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Children with Special Health Care Needs (CSHCN) and Substitute Care Data Book

State of Rhode Island

10-Month Rates for the period 9/1/2010 through 6/30/2011

WITH ARTICLE 20
As Enacted

Final & Confidential

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1

INTRODUCTION

The Rhode Island Department of Human Services (DHS, the State) requested that HealthCare Analytics assist with developing actuarially sound capitation rates for the rate period 9/1/2010 through 6/30/2011 for Children with Special Health Care Needs (CSHCN) and Children in Substitute Care Arrangements (Substitute Care), who are eligible for enrollment into the State's RIte Care program, a Medicaid managed care program implemented under the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration.

This document presents an outline of the development of actuarially sound capitation rates that were made consistent with the guidance provided in the Centers for Medicare and Medicaid Services (CMS) Rate Checklist, and which is sought for the purpose of attaining rate approval from CMS under 42 CFR 438.6(c).

The rates were developed from existing claims data for the target populations. Adjustments were made to account for off-line expenses not reflected in the claims data, as well as programmatic changes that will impact future claims. Such programmatic changes include CAITS services as in-plan benefits which became effective 4/1/2009, Generics Drugs First program initiative and an enacted legislative initiative referred to as 'Article 20' in this document. The data was smoothed to account for the variability in the claims experience due to the relatively small sizes of the target populations. The claims were trended forward to the rate period using the indicated trends in the claims data, tempered by observations of general trends in the marketplace for Medicaid managed care. Where appropriate, further adjustments were incorporated to account for the impact of managed care on the future claims expenses of the target populations. Finally, administrative and premium tax loads were included to develop actuarially sound capitation rates.

We relied on data and analysis produced by DHS and its subcontractors for the CSHCN and Substitute Care claims experience, data related to programmatic changes such as listed above and the following program initiatives and changes to develop the projected rates presented in this data book:

- Communities of Care
- Selective Contracting
- Impact of Drug Rebate Equalization (DRE) on standard plan pharmacy rebates
- Fraud & Abuse

The CSHCN and Substitute Care capitation rates were developed in consultation with the actuarial firm of Donlon & Associates, Inc., who also provided the certification letter required by CMS.

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CAPITATION RATES & DEMOGRAPHICS

The capitation rates representing the "blend" of currently enrolled managed care and target fee-for-service members for the rate period 9/1/2010 – 6/30/2011, including administrative and premium tax loads, are as follows:

Table 1
Capitation Rates

CSHCN and Substitute Care		
9/1/2010 - 6/30/2011		
Capitation Rates		
Population Cohort	**Base Period Average Members**	**PMPM Capitation Rates With Article 20**
Adoption Subsidy	1,613	**$ 335.33**
Katie Beckett	159	**$ 1,282.79**
SSI < 15	3,092	**$ 932.02**
SSI >= 15	1,896	**$ 778.12**
Substitute Care	2,304	**$ 635.72**

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RATE DEVELOPMENT METHODOLOGY

Claims & Enrollment Data

Claims and enrollment data was provided by DHS and its subcontractors on behalf of the State which we used to develop the capitation rates exhibited in the above table. The data and analysis was based on encounter and fee-for-service experience selected by certain qualifications established by the State, including: No Third Party Liability (TPL), In-Plan, in the Community, Rhode Island Residents, Not currently in the Kraft program.

The data reports covered State Fiscal Years (SFY) ending June 2007, 2008 and 2009, and were stated on an incurred basis, paid through September 2009 and estimated at 100% complete.

DHS staff provided the information with which we made adjustments to the claims data for SFY 2008 and SFY 2009. These adjustments were for off-line items not available in the claims data, identified through reconciliation efforts of the encounter data for the managed care populations between DHS staff and the plans.

Table 2
Average Eligible Members

CSHCN & Substitute Care
9/1/2010 - 6/30/2011

Average Eligible Members

Population Cohorts	SFY 2007	SFY 2008	SFY 2009
Adoption Subsidy	1,526	1,606	1,613
Katie Beckett	245	214	159
SSI < 15	3,237	3,191	3,092
SSI >= 15	1,921	1,928	1,896
Substitute Care	2,356	2,258	2,304

Eligible members represent "Target" population and include both currently enrolled (managed care) and not enrolled (fee-for-service), except Substitute Care where it is the managed care population only

Table 3
PMPM and Trends

In-Plan Services
Claims Paid PMPM & Trends
Incurred SFY, PT 9/09, est. 100% complete

PMPM with Offline Adjustments [1]

Population Cohorts	SFY 2007 Total	SFY 2008 Total	Adjusted SFY 2009 Total
Adoption Subsidy	$ 432.47	$ 260.27	$ 289.16
Katie Beckett	$ 903.72	$ 777.27	$ 1,226.44
SSI < 15	$ 865.39	$ 761.13	$ 770.44
SSI >= 15	$ 566.60	$ 634.00	$ 681.19
Substitute Care [2]	$ 482.96	$ 528.94	$ 526.94
Grand Total	$ 614.06	$ 573.12	$ 609.33

Population Cohorts	SFY 2008 over SFY 2007 Total	SFY 2009 over SFY 2008 Total	SFY 2009 over SFY 2007 Total
Adoption Subsidy	-39.8%	11.1%	-18.2%
Katie Beckett	-14.0%	57.8%	16.5%
SSI < 15	-12.0%	1.2%	-5.6%
SSI >= 15	11.9%	7.4%	9.6%
Substitute Care [2]	9.5%	-0.4%	4.5%
Grand Total	-6.7%	6.3%	-0.4%

[1] PMPMs include offline adjustments, which are identified through the reconciliation efforts between DHS and the health plans for claims-related expenses not reflected in the encounter data. EPSDT expenses were excluded from SFY 2009 claims to state the experience on the same basis as SFYs 2007 and 2008 (which did not have the EPSDT adjustment) for trending purposes

[2] Substitute Care represents the managed care population only while the other populations are for the managed care and fee-for-service, representing the "Target"

Trends

Analysis of the year-over-year and 2-year average trends for each cohort and in total, as presented above, did not yield trend indicators with which we felt comfortable, highlighting the volatility in the experience of these populations. Given the nature of the health care needs of the members covered under this program, the claims experience was segregated and reviewed at behavioral health and non-behavioral health levels the past 5 fiscal years. A review of the 3-year and 4-year average trends for non-behavioral health services indicated relatively stable long-term trend whereas behavioral trends indicated a declining long term trends. The 4-year average non-behavioral trend of 4.1% was selected for the rate development.

Table 4
Trend Selection

CSHCN & Substitute Care
9/1/2010 - 6/30/2011
Trend Selection

	Enrolled & Not-Enrolled All Cohort PMPM				
	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Total CSHCN	$ 598.77	$ 668.99	$ 688.53	$ 594.94	$ 621.37
Behavioral	$ 219.77	$ 274.30	$ 269.33	$ 179.35	$ 175.52
Non-Behavioral & Rx	$ 379.00	$ 394.68	$ 419.20	$ 415.59	$ 445.86

	Total CSHCN Trends				
	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Year-Over-Year		11.7%	2.9%	-13.6%	4.4%
Two-Year Average			7.2%	-5.7%	-5.0%
Three-Year Average				-0.2%	-2.4%
					0.9%

	Behavioral Trends				
	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Year-Over-Year		24.8%	-1.8%	-33.4%	-2.1%
Two-Year Average			10.7%	-19.1%	-19.3%
Three-Year Average				-6.6%	-13.8%
					-5.5%

	Non-Behavioral Trends				
	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Year-Over-Year		4.1%	6.2%	-0.9%	7.3%
Two-Year Average			5.2%	2.6%	3.1%
Three-Year Average				**3.1%**	**4.1%**
Four-Year Average					**4.1%**

Base Period Data

As stated above, all of the population cohorts exhibited wide fluctuations in the year over year experience, leading us to employ credibility weighted averages to smooth out the variability and account for both high and low cost and utilization periods. Credibility weights of 30% and 70% were used respectively on the averages of SFY 2008 projected to SFY 2009 and actual SFY 2009 for the managed care and fee-for-service population cohorts, from which a blended base period was developed for rate-setting.

Table 5

Base Period PMPMs

CSHCN & Substitute Care

9/1/2010 - 6/30/2011

Base Period Selection

	SFY '08 Proj to SFY '09		SFY 2009		SFY 2009 Average Members			Base Period [1]		
Population Cohorts	Managed Care	FFS	Managed Care	FFS	Managed Care	FFS	Total	Managed Care	FFS	**Total**
Adoption Subsidy	$ 254.31	$ 325.78	$ 298.20	$ 237.52	1,392	220	1,613	$ 285.03	$ 264.00	**$ 282.16**
Katie Beckett	$ 768.46	$ 841.96	$ 1,135.60	$ 1,406.65	105	54	159	$ 1,025.46	$ 1,237.24	**$ 1,096.90**
SSI < 15	$ 806.04	$ 762.21	$ 804.86	$ 566.71	2,654	438	3,092	$ 805.21	$ 625.36	**$ 779.72**
SSI >= 15	$ 636.82	$ 693.26	$ 644.36	$ 810.89	1,475	421	1,896	$ 642.10	$ 775.60	**$ 671.73**
Substitute Care	$ 550.86		$ 527.78		2,304	225	2,529	$ 534.71		**$ 534.71**

[1] Base Period PMPMs are a credibility-weighted average of SFY 2008 PMPMs projected to SFY 2009 and SFY 2009, at 30% and 70% respectively, for both the managed care and fee-for-service populations

Managed Care Savings

We carried forward the same managed care savings adjustments for the fee-for-service population cohorts which were previously developed in consultation with the actuaries at Donlon & Associates. The managed care savings assumptions address improved access to providers, better reimbursements, and shift of care to more appropriate and lower cost settings.

Consideration for the pharmacy savings was based on the greater of the savings from the Generic Drugs First (GDF) program or the savings from the managed care estimates. The savings from the GDF program was considered separately and prior to any additional savings from managed care. If the savings from the GDF program surpassed the savings from managed care, then no additional savings were assumed from managed care. Conversely, if the savings from the GDF program was less than the savings from managed care, then the net difference was assumed as additional savings to be realized from managed care.

Table 6

Managed Care Savings

CSHCN and Substitute Care 9/1/2010 - 6/30/2011 *Managed Care Savings*					
Mgd. Care and FFS combined					
	With Article 20				
	Adoption Subsidy	**Katie Beckett**	**SSI < 15**	**SSI >= 15**	**Substitute Care**
Fee-For-Service Population [1]					
Estimated Rx Managed Care Savings Target	$ (3.80)	$ (8.29)	$ (6.36)	$ (8.75)	
Estimated Generic Drugs First Savings	$ (3.74)	$ (5.40)	$ (4.23)	$ (5.82)	
Rx Managed Care Savings Net of Generic Drugs First Savings	$ (0.06)	$ (2.89)	$ (2.13)	$ (2.93)	
Estimated Medical Managed Care Savings	$ (18.86)	$ (96.24)	$ (46.67)	$ (56.33)	
Estimated Total Managed Care Savings	$ (18.92)	$ (99.14)	$ (48.80)	$ (59.27)	
Percent Fee-For-Service Enrollment to Total Enrollment	13.7%	33.7%	14.2%	22.2%	0.0%
Estimated Managed Care Savings applied to Blended Rates	$ (2.59)	$ (33.44)	$ (6.92)	$ (13.15)	$ -

[1] Managed care savings, at 8% overall, is applicable only to Fee-For-Service population

Adjustment for Program Changes

Article 20 of the FY 2011 Appropriations Act – We relied on the analysis performed by DHS and its subcontractors to model out the impact of Article 20 to inpatient and outpatient projected claims expense as exhibited in the tables below. The language related to inpatient and outpatient is excerpted here for reference:

page 2	line	
	24	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	25	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	26	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	27	30, 2010. Negotiated increases in inpatient hospital payments for the twelve (12) month period
	28	beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services
	29	national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable
	30	period; (ii) The Rhode Island department of human services will develop an audit methodology
	31	and process to assure that savings associated with the payment reductions will accrue directly to
	32	the Rhode Island Medicaid program through reduced managed care plan payments and shall not
	33	be retained by the managed care plans; (iii) All hospitals licensed in Rhode Island shall accept
	34	such payment rates as payment in full; and (iv) for all such hospitals, compliance with the
page 3	1	provisions of this section shall be a condition of participation in the Rhode Island Medicaid
	2	program.
	3	(2) With respect to outpatient services and notwithstanding any provisions of the law to
	4	the contrary, for persons enrolled in fee for service Medicaid, the department will reimburse
	5	hospitals for outpatient services using a rate methodology determined by the department and in
	6	accordance with federal regulations. With respect to the outpatient rate, it is required as of
	7	January 1, 2011 until December 31, 2011, that the Medicaid managed care payment rates between
	8	each hospital and health plan shall not exceed one hundred percent (100%) of the rate in effect as
	9	of June 30, 2010.

The DHS analysis re-priced SFY 2009 managed care and fee-for-service Medicaid claims data projected to SFY 2011 per the provisions of Article 20, at a health plan and product-line level, the results of which were used in our estimates for the impact of Article 20.

Table 7
Impact of Article 20

CSHCN and Substitute Care 9/1/2010 - 6/30/2011 *Impact of Article 20*					
Mgd. Care and FFS combined					
	Adoption Subsidy	**Katie Beckett**	**SSI < 15**	**SSI >= 15**	**Substitute Care**
Inpatient - Mgd. Care & FFS Combined					
Percent Savings to Total CSHCN & Substitute Care	-2.5%	-2.5%	-2.3%	-3.0%	-2.8%
Forecasted PMPM for Rate Period	$ 307.07	$1,193.75	$ 848.57	$ 731.04	$ 581.92
Estimated Inpatient Savings PMPM on Forecasted PMPM	$ (7.62)	$ (29.50)	$ (19.58)	$ (22.23)	$ (16.10)
Outpatient - Mgd. Care Only [1]					
Percent Savings to Total CSHCN & Substitute Care	-0.3%	-0.5%	-0.4%	-0.4%	-0.3%
Forecasted PMPM for Rate Period	$ 307.07	$1,193.75	$ 848.57	$ 731.04	$ 581.92
Estimated Inpatient Savings PMPM on Forecasted PMPM	$ (0.84)	$ (5.47)	$ (3.63)	$ (2.93)	$ (1.66)

[1] Outpatient savings analysis is limited to the impact to the managed care ("enrolled") only population since FFS was used as a proxy for Article 20

Communities of Care – As defined by DHS, "*the Communities of Care Initiative shall focus on emergency room users who have four or more emergency department (ED) visits within a year, and consists of three components: (1) intensive enhanced care management to meet complex medical conditions and chronic diseases; and care coordination and mentoring activities that assist members navigate the care system and provide support to meet non-medical needs provided by a peer or paraprofessional; (2) incentives and rewards to members to promote personal responsibility, accountability, and good health care practices; and (3) selected high ED use members to be a part of one of two designated provider teams. A Restricted Provider Team (s) shall serve high ED use members who use multiple providers and have prescription narcotic/opiate related claims or who have a demonstrated pattern of inappropriately using medical resources. Members shall select specific providers (i.e. primary care, behavioral health, prescription provider, and pharmacy) to meet their needs. A Select Provider Team shall serve members with complex medical and chronic conditions".* We relied on analysis performed by DHS and its subcontractors to estimate savings from the Communities of Care Initiative effective 9/1/2010. The DHS analysis assumed a 1st-year savings of 3% on Communities of Care-related expenses, including inpatient, ED, E&M, behavioral health and Rx, for members with 4+ ED visits during the year, which yielded savings of less than 1% to total expenses.

Since Communities of Care will require enhanced care management activities from the health plans, DHS recognizes the additional administrative costs associated with the initiative by allocating an additional administrative expense for the effective implementation of Communities of Care – see the table below.

Table 8

Communities of Care

CSHCN and Substitute Care 9/1/2010 - 6/30/2011 *Communities of Care*					
Mgd. Care and FFS combined					
	With Article 20				
	Adoption Subsidy	**Katie Beckett**	**SSI < 15**	**SSI >= 15**	**Substitute Care**
Forecasted PMPM for Rate Period [1]	$ 298.61	$ 1,158.79	$ 825.35	$ 705.89	$ 564.17
Percent Communities of Care Savings to Total CSHCN & Substitute Care	-0.48%	-0.47%	-0.30%	-0.61%	-0.44%
Estimated Communities of Care Savings PMPM on Forecasted PMPM	$ (1.42)	$ (5.48)	$ (2.46)	$ (4.28)	$ (2.50)
Percent Communities of Care Related Admin to Total CSHCN & Substitute Care	0.29%	0.29%	0.18%	0.37%	0.27%
Estimated Communities of Care Admin PMPM on Forecasted PMPM	$ 0.88	$ 3.38	$ 1.51	$ 2.64	$ 1.54

[1] Forecasted PMPM used for estimating the impact of Communities of Care includes all program changes and initiatives except Selective Contracting and Fraud & Abuse

Selective Contracting – As described by DHS, *"MCO's shall implement measures to move selective out-patient procedures currently performed in an institutional setting to a community based setting in an effort to provide services closer to where members live and work in order to take advantage of lower pricing structures typically available in community settings. These out-patient services may include: X-ray and laboratory services, Ear-Nose-Throat (ENT) and out-patient surgeries"*. We relied on analysis performed by DHS and its subcontractors to estimate savings to outpatient claims expense as result of the implementation of Selective Contracting Initiative effective 9/1/2010. For the 1st-year savings estimate, the DHS analysis assumed a 15% shift of X-Ray, Lab and Test services from hospital outpatient setting to a community-based (Independent Lab and Office) setting.

Table 9

Selective Contracting

CSHCN and Substitute Care 9/1/2010 - 6/30/2011 *Selective Contracting*					
Mgd. Care and FFS combined					
	With Article 20				
	Adoption Subsidy	**Katie Beckett**	**SSI < 15**	**SSI >= 15**	**Substitute Care**
Percent Savings to Total CSHCN & Sub. Care	-0.06%	-0.06%	-0.06%	-0.17%	-0.07%
Forecasted Medical PMPM CSHCN & Sub. Care for Rate Period (incl. Article 20)	$ 298.61	$1,158.79	$ 825.35	$ 705.89	$ 564.17
Estimated Selective Contracting Savings PMPM on Forecasted PMPM	$ (0.18)	$ (0.70)	$ (0.51)	$ (1.19)	$ (0.42)

CAITS – We carried forward the program adjustments and amendments made during the 7/1/08 – 6/30/09 rate period related to the inclusion of Children & Adolescent Intensive Treatment Services (CAITS) as in-plan benefits effective 4/1/2009. The CAITS experience was excluded from the SFY 2009 encounter data due to the partial period, and was analyzed separately to develop the CAITS PMPM for the new rate period.

Table 10

CAITS In-Plan Benefit PMPM

CSHCN & Substitute Care
9/1/2010 - 6/30/2011
CAITS PMPM Projections as In-Plan Services

Mgd. Care and FFS combined

	9/08 - 6/09	
Population Cohort	SFY '09 Enrollment	CAITS PMPM
Adoption Subsidy	1,613	$ 9.18
Katie Beckett	159	$ 29.27
SSI <15	3,092	$ 22.92
SSI >=15	1,896	$ 12.28
Substitute Care	2,304	$ 12.23

Projected to the Rate Period, at Selected Trends

Periods	**Annual Trend** [1]	**Trend Period**	**Trend Factor**
Base period midpoint (2/1/09) to 9/1/10-6/30/11	3.6%	2.000	1.073

Population Cohort	SFY '09 Enrollment	CAITS PMPM
Adoption Subsidy	1,613	$ 9.85
Katie Beckett	159	$ 31.40
SSI <15	3,092	$ 24.59
SSI >=15	1,896	$ 13.18
Substitute Care	2,304	$ 13.12

[1] The selected trend is the credibility weighted average of an estimated 3% CIS/CAITS (as indicated by the 2-year weighted average for all population cohorts from SFY '06 to SFY '08), and the selected trend for CSHCN & Sub. Care, at 50% and 50% credibility weights respectively.

DRE Effect – The Drug Rebate Equalization Act of 2009 is anticipated to reduce the standard rebates currently attained by the health plans, although the extent of this impact is not yet known. In anticipation of future reductions in the standard rebates by the health plans, an adjustment was made to "discount" (reduce) the rebate amounts in the forecasted rate year by 50%.

Generic Drugs First – The Generic Drugs First program initiative savings were calculated by DHS from SFY 2009 experience, the results of which we applied to the projected pharmacy claims. As well, to allow for expenses associated with medically necessary exemptions the savings estimates were tempered with a 75% reduction.

Table 11

Generic Drugs First Adjustment:

CSHCN & Substitute Care					
9/1/2010 - 6/30/2011					
Generic Drugs First					
Mgd. Care and FFS combined					
	Adoption Subsidy	**Katie Beckett**	**SSI < 15**	**SSI >= 15**	**Substitute Care**
CSHCN & Sub. Care Rx Experience for SFY 2009					
Percent Savings to Total CSHCN & Sub. Care	-1.6%	-0.6%	-0.8%	-1.0%	-0.7%
Forecasted CSHCN & Sub. Care Rx PMPM for Rate Period	$ 307.07	$1,193.75	$ 848.57	$ 731.04	$ 581.92
Estimated Generic Drugs First Savings PMPM on Forecasted PMPM	$ (4.98)	$ (7.55)	$ (7.14)	$ (7.16)	$ (4.21)

Fraud & Abuse – The additional provisions for healthcare compliance as contained in the model contract, and the healthcare compliance programs as mandated by the Healthcare Reform Law of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to produce additional savings in the healthcare system. In anticipation, an adjustment was applied to recognize such savings at a moderately low first-year level of 0.5% of claims, as Fraud & Abuse prevention and recovery programs are newly introduced or existing ones better implemented.

Administrative Load & Premium Tax

The administrative load rates were restructured to maintain the current rate proportions within each population cohort, while reflecting a weighted average total that is 3.5% higher than the 4/1/09 – 3/31/10 average. The capitation rates for the rate cells were also loaded for 2% premium tax.

Summary

In Summary, the selected base period PMPMs for each population cohort were trended at the selected trends and adjusted for the estimated impact of Article 20, the estimated savings from Selective Contracting initiative, the Communities of Care initiative, the anticipated effects of DRE on future rebates, CAITS in-plan benefits, the Generic Drugs First program initiative and the anticipated impact of PPACA's healthcare compliance – Fraud & Abuse mandate. The resultant PMPMs were then loaded for administration and premium tax.

Table 12

CSHCN & Substitute Care Capitation Rate PMPMs

		Melded Mgd. Care & FFS				Mgd. Care Only
		Rate Period 9/1/2010 - 6/30/2011				9/1/10-6/30/11
		Adoption Sub.	Katie Beckett	SSI <15	SSI >=15	Substitute Care
Base Period In-Plan PMPM w/ Adjustments [1]		**$ 282.16**	**$ 1,096.90**	**$ 779.72**	**$ 671.73**	**$ 534.71**
Base Period Average Members		1,613	159	3,092	1,896	2,304
Implied Trend of the Melded Enrolled and Not Enrolled		**4.1%**	**4.1%**	**4.1%**	**4.1%**	**4.1%**
Projection Period (years)		2.08	2.08	2.08	2.08	2.08
Melded 9/1/10 - 6/30/11 PMPM For Enrolled & Not Enrolled		$ 307.07	$ 1,193.75	$ 848.57	$ 731.04	$ 581.92
Adjustments to Medical:						
Article 20 - Inpatient		$ (7.62)	$ (29.50)	$ (19.58)	$ (22.23)	$ (16.10)
Article 20 - Outpatient		$ (0.84)	$ (5.47)	$ (3.63)	$ (2.93)	$ (1.66)
Communities of Care		$ (1.42)	$ (5.48)	$ (2.46)	$ (4.28)	$ (2.50)
Communities of Care Admin		$ 0.88	$ 3.38	$ 1.51	$ 2.64	$ 1.54
Selective Contracting - X-Ray, Lab & Tests		$ (0.18)	$ (0.70)	$ (0.51)	$ (1.19)	$ (0.42)
Adjusted Melded 9/1/10 - 6/30/11 PMPM For Enrolled & Not Enrolled		$ 297.89	$ 1,155.99	$ 823.90	$ 703.05	$ 562.80
Managed Care Savings Adjustments:						
Managed Care Savings for Not Enrolled (Net of Generic First Rx)		$ (2.59)	$ (33.44)	$ (6.92)	$ (13.15)	$ -
Net Melded 9/1/10 - 6/30/11 PMPM For Enrolled & Not Enrolled		$ 295.30	$ 1,122.55	$ 816.98	$ 689.90	$ 562.80
Program Adjustments:						
CAITS Rate Adjustment PMPM (9/1/10 - 6/30/11)		$ 9.85	$ 31.40	$ 24.59	$ 13.18	$ 13.12
DRE Effect on Rx Rebates		$ 0.65	$ 2.51	$ 1.79	$ 1.54	$ 1.23
Generic First Rx Program (@ 25% for 1st yr.)		$ (4.98)	$ (7.55)	$ (7.14)	$ (7.16)	$ (4.21)
Adjusted 9/1/10 - 6/30/11 PMPM For Not Enrolled		$ 300.81	$ 1,148.92	$ 836.22	$ 697.45	$ 572.93
Fraud & Abuse Recovery / Prevention	0.5%	$ (1.50)	$ (5.74)	$ (4.18)	$ (3.49)	$ (2.86)
Adjusted Melded 9/1/10 - 6/30/11 PMPM		$ 299.31	$ 1,143.17	$ 832.04	$ 693.96	$ 570.07
Projected Admin. Exp. 9/1/10 - 6/30/11 [2]		$ 29.31	$ 113.96	$ 81.34	$ 68.59	$ 52.94
Projected Total In-Plan PMPM with Admin.		**$ 328.62**	**$ 1,257.14**	**$ 913.38**	**$ 762.55**	**$ 623.00**
Projected Rates with 2% Premium Tax		**$ 335.33**	**$ 1,282.79**	**$ 932.02**	**$ 778.12**	**$ 635.72**

[1] The base period PMPM is a credibility weighted average of SFY 2008 trended to SFY 2009 and SFY 2009 because the claims experience for this program varies widely from year to year. Adjustments are from plan reconcilations between DHS and the health plans to account for claims not reflected in the encounter data

[2] Projected Admin Expense for 9/1/10 - 6/30/11 was re-balanced based on current expense ratio, since the updated base period claims pmpm changed noticeably for some population cohorts. Current rates were further adjusted up 3.5% to recognize expenses associated with managed care implementation

Actuarial Certification

Certification of the CSHCN and Substitute Care capitation rates for the rate period 9/1/2010 – 6/30/2011 is provided under a separate cover by the actuarial firm of Donlon & Associates, Inc., in support of this data book.

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APPENDIX