the District, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections and risk adjustment to understand the technical nature of these results. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

## CONCLUSION

Mercer appreciates the opportunity to provide additional information supporting the development of the FFY 2020 risk adjusted capitation rates. We are available to answer any questions on the material contained in this letter or to provide explanation or further details, as may be appropriate. The Actuary noted below meets the qualification standards of the American Academy of Actuaries to render the actuarial opinion contained in this letter.

Jonathan C. Marsden, FSA, MAAA  
Partner

## RISK ADJUSTMENT EXHIBITS

The appendix and exhibits show details of the risk adjustment process for each MCO and risk-adjusted rate cell.

- Exhibit 1, MCO Risk Score Distribution, indicates each MCO's enrollment, scored percentages and risk score information (both unadjusted and budget neutral) for each applicable risk-adjusted rate cell.
- Exhibit 2 shows the final risk-adjusted capitation rates for each MCO.
- Exhibit 3 provides the contract rate summary for all MCOs and rate cells, including non-risk-adjusted rate cells. Exhibit 3 also illustrates the contract rates reflecting the withhold for the pay-for-performance program (P4P).
- Exhibit 4, CDPS+Rx Model Category Distribution, details the calculation of each MCO's unadjusted risk score by displaying demographic and disease category prevalence, along with the cost weights applicable for each risk-adjusted rate cell. Exhibit 4 also shows the calculation of each MCO's final budget-neutral risk score.

## APPENDIX A

### CDPS+Rx Background

This Appendix contains additional background information related to the CDPS+Rx risk adjustment model.

The intent of the CDPS+Rx model is to include readily available demographic and disease characteristics that are valid and accurate estimators of current and future health care costs. As many services require the provision of diagnoses in order to receive payment for services rendered, the presence of diagnoses on electronic claims information is a viable method of collecting data for risk adjustment purposes. Many diagnoses are indicative of symptoms rather than a specific disease condition that is likely to persist. For example, a diagnosis of chest pain can be indicative of many conditions and is most likely not a good estimator/predictor of health care expense. Along with ill-defined conditions, claims/encounter records that do not involve an encounter with a physician, such as laboratory and diagnostic radiology claims, were excluded from the risk adjustment process for professional services and other categories thought to produce false positive diagnosis information. In this instance, false positives are defined as conditions that may be prematurely or incorrectly identified through laboratory or diagnostic radiology tests performed in order to “rule-out” certain illnesses (e.g., HIV/AIDS). We assume that a diagnosis that results from a laboratory or diagnostic radiology service will be seen on a subsequent provider encounter record for an office visit or procedure. Since claims and encounters for therapeutic services do not include “rule-out” diagnoses, the diagnoses on therapeutic radiology encounters are included in the risk adjustment process.

Once the ill-defined conditions and potential false positive data were isolated, the remaining diagnoses were placed into major categories. Some are representative of specific body systems (e.g., cardiovascular or pulmonary) and others fall into a group of illnesses that affect multiple systems (e.g., infectious disease or diabetes). These major categories are further delineated into subcategories based on their perceived medical intensity.

Prior to assessing the value associated with each of the CDPS+Rx categories, a protocol was established as to how individuals could be classified into one of the CDPS+Rx diagnostic categories. To reduce the effects of data reporting and possible abuse only a single diagnosis, regardless of position (primary, secondary, tertiary, etc.), is necessary to establish a CDPS+Rx diagnostic category. In the event that multiple conditions are identified within a major category, the individual is assigned to the subcategory with the highest intensity level. This protocol recognizes that individuals with multiple conditions in the same major category will most likely be treated simultaneously and not incur substantial additional costs. Although the CDPS+Rx model only incorporates the most serious diagnostic intensity within each major category, it recognizes the increased medical cost when multiple systems are affected with chronic conditions. For example, consider a person who is diagnosed with malignant melanoma (cancer, medium), lung cancer (cancer, high) and hypertension (cardiovascular, extra low). The risk score for this individual would include the relative cost weight associated with the cancer, high and cardiovascular, extra low categories.

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