Section IX. Medicaid Managed Care Draft Rate Book (SFY 2020)
North Carolina Department of Health and Human Services

TABLE OF CONTENTS

Executive Summary 5

1 Introduction 9

2 Data Sources 10

3 PHP Regions 11

4 Population Groupings 12
- 4.1 Standard Plan Population 12
- 4.2 Future Managed Care Populations 13
- 4.3 Excluded Populations 14

5 Service Categories 15

6 Historical Data Analysis 18
- 6.1 MMs Adjustment 18
- 6.2 Retroactive Eligibility and Application Period 19
- 6.3 Completion Factors 20
- 6.4 GME Adjustment 21
- 6.5 TPL Adjustment 21
- 6.6 NEMT Adjustment 22
- 6.7 Fraud, Waste and Abuse Recoveries Adjustment 22
- 6.8 LME/MCO Data Adjustments 23
  - 6.8.1 Patient Liability Adjustment 23
  - 6.8.2 Payments Made Outside of the Claims System 23

7 Historical Data Exhibits 24
- 7.1 SFY 2016 Exhibits 25
  - 7.1.1 SFY 2016 Region 1 Exhibits 26
  - 7.1.2 SFY 2016 Region 2 Exhibits 33
  - 7.1.3 SFY 2016 Region 3 Exhibits 40
  - 7.1.4 SFY 2016 Region 4 Exhibits 47
  - 7.1.5 SFY 2016 Region 5 Exhibits 54
  - 7.1.6 SFY 2016 Region 6 Exhibits 61
- 7.2 SFY 2017 Exhibits 68
  - 7.2.1 SFY 2017 Region 1 Exhibits 69
  - 7.2.2 SFY 2017 Region 2 Exhibits 76
  - 7.2.3 SFY 2017 Region 3 Exhibits 83
  - 7.2.4 SFY 2017 Region 4 Exhibits 90
  - 7.2.5 SFY 2017 Region 5 Exhibits 97
  - 7.2.6 SFY 2017 Region 6 Exhibits 104

8 Capitation Rate Development 111

9 Base Data Development 112

10 Trend Assumptions 113
- 10.1 Trend Development Methodology 113
- 10.2 Overall Trend Assumptions 113
  - 10.2.1 Inpatient Hospital 114
  - 10.2.2 Prescription Drugs 114

11 Program Design Considerations 116

11.1 Hospital Reimbursement Methodology 116
11.2 Maternity Enhanced Rate 117
11.3 Long-Term Nursing Home Stay Beneficiaries 117
11.4 Other Provider Reimbursement Considerations 118
11.4.1 Provider Rate Floors 118
11.4.2 LME/MCO Services Reimbursement 118
11.4.3 FQHC/RHC Providers 118
11.4.4 Historical Cost Settlements 118
11.5 Additional Programmatic Considerations 119
12 Managed Care Assumptions 120
12.1 Overall Managed Care Findings 120
12.2 Non-Pharmacy Benefits 121
12.2.1 Other State Medicaid Experience 121
12.2.2 Efficiency Analysis 122
12.2.3 Other Medical Services 123
12.3 Pharmacy Benefits 123
13 Non-Benefit Expense Considerations 124
13.1 Methodology and Data Sources 125
13.2 Program Management and Administrative Operations Personnel 126
13.3 Care Management Personnel 126
13.4 Non-Personnel Costs 128
13.5 Non-Benefit Expense Load Application to Capitation Rates 128
13.6 Profit/Underwriting Gain and Premium Taxes 128
13.7 Health Insurer Provider Fee (HIPF) 128
14 Capitation Rate Development Exhibits 130
14.1 Region 1 Capitation Rate Development Exhibits 132
14.2 Region 2 Capitation Rate Development Exhibits 138
14.3 Region 3 Capitation Rate Development Exhibits 144
14.4 Region 4 Capitation Rate Development Exhibits 150
14.5 Region 5 Capitation Rate Development Exhibits 156
14.6 Region 6 Capitation Rate Development Exhibits 162
15 Other Considerations 168
15.1 Member Choice 168
15.1.1 Tribal Members 168
15.1.2 BH I/DD Tailored Plan 168
15.2 Performance Withholds 168
15.3 Risk Adjustment 169
15.3.1 Risk Adjustment Model 169
15.3.2 Data Collection 170
15.3.3 Calculation of Risk Scores 170
15.3.4 Frequency of Updates 171
15.3.5 Final Capitation Rates 171
15.4 Medical Loss Ratio 172
15.4.1 Implied MLR Calculation based on Capitation Rate Development 172
15.4.2 Minimum MLR Threshold 173
Appendix A — Maternity Event Criteria 174
Budget-Neutral Maternity Adjustment 177

Appendix B — Other Population Eligibility Criteria 178
Future Managed Care Populations Criteria 178
Permanently Excluded Population Criteria 178
Appendix C — Rate Cell Determination 179
Methodology 179
Population Rate Cell Recommendations 180
Regional Rate Cell Recommendations 181
Appendix D — Category of Service Criteria 182
Appendix E — BH I/DD Tailored Plan Criteria 186
I/DD Criteria 186
SED (Ages 0-17.99) and SPMI (Ages 18+) Criteria 187
SUD Criteria 190
Appendix F — BH I/DD Tailored Plan Population 192
Population Eligible for BH I/DD Tailored Plan 192
Standard Plan Beneficiaries Demonstrating Potential Need for BH I/DD Tailored Plans 193
Appendix G – Approach to Medicaid Hospital Payments After the Transition to Managed Care 194

EXECUTIVE SUMMARY

The Department of Health and Human Services (DHHS) is implementing managed care in a way that advances high-value care, improves population health, engages and supports providers and establishes a sustainable program with predictable costs. At the core of these efforts is the goal to improve the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care, which addresses medical and non-medical drivers of health. In managed care, DHHS will remain responsible for all aspects of the Medicaid and NC Health Choice programs. However, as directed by the General Assembly, DHHS will delegate the direct management of certain health services and financial risks to Prepaid Health Plans (PHPs). PHPs will receive capitation payments and will contract with providers to deliver health services to their members.[1]

DHHS has contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop the PHP capitation rates. As such, Mercer has produced the Draft Rate Book for DHHS as documentation of the development of the draft capitation rates effective in Contract Year 1 of managed care for the proposed Standard Plan population. The capitation rates will be certified as actuarially sound in accordance with applicable laws and regulations, including Actuarial Standards of Practice, to comply with the Center for Medicare and Medicaid Services (CMS) regulations. Per 42 CFR 438.4(a), "actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in [42 CFR 438.4(b)]." 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 proposed Standard Plan population.

Following initial implementation of managed care and the rollout to the proposed Standard Plan population, additional populations will be phased-in over a five year period, as proposed by DHHS. However, information for these populations is outside of the scope of the Draft Rate Book.

Contract Year 1 Standard Plan Draft Capitation Rates

The Contract Year 1 draft capitation rates were developed for non-dual Medicaid and NC Health Choice beneficiaries in the Standard Plan, assuming Contract Year 1 runs from July 1, 2019 – June 30, 2020. Final rates will reflect any changes in the Contract Year 1 start date or duration. For purposes of capitation rate development, the Standard Plan population was stratified by Aged, Blind, Disabled (ABD) and Temporary Assistance for Needy Families and Other Related Children/Adults (TANF) beneficiaries. The capitation rates will be paid on a per member per month (PMPM) basis, along with a one-time Maternity Event payment in the instance of a live birth event. The table below reflects the draft base capitation rates; detailed summaries by region, population and service category are provided in Section 14 of the Draft Rate Book.

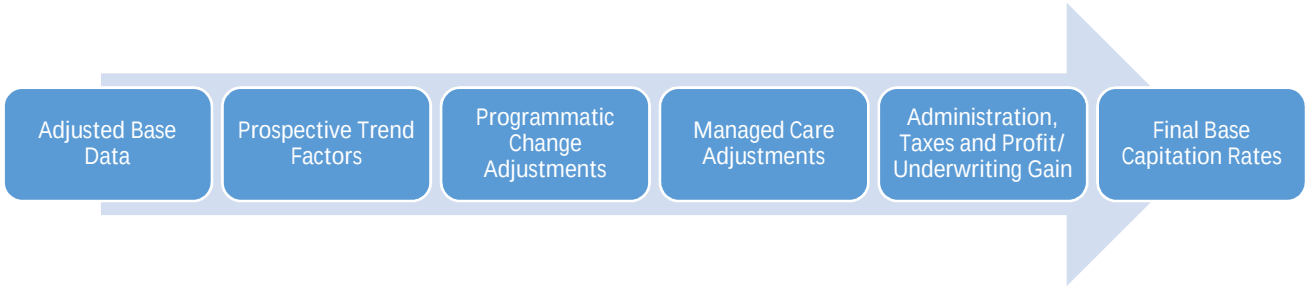
Category of Aid	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,373.30	$1,356.05	$1,529.02	$1,415.53	$1,278.26	$1,158.50
TANF, Newborn (<1)	$749.33	$707.22	$736.81	$660.06	$736.49	$563.56
TANF, Child (1-20)	$166.46	$148.78	$141.55	$141.70	$147.03	$136.70
TANF, Adult (21+)	$413.55	$437.60	$394.18	$385.86	$422.14	$373.97
Maternity Event Payment	$9,555.60	$9,760.42	$9,431.17	$8,857.91	$10,192.86	$8,844.00

[1] Prepaid Health Plans in North Carolina Medicaid Managed Care. May 16, 2018. https://files.nc.gov/ncdhhs/documents/PHPs-in-Medicaid-Managed-Care-PolicyPaper_revFINAL_20180516.pdf

The base capitation rates will also be risk adjusted, as required by Session Law (S.L.) 2015-245[2], to reflect the underlying health risk of the members enrolled in each PHP. Risk adjustment differentiates capitation payments to PHPs; however, this modeling has not yet occurred and will be forthcoming for final capitation rates. Additionally, DHHS will institute a Medical Loss Ratio (MLR) reporting and remittance process for all PHPs.

Capitation Rate Development Methodology

The rate-setting process is the means for determining the capitation payments DHHS will pay to the PHPs for each beneficiary enrolled in the program, regardless of the amount of future services that beneficiary receives. This process involves summarizing historical claims and eligibility data that represent the covered populations and services and projecting future medical claims costs on a per member per month basis into the rating period.



Mercer leveraged two years of historical claims and encounter data for the State Medicaid and NC Health Choice program to summarize cost and utilization information for the proposed Standard Plan population. This data includes experience for services covered under the State fee-for-service (FFS) program, as well as behavioral health (BH) services covered under the Medicaid BH managed care program currently operated by the Local Management Entity/Managed Care Organizations (LME/MCOs). Mercer used this information as the basis for capitation rate development. For service category detail, please see Section 5 of the Draft Rate Book. Mercer also used member-level eligibility information provided by DHHS to summarize the data and identify the Standard Plan population.

The base data has been adjusted to account for historical program changes and considerations for the proposed future managed care design. Detailed methodology and impact of base data adjustments is outlined in Section 6 of the Draft Rate Book. Historical data summaries by region, population and service category are included in Section 7 of the Draft Rate Book.

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 utilization of certain services as a result of PHP utilization and care management initiatives. Further detail and methodology regarding prospective adjustments can be found in Section 9 through Section 12 of the Draft Rate Book.

The final component of the capitation rate development is application of the non-benefit expense load. This portion of the capitation rates accounts for PHP administration costs and care management costs incurred to operate the Medicaid managed care program. The non-benefit load considerations were developed to reflect the PHP contract requirements as defined by DHHS. 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 PHPs. In DHHS'

[2] SL 2015-245 An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs https://www.ncleg.net/Sessions/2015/Bills/House/PDF/H372v8.pdf

approach to managed care, care management is foundational to the success of North Carolina's health care system for Medicaid and NC Health Choice beneficiaries, supporting high-quality delivery of the right care at the right place and at the right time in the right setting. Beneficiaries will have access to appropriate care management and coordination support across multiple settings of care, including a strong basis in primary care and connections to specialty care and community-based resources. Access to local care management will draw from the Advanced Medical Home (AMH) model and participation from the Local Health Departments; additionally, DHHS is committed to providing care management for beneficiaries to address the four priority domains of opportunities for health: housing, food, transportation, and interpersonal safety. Mercer has aligned the care management modeling with DHHS care management strategy. Section 13 of the Draft Rate Book provides additional information on the non-benefit expense considerations.

Outstanding Rate Considerations

The capitation rates put forth in the Draft Rate Book are subject to change. Due to the timing of legislative changes made during the 2018 legislative session, the draft rates contained herein do not reflect the most recent legislation. The following items have not yet been reflected in the capitation rates; impact of these items on the capitation rates will be evaluated and reflected in the final rate development.

- PHP Contract Period – The draft capitation rates have been developed assuming a 12-month contract period of July 1, 2019 through June 30, 2020. The PHP RFP indicates that the Standard Plan Contracts will begin November 1, 2019. Additionally, S.L. 2018-49[3] allows DHHS to phase-in populations by region over a five month period. Information on the phase-in schedule will be released after PHP contract award. As such, the final capitation rates will reflect the appropriate contract period duration, including an adjustment to the number of trend months applied, and the assumed level of managed care savings to be achieved in Contract Year 1 of the program. The Department intends to have the rate period end on June 30, 2020 to align the future rate periods with the state fiscal year.
- Base Data – The base data underlying the draft capitation rates reflects July 1, 2015 – June 30, 2017 claims experience and eligibility information. This base data will be updated to include more recent information and reflect July 1, 2016 – June 30, 2018 experience for purposes of final rate development.
- BH and Intellectual/Developmental Disability (BH I/DD) Tailored Plan Populations — Per S.L. 2018-48[4], the BH I/DD Tailored Plan will be implemented one year following the first contracts for the Standard Plan benefit. Prior to implementation of the BH I/DD Tailored Plan, beneficiaries meeting BH I/DD Tailored Plan eligibility criteria will be defaulted into their current delivery system (FFS and LME/MCO for most beneficiaries), and have the option to enroll in a Standard Plan. The draft capitation rates assume eligibility for BH I/DD Tailored Plans based on criteria proposed by DHHS in the Fall of 2018. S.L. 2018-48 includes additional eligibility criteria not reflected in the draft capitation rates. Additionally, the draft capitation rates do not account for the potential that a BH I/DD Tailored Plan eligible beneficiary may choose to enroll in a Standard Plan. Both of these items have a potential cost impact that is not yet reflected in the draft capitation rates.
- Tribal Member Choice — Members of federally recognized tribes will have the choice to enroll in a PHP and will be exempt from mandatory enrollment into managed care. This has a potential cost impact that is not yet reflected in the draft capitation rates.
- Final Provider Reimbursement Arrangements — The capitation rates reflect adjustments for historical provider reimbursement arrangements and historical supplemental payments. To the extent there are expected reimbursement changes under managed care program design, an impact to the capitation rates will need to be evaluated. This includes potential future fee schedule changes prior to or

[3] SL 2018-49/House Bill 156 Medicaid PHP Licensure & Transformation Mods. https://www2.ncleg.net/BillLookUp/2017/h156

[4] SL 2018-48/House Bill 403 Medicaid and Behavioral Health Modifications. https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H403v6.pdf

concurrent with managed care implementation, provider rate floors, and reimbursement requirements for hospitals and Federally Qualified Health Centers and Rural Health Clinics.

- Extended Coverage for Services Delivered in an Institution for Mental Disease (IMD) — It is anticipated that this provision will have minimal impact to the Standard Plan member costs; however, this will continue to be evaluated for final rate development.
- Substance Use Disorder (SUD) Service Array Expansion — The State is working on updates to the SUD service array, which may require updates to the State Plan. No adjustment is currently reflected in the draft capitation rates for SUD service array changes.
- Number of PHPs — The non-benefit load rate considerations are dependent upon an assumed number of PHPs administering the program, and their allocation across the six proposed PHP regions. The modeling currently reflects four statewide PHPs and four regional provider-led entities (PLEs). Upon contract award, this assumption will be updated to reflect the actual number of PHPs operating within/across regions.
- AMH Tier 3 Beneficiaries — Currently, the draft rates reflect an assumption that 65.0% of beneficiaries will receive care management through an AMH Tier 3 practice; this assumption will be revisited for final rate determination.
- Premium Tax — The rates reflect consideration for a premium tax component and regulatory surcharge, which is consistent with the legislative intent included in S.L. 2018-49.
- Health Insurer Provider Fee (HIPF) — The HIPF is considered a cost of doing business that is appropriate to recognize in the payments to PHPs. Currently, there is a moratorium on the HIPF for premiums earned in 2018 and uncertainty with respect to the applicability of the HIPF in the future, so at this point the draft rates do not reflect consideration for the HIPF.
- Performance Withholds — DHHS plans to include a performance-based incentive system financed through a withhold as part of the program design. Per S.L. 2018-49, the withhold program will not begin until at least 18 months after managed care implementation.
- Optical Services – This Draft Rate Book reflects the removal of optical services including services for eyeglasses frames, lenses, lens treatment, fabrication and fittings. Should additional legislation not be put forth, an adjustment to the draft capitation rates will be made to include the costs associated with eyeglass fittings.
- Fraud, Waste, and Abuse Recoveries – The base data reflected in this Draft Rate Book does not include an adjustment for recoveries collected for fraud, waste, and abuse. Mercer is working with DHHS to obtain more detailed information on these recoveries for Medicaid and NC Health Choice beneficiaries under the FFS program to evaluate potential impact to the Standard Plan.

Mercer and DHHS have agreed to reevaluate the appropriateness of the capitation rates using more recent claims and encounter experience before managed care implementation, along with considering applicable changes to legislation, regulation, state plan, waivers, federal guidance or policy decisions that may not have been reflected in draft rates. As such, the capitation rates will be finalized at a later point in time, and the base data, adjustments and capitation rates reflected in the Draft Rate Book are considered draft and are subject to change.

1 INTRODUCTION

Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, has produced this Draft Rate Book for the State of North Carolina (State) Department of Health and Human Services (DHHS) as documentation of the development of the draft capitation rates effective in Contract Year 1 of managed care (assumed July 1, 2019 through June 30, 2020) for the Standard Plan population. Following initial implementation of managed care and the rollout to the Standard Plan population, additional populations will be phased-in over a five year period, as proposed by DHHS. However, detailed cost and utilization information for these populations is outside of the scope of this Draft Rate Book.

As a part of capitation rate development for the Standard Plan population, Mercer leveraged claims and encounter data for the State Medicaid and NC Health Choice programs to summarize cost and utilization information for the Standard Plan population. This data includes experience for services covered under the State fee-for-service (FFS) program, as well as behavioral health (BH) services covered under the Medicaid BH managed care program currently operated by the Local Management Entity/Managed Care Organizations (LME/MCOs). Mercer used this information as the basis for capitation rate development.

The intent of the Draft Rate Book is to summarize historical data and outline key prospective rate considerations for the Standard Plan population for purposes of providing transparency into the current program costs and utilization along with insight into the rate development process for potential Prepaid Health Plans (PHPs) and other interested stakeholders. The Draft Rate Book includes information on the cost and utilization patterns of Medicaid and NC Health Choice eligibles by region, rate cell and category of service (COS). Sections 2 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 region, rate cell and COS.

Additionally, the Draft Rate Book outlines key components of the capitation rate development process, including information on specific prospective adjustments along with non-benefit cost considerations. Sections 8 through 14 provide information on the key steps of the rate development process, details on trend, programmatic considerations, managed care adjustments and non-benefit load assumptions, with detailed rate development summaries by region, rate cell and COS.

Finally, Section 15 provides details on other considerations for rate development and potential adjustments that may be forthcoming between the draft rates outlined in this Draft Rate Book and the final capitation rates for the implementation of managed care.

The users of this Draft Rate Book are cautioned against relying solely on the data contained herein. DHHS and Mercer provide no guarantee, either written or implied, that this book is 100% accurate or error-free. Additionally, it is important to note that information contained in this Draft Rate Book is considered draft. Mercer and DHHS have agreed to reevaluate the appropriateness of the capitation rates using more recent claims and encounter experience before managed care implementation, along with considering applicable changes to legislation, regulation, state plan, waivers, federal guidance or policy decisions that may not have been reflected in draft rates. Refer to Section 15 for examples of such items that may require adjustments to final rates. As such, the content of this Draft Rate Book and final capitation rates are subject to change pending updated base experience, possible adjustments not included in draft rates, additional guidance from DHHS on policy determination, and/or final program design elements currently pending legislation.

2 DATA SOURCES

Mercer used the FFS claims data from the DHHS Medicaid management information system, NC Tracks, which was provided by DHHS, and the BH encounter data provided to Mercer directly from the LME/MCOs to form the base data. This data is summarized on a date of service (incurred) basis and includes actual experience from July 1, 2015 through June 30, 2017 paid through September 30, 2017. For the base data development, this data is summarized by state fiscal year (SFY) 2016 (July 1, 2015 through June 30, 2016) and SFY 2017 (July 1, 2016 through June 30, 2017).

As a part of the data summarization process, Mercer also analyzed eligibility information from the member extract file provided by DHHS in October 2017. Eligibility information was used to categorize recipient-level claims experience into the populations outlined in Section 4. This information was also used to summarize the member month (MM) information reflected in various summaries throughout the Draft Rate Book.

Mercer also leveraged other data sources supplied by DHHS to calculate specific data adjustments outlined in Section 6, such as:

- State Medicaid monthly enrollment counts
- Member-level information from the North Carolina Families Accessing Services through Technology (NC FAST) system related to member retroactive eligibility and/or application period
- Information provided by DHHS on historical Graduate Medical Expense (GME) expenditures
- Non-Emergency Medical Transportation (NEMT) payments made outside of the FFS claims system
- Third Party Liability (TPL) monthly costs and, where available, member-level information for Medicaid participants
- Fraud, waste and abuse recovery information for payments collected specific to the Medicaid and NC Health Choice population
- LME/MCO data adjustment information leveraged from the BH LME/MCO rate-setting process

For final capitation rate development, the base data will be updated to reflect more recent experience and will include SFY 2017 and SFY 2018 (July 1, 2017 through June 30, 2018) data.

The users of this Draft Rate Book are cautioned that direct comparisons cannot be made between the information in the data summaries and raw claims data. The data received was summarized on a date of service (incurred) basis, and Mercer applied additional adjustments to the summarized raw data. Mercer has used and relied upon eligibility, claims, encounter and supplemental data and information supplied by both DHHS and the LME/MCOs. Aforementioned parties are solely responsible for the validity and completeness of these supplied data and information. Mercer has reviewed the summarized data in compliance with the Actuarial Standard of Practice (ASOP) on data quality (ASOP 23), which included checks for: completeness of data, accuracy of the data and consistency of data across data sources and years, including comparisons of BH encounter data to financial reports provided by the LME/MCOs. However, Mercer did not perform a complete audit.

3 PHP REGIONS

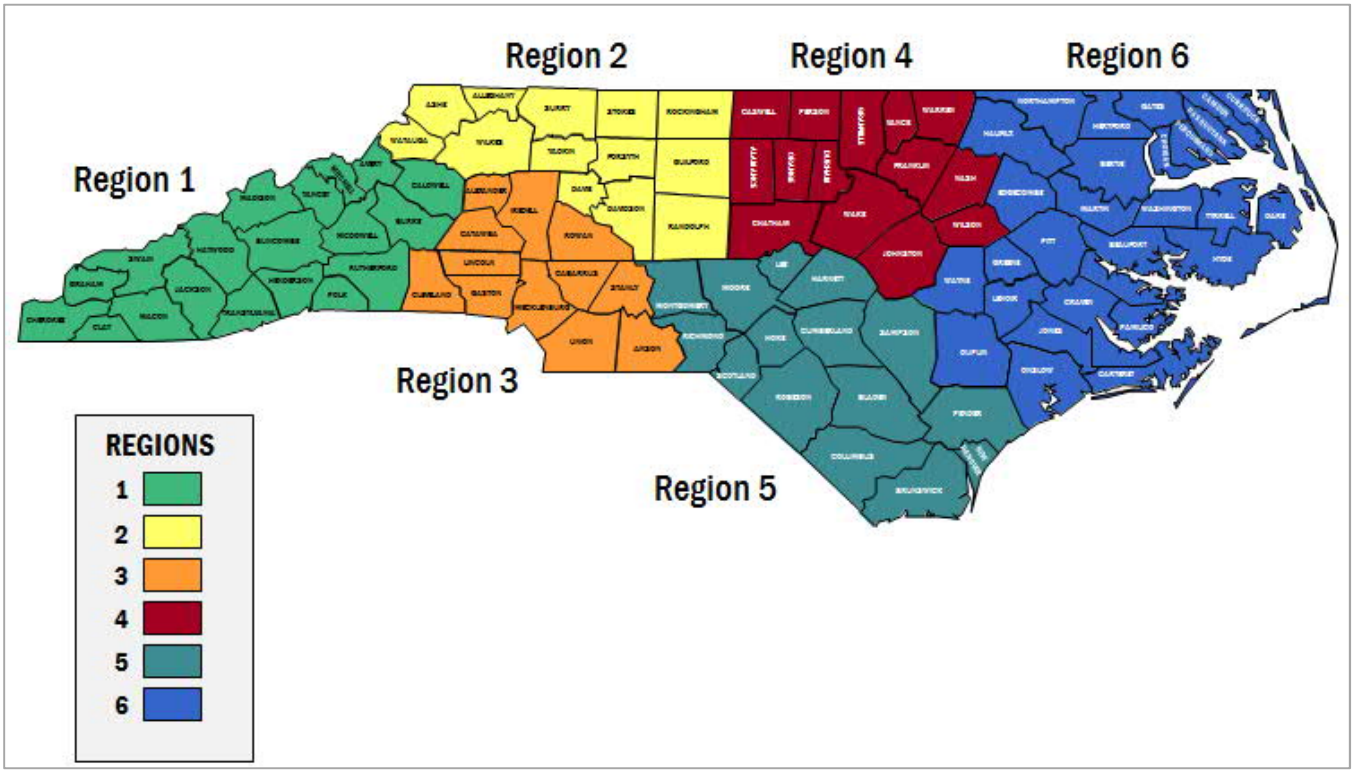
DHHS has defined six regions for the Standard Plan population. Table 1 outlines the counties included in each of the six PHP regions and Figure 1 illustrates the PHP regions in map format. Base data and capitation rates contained in this Draft Rate Book are summarized and developed by the six regions. Note that the capitation rates are developed for all regions for a managed care effective date of July 1, 2019. However, DHHS will phase the regions into managed care; information on the phase-in schedule will be released after PHP contract award.

As a part of final capitation rate development, Mercer will evaluate further regional breakouts that may be necessary due to meaningful cost and utilization variances within certain regions beyond those addressed through rate cells and risk adjustment.

Table 1: List of Counties in PHP Regions

PHP Regions	Counties
Region 1	Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
Region 2	Alleghany, Ashe, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes, Yadkin
Region 3	Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union
Region 4	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Johnston, Nash, Orange, Person, Vance, Wake, Warren, Wilson
Region 5	Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland
Region 6	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne

Figure 1: Map of PHP Regions



4 POPULATION GROUPINGS

DHHS will reimburse PHPs using full-risk capitation payments for eligible populations. Mercer determined rate cells for the Standard Plan population to account for material cost differences amongst populations. Since the managed care population will have choice of PHPs, the rate cell structure is intended to differentiate payments to PHPs where disproportionate enrollment of certain populations may occur. However, since the State has chosen to risk adjust the capitation rates, fewer rate cells are necessary since a risk adjustment model accounts for much of the age/gender risk within a population and differentiates payments to PHPs based on their enrolled population risk profile. Alongside the monthly per member capitation rates, DHHS will make a one-time Maternity Event payment that will cover prenatal, delivery and postpartum care for the mother. The final rate cell structure for the Standard Plan population is outlined in Section 4.1.

While the base data and rate development outlined in this Draft Rate Book is specific to the Standard Plan population, identification logic for future managed care populations and permanently excluded populations is outlined in Sections 4.2 and 4.3, respectively.

4.1 Standard Plan Population

The information summarized in this Draft Rate Book is specific to the Standard Plan population, including both Medicaid and NC Health Choice beneficiaries. As outlined, initial program implementation would enroll all non-dual beneficiaries into the Standard Plan who are otherwise not eligible for the BH and Intellectual/Developmental Disability (BH I/DD) Tailored Plan or fall into another excluded or delayed population as proposed by DHHS[5].

Based on a review of the Standard Plan population membership levels and cost variances by population, historical cost/utilization experience and rates for the Standard Plan population are summarized and developed for the following rate cells. Please see Appendix C for an overview of the rate cell determination process.

- Aged, Blind, Disabled (ABD), all ages
- Temporary Assistance for Needy Families (TANF) and Other Related Children (ages <1)
- TANF and Other Related Children (ages 1–20)
- TANF and Other Related Adults (ages 21+)
- Maternity Event, all ages

The table below outlines the logic used to summarize the broader categories of aid (COA) for the Standard Plan population; this includes information on detailed eligibility codes and sub-population groups.

Table 2: Standard Plan Population Criteria[6]

COA	Detailed Population Group	Program Aid Code/Eligibility Code
ABD	Aged	MAABN, MAACY, MAAMN , MAANN, MAAQN, MAAQY, SAABN, SAACN, SAACY, SAAQN, SAAQY
	Blind	MABBN, MABCY, MABMN, MABNN, MABQN, MABQY
	Disabled	MADBN, MADCY, MADMN, MADNN, MADQN, MADQY, SADBN, SADCN, SADCY, SADQN, SADQY

[5] Information on proposed program design can be found in the Policy Papers published by DHHS: https://www.ncdhhs.gov/concept-papers

[6] For specific program eligibility requirements, refer to the NC Basic Medicaid Income Eligibility Chart (https://files.nc.gov/ncdma/documents/files/BASIC_MEDICAID_INCOME_ELIGIBLITY_CHART_2017_03_10.pdf).

COA	Detailed Population Group	Program Aid Code/Eligibility Code
TANF and Other Related Children/Adults	Aid to Families with Dependent Children	AAFCN, AAFCY
	Other Children	MAFCN, MAFMN, MAFNN
	Pregnant Women	MPWNN
	Infants and Children	MICNN
	Breast and Cervical Cancer (BCC)	MAFWN
	Legal Aliens (Full Medicaid)	Eligibility codes with a fourth character of G, P, I or T
	NC Health Choice	MICAN, MICJN, MICKN, MICSN
	NC Health Choice — Extended Coverage[7]	MICLN
	Medicaid-Children's Health Insurance Program (M-CHIP)	MIC1N
Maternity Event	N/A	Cost summarized for pregnancy-related services for beneficiaries with a live birth event. The live birth event is identified by Current Procedural Terminology (CPT) codes or Diagnosis-Related Groups (DRGs). Prenatal services are included 8 whole months prior to the live birth event, and postpartum services are included 2 whole months following the live birth event. Please see Appendix A for the detailed logic used to identify these pregnancy-related services.

Members of federally recognized tribes are eligible to participate in managed care but are not required to enroll in PHPs. Members may voluntarily enroll in PHPs on an opt-in basis and may dis-enroll without cause at any time. For purposes of draft capitation rates, cost and utilization associated with members of federally recognized tribes have not been separately identified nor excluded for purposes of base data development. Mercer is working with DHHS to evaluate the impact of cost and enrollment considerations for this population; please see Section 15.1.1 for more information on this population.

Members of the Standard Plan population and the future BH I/DD Tailored Plan population will have the ability to shift between plans under specific circumstances under managed care. Given the cost profile of these members, this could have implications on the capitation rates. No considerations have been made in the draft rates for any shifting expectation at this point. Mercer and DHHS will continue to discuss this issue and may incorporate consideration into risk adjustment or an adjustment into final rate development. Please refer to Appendix F for more detail on potential cost implications for this group.

4.2 Future Managed Care Populations

Following initial implementation of managed care and the rollout to the Standard Plan population, additional populations will be phased-in over a five-year period, pursuant to Session Law (S.L.) 2015-245[8], as amended. The table below outlines the treatment of each of these population cohorts for Contract Year 1. As mentioned, detailed cost and utilization information for populations other than the Standard Plan population is outside the scope of this Draft Rate Book.

[7] NC Health Choice extended coverage is optional coverage for beneficiaries at 211%-225% Federal Poverty Level (FPL); beneficiaries may remain on NC Health Choice for a period not to exceed one year (NC DHHS On-Line Manual, https://www2.ncdhhs.gov/info/olm/manuals/dma/fcm/man/MA3255-05.htm).

[8] SL 2015-245 An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs https://www.ncleg.net/Sessions/2015/Bills/House/PDF/H372v8.pdf

Table 3: Future Managed Care Population Cohorts

Special Population	Standard Plan PHP Status for Contract Year 1
Standard Plan	Mandatory
Foster Children and Adopted Children	Excluded
BH I/DD Tailored Plan (including both non-dual and dual eligibles)	Exempt; choice of current delivery system or Standard Plan enrollment
Medicaid-only beneficiaries receiving long-stay nursing home services	Excluded
Dual Eligibles with full Medicaid benefits	Excluded

Please see Appendix B for detailed data summarization logic for the identification of the future managed care populations.

4.3 Excluded Populations

The following populations are permanently excluded from PHP enrollment, pursuant to S.L. 2015-245, as amended:

- Beneficiaries eligible for Medicare, but not full Medicaid benefits, including beneficiaries in those categories limited to Medicare cost sharing programs.
- Beneficiaries enrolled in Program of All-Inclusive Care for the Elderly (PACE).
- Beneficiaries enrolled in North Carolina's Health Insurance Premium Program.
- Beneficiaries enrolled in Medicaid for emergency services only.
- Medically needy beneficiaries.
- Beneficiaries eligible for family planning services only
- Beneficiaries who are inmates of prisons.
- Expenditures for periods of presumptive eligibility.
- Beneficiaries being served through the Community Alternatives Program for Children (CAP/C) waiver
- Beneficiaries being served through the Community Alternatives Program for Disabled Adults (CAP/DA) waiver

Additionally, refugees receiving coverage through the Refugee Medical Assistance program are excluded from PHP enrollment.

Please see Appendix B for the detailed data summarization logic for the identification of the permanently excluded populations.

5 SERVICE CATEGORIES

DHHS will reimburse PHPs using full-risk capitation payments for eligible services. Mercer has summarized the cost and utilization information from the historical FFS data and the LME/MCO encounter data into major COS.

The table below shows how the detailed service categories covered by the Standard Plans were grouped for purposes of this report and the exhibits in Section 7. Please refer to the Request for Proposal (RFP) for details on the covered and excluded services for the Standard Plan population.

Table 4: Standard Plan COS Groupings

COS Grouping	FFS Data Detailed COS	Encounter Data Detailed COS	Unit Type
Inpatient — Physical Health (PH)	Inpatient	N/A	Days
Inpatient — BH	N/A	Inpatient	Days
Outpatient Hospital	Outpatient	N/A	Visits
Emergency Room	Emergency Room	Emergency Room	Visits
Physician	Physician	N/A	Visits
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)	FQHC RHC	N/A	Visits
Other Clinic	Free-standing Clinics Health Check — Health Department Family Planning Services	N/A	Visits
Other Practitioner	Chiropractic Podiatry	N/A	Visits
Therapies	Physical Therapy Speech Therapy Occupational Therapy	N/A	Visits
Prescribed Drugs	Prescribed Drugs	N/A	Scripts
Other BH Services	Mental Health services for non-LME/MCO population (Ages 0–3 and NC Health Choice)	Crisis Services Outpatient (including psychotherapy and alcohol/drug services) Partial Hospitalization	Procedure Count
Long Term Services and Supports (LTSS) Services	Home Health Hospice Nursing Home Personal Care	N/A	Procedure Count
Durable Medical Equipment	Durable Medical Equipment	N/A	Procedure Count
Lab and X-Ray[9]	Lab and X-Ray	N/A	Procedure Count
Optical	Optical, excluding costs for eyeglasses frames, lenses, lens treatments, fabrication and fittings	N/A	Procedure Count

[9] To support the data summarization process eviCore (previously MedSolutions) capitation payments for lab and radiology services were removed in order to not duplicate actual cost and utilization reflected in the FFS data.

COS Grouping	FFS Data Detailed COS	Encounter Data Detailed COS	Unit Type
Limited Dental Services[10]	Into the Mouth of Babes program	N/A	Procedure Count
Transportation	Ambulance NEMT	N/A	Claim Count
Medical Home Payments	Historical payments made to practices in Carolina ACCESS (CA) program (practices in CA I receive fees of $1.00 per member per month [PMPM] and practices in CA II receive fees of $2.50 or $5.00 PMPM)	N/A	Claim Count
Obstetric Care Management (OBCM) Payments	OBCM Payments	N/A	Claim Count
Care Coordination for Children (CC4C) Payments	CC4C Payments	N/A	Claim Count

Note that there are additional covered services specific to populations that will phase into managed care after Contract Year 1. Specifically, there are services unique to the BH I/DD Tailored Plan population and individuals enrolled in a 1915(c) waiver. See below for a list of covered services for the delayed populations that are assumed to not be covered under Standard Plans for purposes of these draft rates.

- The following Medicaid COS are proposed to be covered under the LME/MCOs and subsequently BH I/DD Tailored Plan, and not the Standard Plans:
    - 1915(b)(3) Services
    - Innovations Waiver Services
    - Intermediate Care Facility for beneficiaries with I/DDs
    - Traumatic Brain Injury (TBI) Waiver Services
    - Other BH Services
        - Assertive Community Treatment
        - Child and Adolescent Day Treatment Services
        - Community Support Team
        - Intensive In-home Services
        - Multi-systemic Therapy Services
        - Psychiatric Residential Treatment Facilities
        - Psychosocial Rehabilitation
        - Residential Treatment Facility Services
        - Substance Abuse Medically Monitored Residential Treatment
        - Substance Abuse Non-medical Community Residential Treatment
- The following COS are covered for the LTSS 1915(c) waiver populations, and thus excluded from Standard Plans in Contract Year 1:
    - CAP/C Waiver Services
    - CAP/DA Waiver Services

Covered services that are excluded from PHPs, and continue under FFS, are summarized below:

- Children's Developmental Services Agencies
- Dental services not identified in the COS table above
- Local Education Agency

[10] Costs associated with oral/maxillofacial surgery and adjunctive general dental services will be covered by PHPs when billed as a medical or professional claim; based on the COS mapping logic, these costs are captured in the above medical/professional service lines and thus not captured under the 'Limited Dental Services' COS.

- Optical services for eyeglasses frames, lenses, lens treatments, fabrication and fittings are considered non-covered services in this Rate Book, however this is subject to change pending legislation

As outlined in Table 4, Medical Home and Local Health Department (LHD) OBCM and CC4C PMPM payments are included in draft rate development since DHHS is requiring that PHPs continue these payments to those providers. Other historical payments made through Community Care of North Carolina (CCNC) were not included in the data summaries in Section 7 (identified as Excluded Patient-Centered Medical Home [PCMH] Payments in Appendix D). These costs were related to monthly per member payments to coordinate and manage care for members along with payments made to administer the Health Check and Pregnancy Medical Home (PMH) programs. Additionally, Mercer did not include costs related to case management for Human Immunodeficiency Virus (HIV) members as consideration for these care management activities is included as a non-benefit component of the rate development process.

Appendix D contains detailed coding logic used to define all detailed categories noted above.

6 HISTORICAL DATA ANALYSIS

This section provides an overview of the adjustments Mercer made to the data sources summarized in this report. These adjustments are reflected in the exhibits shown in Section 7.

6.1 MMs Adjustment

Medicaid eligibility data provided by DHHS was used to summarize MM information throughout this Rate Book. Use of this information ensures consistency in claims and MM summarization for the PMPM calculation. Mercer observed declines in eligibility counts in the later months of SFY 2017 when comparing to other eligibility data sources. Thus, Mercer calculated an adjustment to the MMs to account for the observed lag in the membership counts for more recent months in the base data.

The adjustment was developed based on a review of the enrollment trends by population for the July 2015 through September 2017 time period in the detailed Medicaid eligibility data compared to other State monthly Medicaid enrollment information available on the DHHS website[11]. Notable membership lag was observed beginning in February 2017 for the TANF population, while changes to the enrollment pattern for the ABD population were not observed until the last few months of SFY 2017. Mercer did not adjust the count of deliveries, tied to the Maternity Event payment, as these are calculated utilizing the live birth events as outlined in Section 4.

The tables below reflect the impact of the MM adjustment. Note that these MMs represent membership prior to the removal of MMs associated with the retroactive eligibility or application lag period.

Table 5: SFY 2017 Impact of MM Adjustment by COA

COA	Unadjusted MMs	Adjustment MMs	Final MMs
ABD	1,643,081	1,230	1,644,312
TANF, Newborn (<1)	849,190	516	849,705
TANF, Children (1-20)	13,251,138	90,754	13,341,893
TANF, Adults (21+)	2,871,705	42,871	2,914,576
Total Standard Plan	18,615,114	135,372	18,750,485

Table 6: SFY 2017 Impact of MM Adjustment by Month

Month	Unadjusted MMs	Adjustment MMs	Final MMs
July 2016	1,546,766	0	1,546,766
August 2016	1,554,328	0	1,554,328
September 2016	1,557,288	0	1,557,288
October 2016	1,557,384	0	1,557,384
November 2016	1,558,362	0	1,558,362
December 2016	1,557,646	0	1,557,646
January 2017	1,558,724	0	1,558,724
February 2017	1,556,196	10,449	1,566,645
March 2017	1,553,372	20,824	1,574,196
April 2017	1,544,809	30,600	1,575,409
May 2017	1,539,275	36,489	1,575,764

[11] https://dma.ncdhhs.gov/documents/medicaid-and-health-choice-enrollment-reports

Month	Unadjusted MMs	Adjustment MMs	Final MMs
June 2017	1,530,962	37,010	1,567,972
Total Standard Plan	18,615,114	135,372	18,750,485

6.2 Retroactive Eligibility and Application Period

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

The application period represents the time between initial application for Medicaid eligibility and Medicaid eligibility determination. Proposed policy indicates that PHP enrollment and responsibility for beneficiaries will be effective the first day of the month of eligibility determination. Therefore, Mercer has excluded the application period from the base data, which is considered to be from the first of the month of the application filing up to the first of the month of eligibility determination.

Mercer received eligibility files from NC FAST that indicated recipient-level retroactive eligibility and application periods. Mercer used this information to identify the retroactive eligibility and application periods within the base data. The files provided by NC FAST were summarized based on disposition date, or date of eligibility determination, and went through June 2017. As such, a lag was observed in the data in more recent months for applications in which the eligibility determination had not yet been made. To account for this lag, Mercer leveraged the impact from the July through December 2016 time period and applied a similar impact to the January through June 2017 time period, where the lag was observed.

The tables below summarize the combined impact for the proposed Standard Plan population, by COA and by region. For the Standard Plan population, the retroactive eligibility period adjustment has a -1.3% and -1.0% PMPM impact in SFY 2016 and SFY 2017, respectively; and the application lag period adjustment has a -1.1% and -1.1% PMPM impact in SFY 2016 and SFY 2017, respectively. In total, for the Standard Plan population, this amounts to an overall PMPM impact of -2.3% and -2.1% in SFY 2016 and SFY 2017, respectively (as shown in the table below). The most impacted service for both the retroactive eligibility and application lag period combined was Inpatient — PH.

Table 7: Combined Impact of Retroactive Eligibility Period and Application Period Adjustments by COA

	SFY 2016			SFY 2017		
COA	Aggregate Dollar Impact	Member Month Impact	PMPM/ Payment Impact	Aggregate Dollar Impact	Member Month Impact	PMPM/ Payment Impact
ABD	-7.5%	-4.0%	-3.7%	-6.6%	-3.1%	-3.7%
TANF, Newborn (<1)	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
TANF, Children (1-20)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TANF, Adults (21+)	-0.4%	-0.3%	-0.1%	-0.3%	-0.2%	-0.1%
Maternity Event	-0.5%	0.0%	-0.5%	-0.5%	0.0%	-0.5%
Total Standard Plan	-2.8%	-0.4%	-2.3%	-2.4%	-0.3%	-2.1%

Table 8: Combined Impact of Retroactive Eligibility Period and Application Period Adjustments by Region

Region	SFY 2016			SFY 2017		
	Aggregate Dollar Impact	Member Month Impact	PMPM/ Payment Impact	Aggregate Dollar Impact	Member Month Impact	PMPM/ Payment Impact
Region 1	-3.0%	-0.6%	-2.5%	-2.5%	-0.4%	-2.2%
Region 2	-2.8%	-0.4%	-2.3%	-2.4%	-0.3%	-2.1%
Region 3	-2.7%	-0.4%	-2.4%	-2.2%	-0.3%	-1.9%
Region 4	-2.8%	-0.4%	-2.4%	-2.3%	-0.3%	-2.0%
Region 5	-2.6%	-0.4%	-2.2%	-2.4%	-0.3%	-2.1%
Region 6	-2.8%	-0.4%	-2.3%	-2.5%	-0.4%	-2.2%
Total Standard Plan	-2.8%	-0.4%	-2.3%	-2.4%	-0.3%	-2.1%

6.3 Completion Factors

The summarized data include claims for dates of service for SFY 2016 and SFY 2017. Mercer developed completion factors to estimate incurred-but-not-reported (IBNR) claims (those claims not yet adjudicated). The FFS data and the LME/MCO encounter data reflect payments through September 2017. The following factors are applied to both dollars and utilization.

Table 9: Completion Factors

COS	Data Factors	
	SFY 2016	SFY 2017
Inpatient — PH	1.008	1.065
Inpatient — BH	1.001	1.047
Outpatient Hospital	1.000	1.023
Emergency Room	1.000	1.026
Physician	1.001	1.030
FQHC/RHC	1.001	1.030
Other Clinic	1.001	1.029
Other Practitioner	1.001	1.030
Therapies	1.001	1.032
Prescribed Drugs	1.000	1.001
Other BH Services	1.001	1.010
LTSS Services	1.000	1.012
Durable Medical Equipment	1.000	1.026
Lab and X-Ray	1.000	1.026
Optical	1.000	1.024
Limited Dental Services	1.000	1.026
Transportation	1.000	1.051
Medical Home Payments	1.000	1.021
OCBM Payments	1.000	1.000
CC4C Payments	1.000	1.000
Total Standard Plan	1.001	1.024

6.4 GME Adjustment

DHHS will make GME payments directly to eligible hospitals, as permitted under 42 CFR 438.6(a). As a result, PHPs will not be required to make GME payments to hospitals. Under FFS, historically DHHS has reimbursed providers through both a GME add-on paid through the base rate captured in the historical FFS claims expenditures and as a part of the supplemental payments made outside of the claims system. As such, Mercer calculated an adjustment to exclude the GME portion of the Inpatient claims in the base FFS data. To calculate this adjustment, Mercer relied on the GME payment information provided by DHHS that listed GME add-on amount by hospital. The total historical GME add-on amount for all populations is approximately $90 million in both SFY 2016 and SFY 2017. Note that the impacts cited for the total population and in the table below are after the removal of the retroactive eligibility and application lag period. The table below illustrates the adjustment applied to each base year for the Standard Plan.

Table 10: GME Adjustment Impact

		SFY 2016		SFY 2017	
Region	COS	Dollar Amount	Percentage Impact	Dollar Amount	Percentage Impact
Region 1	Inpatient — PH	$(3,557,761)	-5.8%	$(3,199,160)	-5.1%
Region 2	Inpatient — PH	$(13,728,862)	-12.5%	$(14,306,477)	-12.4%
Region 3	Inpatient — PH	$(8,837,844)	-6.3%	$(8,328,723)	-5.8%
Region 4	Inpatient — PH	$(19,443,789)	-15.1%	$(20,482,036)	-15.0%
Region 5	Inpatient — PH	$(11,107,776)	-9.2%	$(12,062,262)	-9.6%
Region 6	Inpatient — PH	$(11,218,598)	-11.6%	$(11,527,158)	-11.6%
Total Standard Plan	Inpatient — PH	$(67,894,630)	-10.3%	$(69,905,815)	-10.2%

Please see Section 11.1 and Appendix G of this Rate Book for information on how GME will be factored into future hospital reimbursement requirements.

6.5 TPL Adjustment

The FFS claims data from NC Tracks reflects the reduction for TPL if the amount is reported on the claim submitted by the provider. However, NC Tracks data is not subsequently adjusted for TPL recoveries collected by DHHS. In the proposed policy, PHPs will have the responsibility of collecting TPL for all recovery types with the exception of Trust and Estate recoveries. The following table illustrates the total TPL recoveries for all populations (including those excluded from PHPs) by type for the SFY 2016 and SFY 2017 time periods for the recovery types to be collected by the PHPs.

Table 11: Total TPL Recovery Amounts

Recovery Type	SFY 2016 Recovery Amount	SFY 2017 Recovery Amount
Commercial Insurance	$(51,144,021)	$(52,255,224)
Medicare	$(1,620,651)	$(2,465,439)
Casualty	$(16,698,729)	$(18,021,105)
Credit Balance	$(7,603,627)	$(3,888,072)
Total	$(77,067,028)	$(76,629,840)

Mercer utilized TPL recovery information provided by DHHS to calculate a downward adjustment to reflect the TPL recoveries that are not present in the claims data and are anticipated to be collected by the PHPs. Mercer

leveraged member-level recovery information to allocate the adjustment by population. The table below illustrates the TPL recoveries removed for the Standard Plan population for the base time periods.

Table 12: TPL Adjustment Amount for Standard Plan Population

COA	SFY 2016 Dollar Adjustment	SFY 2017 Dollar Adjustment
ABD	$(9,106,020)	$(7,005,985)
TANF, Newborn (<1)	$(1,405,814)	$(241,136)
TANF, Children (1-20)	$(12,680,291)	$(13,593,281)
TANF, Adults (21+)	$(8,683,166)	$(8,087,896)
Maternity Event	$(2,503,874)	$(2,393,280)
Total Standard Plan	$(34,379,165)	$(31,321,578)

6.6 NEMT Adjustment

Historically, payments for NEMT providers were processed outside of NC Tracks; DHHS supplied information on NEMT payments for the SFY 2016 and SFY 2017 time periods. Effective September 2016, DHHS began to process NEMT payments for pilot counties through NC Tracks. Mercer leveraged the SFY 2016 and SFY 2017 NEMT payments provided by DHHS and the distribution of NEMT costs after September 2016 in the FFS data to allocate the historical NEMT costs across the population groupings. Mercer leveraged the PMPM for the piloted counties within a region to project the costs for counties without SFY 2017 claims experience.

The total NEMT spend across all populations is approximately $60 million in both SFY 2016 and SFY 2017. For SFY 2016, Mercer built in the full NEMT costs provided by DHHS, and for SFY 2017 Mercer built in the difference between the full NEMT costs provided by DHHS and the amount reflected in the base FFS experience given the pilot began during the SFY 2017 time period. The table below illustrates the allocated NEMT costs for the Standard Plan population for the base time periods.

Table 13: NEMT Adjustment Amount

	SFY 2016	SFY 2017		
COA	Total Dollars	Base FFS Dollars	Adjustment Dollars	Total Dollars
ABD	$8,374,742	$1,551,023	$7,041,725	$8,592,747
TANF, Newborn (<1)	$117,353	$21,397	$99,011	$120,407
TANF, Children (1-20)	$1,318,991	$244,962	$1,108,364	$1,353,326
TANF, Adults (21+)	$1,552,060	$314,757	$1,277,705	$1,592,462
Maternity Event	$899	$179	$744	$922
Total Standard Plan	$11,364,044	$2,132,317	$9,527,548	$11,659,865

6.7 Fraud, Waste and Abuse Recoveries Adjustment

CMS is committed to combating Medicaid provider fraud, waste and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid enrollees[12]. Based on information provided by DHHS, the total annual recovery amount was $28.6 million in SFY 2016 and $8.0 million in SFY 2017. Mercer is working with DHHS to obtain more detailed information related to fraud, waste and abuse recoveries for Medicaid and NC Health Choice beneficiaries under the FFS program, and how these recoveries may be attributable to covered populations and services. Note that based on the annual recovery information above,

[12] https://www.medicaid.gov/medicaid/program-integrity/index.html

this could necessitate up to a 0.6% downward adjustment to the Standard Plan population claims; however, at this point no adjustment has been applied to the base data.

6.8 LME/MCO Data Adjustments

The following represents adjustments specific to the LME/MCO encounter data.

6.8.1 Patient Liability Adjustment

In the North Carolina BH managed care program operated by the LME/MCOs under concurrent 1915(b)/(c) waiver authority, certain beneficiaries receiving services in Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IIDs) have patient liability responsibilities through post-eligibility treatment of income to contribute to the reimbursement of their services. In the Medicaid FFS program, the ICF/IID collects these patient liability payments directly from the beneficiary and submits a FFS claim to Medicaid identifying the collected patient liability and the remaining expense eligible for Medicaid reimbursement.

Under the LME/MCO BH managed care program, DHHS has been following a similar transactional process, where the ICF/IID continues to collect the patient liability directly from the beneficiary and submits a claim to the LME/MCO for the balance of the charges. Mercer has reviewed the patient liability required for the impacted beneficiaries each month from the statewide eligibility file and compared to the patient liability collected and documented by the LME/MCO. Based on this review of ICF/IID encounter claims, an adjustment was made to account for the difference between the required amount and reported amount of patient liability observed in the documentation provided by the LME/MCO. The adjustment ensures the base data reflects claims expenses that are the responsibility of the LME/MCOs.

The patient liability adjustment is applied to the LTSS Services COS, for LME/MCO beneficiaries. As mentioned, this adjustment is only applicable to the LME/MCO encounter data since there is a process in place to account for patient liability during FFS claims processing. The overall impact across all populations is approximately $(30,000) in SFY 2016 and SFY 2017, which rounds to a 0.0% overall adjustment in each year. There is no impact to the Standard Plan population for this adjustment; however, the impact applies to future managed care populations.

6.8.2 Payments Made Outside of the Claims System

LME/MCOs have historically documented payments for services paid outside of the claims system that were not otherwise represented in the base data. LME/MCOs provided Mercer with documentation of these payments by COS and date of service. Mercer used this information to build in an adjustment to the historical experience to ensure that the data was fully representative of all BH service costs. For the Standard Plan, this adjustment increased the SFY 2016 and SFY 2017 LME/MCO BH encounter data by approximately 1.5% each year, which rounds to a 0.0% adjustment as a percentage of total Standard Plan program costs (both FFS claims and LME/MCO BH encounter data).

7 HISTORICAL DATA EXHIBITS

Mercer summarized the base data experience for the Standard Plan population in the following exhibits. These summaries reflect the base data adjustments outlined in Section 6 of the narrative and are shown on a regional basis.

The top of each exhibit includes the following identifying information:

- Time Period: SFY 2016 or SFY 2017
- Region: Regional breakouts based on Section 3 of the narrative
- COA: Specific COA group for the Standard Plan population as defined in Section 4.1 of the narrative:
    - ABD
    - TANF
    - Maternity Event
    - All COAs combined
- Age Grouping: Specific age groups as defined in Section 4.1 of the narrative

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 live birth events related to the Maternity Event payment.
- Average Monthly Members/Deliveries: MMs or Deliveries divided by 12.
- Eligibles: Reflect a unique count of eligibles for the time period and population indicated.
- COS: 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 provided by DHHS and the encounter data provided by the LME/MCOs; 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 Table 4 in Section 5 for the unit types used to define utilization for the various service categories.
- Users: Unique user count for each service.
- Utilization per 1,000: Annual utilization for each service divided by total MMs multiplied by 12,000.
- Unit Cost: Average cost of each service line item; paid claims divided by the utilization of services delivered.
- PMPM/Payment: PMPM is the incurred claims divided by total MMs; the Maternity Event payment is the incurred claims divided by the Deliveries.

7.1 SFY 2016 Exhibits

Cost and utilization information for the July 1, 2015 through June 30, 2016 (SFY 2016) time period is illustrated in Section 7.1.

7.1.1 SFY 2016 Region 1 Exhibits

Exhibit 1

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	148,496
Average Monthly Members/Deliveries:	12,375
Eligibles:	15,638

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 19,105,350	18,289	2,317	1,478	$ 1,044.61	$ 128.66
Inpatient — BH	$ 1,201,247	1,421	266	115	$ 845.37	$ 8.09
Outpatient Hospital	$ 17,235,526	41,158	8,846	3,326	$ 418.77	$ 116.07
Emergency Room	$ 8,978,926	18,173	6,929	1,469	$ 494.07	$ 60.47
Physician	$ 15,472,795	116,916	11,959	9,448	$ 132.34	$ 104.20
FQHC/RHC	$ 1,758,848	13,792	3,255	1,115	$ 127.53	$ 11.84
Other Clinic	$ 1,020,955	3,751	2,332	303	$ 272.15	$ 6.88
Other Practitioner	$ 168,032	2,191	616	177	$ 76.71	$ 1.13
Therapies	$ 334,646	3,156	162	255	$ 106.03	$ 2.25
Prescribed Drugs	$ 62,314,043	493,975	11,989	39,918	$ 126.15	$ 419.63
Other BH Services	$ 2,025,598	34,240	2,999	2,767	$ 59.16	$ 13.64
LTSS Services	$ 5,302,014	710,667	1,080	57,429	$ 163.71	$ 35.70
Durable Medical Equipment	$ 5,090,039	1,759,092	3,861	142,152	$ 2.89	$ 34.28
Limited Dental Services	$ 2,184	89	34	7	$ 24.53	$ 0.01
Optical	$ 126,122	1,834	1,160	148	$ 68.78	$ 0.85
Lab and X-Ray	$ 1,412,335	74,497	5,008	6,020	$ 18.96	$ 9.51
Transportation	$ 1,619,999	27,127	2,470	2,192	$ 59.72	$ 10.91
Subtotal (Medical)	$ 143,168,658	3,320,368	13,675			$ 964.12
CC4C LHD Payments	$ 713	158	N/A	13	$ 4.51	$ 0.00
OBCM LHD Payments	$ 115,319	23,487	N/A	1,898	$ 4.91	$ 0.78
Medical Home Payments	$ 559,250	120,171	N/A	9,711	$ 4.65	$ 3.77
Subtotal (LHD/Medical Home Payments)	$ 675,282	143,816	N/A			$ 4.55
Total (Medical + LHD/Medical Home)	$ 143,843,939	3,464,184	N/A			$ 968.67

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 2

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	83,575
Average Monthly Members/Deliveries:	6,965
Eligibles:	13,657

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 15,843,523	24,693	6,054	3,546	$ 641.62	$ 189.57
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,539,559	9,727	3,955	1,397	$ 158.28	$ 18.42
Emergency Room	$ 1,395,662	6,016	3,603	864	$ 232.00	$ 16.70
Physician	$ 6,139,695	71,067	11,516	10,204	$ 86.39	$ 73.46
FQHC/RHC	$ 780,550	6,193	1,280	889	$ 126.04	$ 9.34
Other Clinic	$ 2,881,190	30,145	10,345	4,328	$ 95.58	$ 34.47
Other Practitioner	$ 5,002	164	47	24	$ 30.47	$ 0.06
Therapies	$ 67,043	812	175	117	$ 82.61	$ 0.80
Prescribed Drugs	$ 1,121,377	26,052	6,772	3,741	$ 43.04	$ 13.42
Other BH Services	$ 3,964	239	8	34	$ 16.58	$ 0.05
LTSS Services	$ 175,369	4,931	230	708	$ 35.56	$ 2.10
Durable Medical Equipment	$ 781,572	185,881	1,506	26,690	$ 4.20	$ 9.35
Limited Dental Services	$ 142,761	5,779	2,399	830	$ 24.71	$ 1.71
Optical	$ 787	10	8	1	$ 78.73	$ 0.01
Lab and X-Ray	$ 42,938	2,116	1,058	304	$ 20.29	$ 0.51
Transportation	$ 103,428	1,204	346	173	$ 85.92	$ 1.24
Subtotal (Medical)	$ 31,024,420	375,027	12,602			$ 371.22
CC4C LHD Payments	$ 373,167	82,565	N/A	11,855	$ 4.52	$ 4.47
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 156,930	64,349	N/A	9,240	$ 2.44	$ 1.88
Subtotal (LHD/Medical Home Payments)	$ 530,097	146,914	N/A			$ 6.34
Total (Medical + LHD/Medical Home)	$ 31,554,518	521,941	N/A			$ 377.56

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 3

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	1,201,019
Average Monthly Members/Deliveries:	100,085
Eligibles:	118,468

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 4,512,089	4,336	959	43	$ 1,040.71	$ 3.76
Inpatient — BH	$ 1,092,262	1,243	190	12	$ 878.76	$ 0.91
Outpatient Hospital	$ 19,020,503	81,676	33,437	816	$ 232.88	$ 15.84
Emergency Room	$ 14,661,088	49,031	30,011	490	$ 299.01	$ 12.21
Physician	$ 25,651,627	366,338	83,459	3,660	$ 70.02	$ 21.36
FQHC/RHC	$ 4,563,549	32,924	11,155	329	$ 138.61	$ 3.80
Other Clinic	$ 6,679,000	63,001	52,689	629	$ 106.01	$ 5.56
Other Practitioner	$ 232,590	4,191	1,271	42	$ 55.50	$ 0.19
Therapies	$ 4,131,823	41,538	3,061	415	$ 99.47	$ 3.44
Prescribed Drugs	$ 47,024,745	496,715	72,501	4,963	$ 94.67	$ 39.15
Other BH Services	$ 8,499,056	113,879	9,648	1,138	$ 74.63	$ 7.08
LTSS Services	$ 439,129	39,450	47	394	$ 133.93	$ 0.37
Durable Medical Equipment	$ 2,742,607	780,094	6,983	7,794	$ 3.52	$ 2.28
Limited Dental Services	$ 350,099	14,214	5,703	142	$ 24.63	$ 0.29
Optical	$ 1,118,143	13,563	12,457	136	$ 82.44	$ 0.93
Lab and X-Ray	$ 765,815	44,454	10,447	444	$ 17.23	$ 0.64
Transportation	$ 621,485	9,108	2,042	91	$ 68.23	$ 0.52
Subtotal (Medical)	$ 142,105,609	2,155,755	99,252			$ 118.32
CC4C LHD Payments	$ 1,263,406	280,424	N/A	2,802	$ 4.51	$ 1.05
OBCM LHD Payments	$ 712,572	145,411	N/A	1,453	$ 4.90	$ 0.59
Medical Home Payments	$ 2,574,411	1,057,454	N/A	10,566	$ 2.43	$ 2.14
Subtotal (LHD/Medical Home Payments)	$ 4,550,389	1,483,289	N/A			$ 3.79
Total (Medical + LHD/Medical Home)	$ 146,655,997	3,639,044	N/A			$ 122.11

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 4

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	276,458
Average Monthly Members/Deliveries:	23,038
Eligibles:	34,961

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 7,333,312	6,379	1,315	277	$ 1,149.59	$ 26.53
Inpatient — BH	$ 920,217	1,163	245	50	$ 790.96	$ 3.33
Outpatient Hospital	$ 13,668,579	45,643	15,014	1,981	$ 299.47	$ 49.44
Emergency Room	$ 12,332,425	29,363	12,806	1,275	$ 419.99	$ 44.61
Physician	$ 11,676,538	115,387	21,729	5,008	$ 101.19	$ 42.24
FQHC/RHC	$ 1,677,174	13,147	4,374	571	$ 127.57	$ 6.07
Other Clinic	$ 2,510,068	10,784	8,093	468	$ 232.75	$ 9.08
Other Practitioner	$ 138,640	2,652	837	115	$ 52.28	$ 0.50
Therapies	$ 51	1	1	0	$ 51.06	$ 0.00
Prescribed Drugs	$ 24,434,442	335,088	20,962	14,545	$ 72.92	$ 88.38
Other BH Services	$ 1,973,518	27,250	3,895	1,183	$ 72.42	$ 7.14
LTSS Services	$ 357,563	26,745	154	1,161	$ 181.27	$ 1.29
Durable Medical Equipment	$ 1,452,570	648,631	2,749	28,155	$ 2.24	$ 5.25
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 88,942	1,303	854	57	$ 68.23	$ 0.32
Lab and X-Ray	$ 2,762,326	132,365	10,539	5,745	$ 20.87	$ 9.99
Transportation	$ 513,916	7,358	1,767	319	$ 69.84	$ 1.86
Subtotal (Medical)	$ 81,840,280	1,403,259	27,307			$ 296.03
CC4C LHD Payments	$ 9	2	N/A	0	$ 4.40	$ 0.00
OBCM LHD Payments	$ 943,885	193,057	N/A	8,380	$ 4.89	$ 3.41
Medical Home Payments	$ 434,796	184,182	N/A	7,995	$ 2.36	$ 1.57
Subtotal (LHD/Medical Home Payments)	$ 1,378,690	377,241	N/A			$ 4.99
Total (Medical + LHD/Medical Home)	$ 83,218,970	1,780,500	N/A			$ 301.02

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 5

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	5,294
Average Monthly Members/Deliveries:	441
Eligibles:	5,450

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,649,440	14,314	5,168	32,444	$ 744.00	$ 2,011.54
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 2,317,698	18,194	2,660	41,238	$ 127.39	$ 437.78
Emergency Room	$ 1,333,244	4,004	547	9,076	$ 332.97	$ 251.83
Physician	$ 8,048,706	41,885	5,081	94,939	$ 192.16	$ 1,520.29
FQHC/RHC	$ 838,583	5,266	474	11,936	$ 159.24	$ 158.40
Other Clinic	$ 952,430	7,788	1,254	17,653	$ 122.29	$ 179.90
Other Practitioner	$ 322	12	48	27	$ 26.86	$ 0.06
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ -	-	-	-	$ -	$ -
LTSS Services	$ 9,645	2,038	8	4,619	$ 4.73	$ 1.82
Durable Medical Equipment	$ 29,121	333	164	755	$ 87.42	$ 5.50
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 200	2	12	5	$ 100.04	$ 0.04
Lab and X-Ray	$ 155,314	7,930	719	17,975	$ 19.58	$ 29.34
Transportation	$ 64,394	604	225	1,369	$ 106.59	$ 12.16
Subtotal (Medical)	$ 24,399,097	102,371	5,416			$ 4,608.67
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 24,399,097	102,371	N/A			$ 4,608.67

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 6

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	1,709,548
Average Monthly Members/Deliveries:	142,462
Eligibles:	188,174

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 57,443,714	68,011	15,813	477	$ 844.63	$ 33.60
Inpatient — BH	$ 3,213,725	3,827	702	27	$ 839.67	$ 1.88
Outpatient Hospital	$ 53,781,865	196,396	63,912	1,379	$ 273.84	$ 31.46
Emergency Room	$ 38,701,344	106,588	53,896	748	$ 363.09	$ 22.64
Physician	$ 66,989,361	711,593	133,744	4,995	$ 94.14	$ 39.19
FQHC/RHC	$ 9,618,704	71,321	20,538	501	$ 134.86	$ 5.63
Other Clinic	$ 14,043,642	115,470	74,713	811	$ 121.62	$ 8.21
Other Practitioner	$ 544,586	9,209	2,819	65	$ 59.13	$ 0.32
Therapies	$ 4,533,563	45,506	3,399	319	$ 99.63	$ 2.65
Prescribed Drugs	$ 134,894,607	1,351,830	115,478	9,489	$ 99.79	$ 78.91
Other BH Services	$ 12,502,136	175,608	16,703	1,233	$ 71.19	$ 7.31
LTSS Services	$ 6,283,719	783,831	1,519	5,502	$ 164.47	$ 3.68
Durable Medical Equipment	$ 10,095,909	3,374,031	15,263	23,684	$ 2.99	$ 5.91
Limited Dental Services	$ 495,044	20,082	8,136	141	$ 24.65	$ 0.29
Optical	$ 1,334,194	16,712	14,491	117	$ 79.83	$ 0.78
Lab and X-Ray	$ 5,138,727	261,362	27,771	1,835	$ 19.66	$ 3.01
Transportation	$ 2,923,222	45,401	6,850	319	$ 64.39	$ 1.71
Subtotal (Medical)	$ 422,538,064	7,356,779	158,137			$ 247.16
CC4C LHD Payments	$ 1,637,295	363,149	N/A	2,549	$ 4.51	$ 0.96
OBCM LHD Payments	$ 1,771,776	361,955	N/A	2,541	$ 4.90	$ 1.04
Medical Home Payments	$ 3,725,386	1,426,156	N/A	10,011	$ 2.61	$ 2.18
Subtotal (LHD/Medical Home Payments)	$ 7,134,457	2,151,260	N/A			$ 4.17
Total (Medical + LHD/Medical Home)	$ 429,672,521	9,508,039	N/A			$ 251.34

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.2 SFY 2016 Region 2 Exhibits

Exhibit 7

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	265,984
Average Monthly Members/Deliveries:	22,165
Eligibles:	26,813

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 34,460,023	35,532	3,810	1,603	$ 969.84	$ 129.56
Inpatient — BH	$ 1,591,719	2,368	421	107	$ 672.19	$ 5.98
Outpatient Hospital	$ 29,418,670	61,032	12,528	2,754	$ 482.02	$ 110.60
Emergency Room	$ 16,700,555	32,769	11,885	1,478	$ 509.65	$ 62.79
Physician	$ 26,666,391	202,317	20,595	9,128	$ 131.81	$ 100.26
FQHC/RHC	$ 521,458	4,427	1,393	200	$ 117.79	$ 1.96
Other Clinic	$ 2,193,531	7,421	4,322	335	$ 295.60	$ 8.25
Other Practitioner	$ 200,337	2,660	1,069	120	$ 75.32	$ 0.75
Therapies	$ 713,572	5,980	392	270	$ 119.33	$ 2.68
Prescribed Drugs	$ 106,617,766	754,878	19,990	34,057	$ 141.24	$ 400.84
Other BH Services	$ 3,747,230	65,003	5,475	2,933	$ 57.65	$ 14.09
LTSS Services	$ 15,890,578	2,957,310	2,224	133,421	$ 162.49	$ 59.74
Durable Medical Equipment	$ 9,568,592	3,084,897	6,221	139,177	$ 3.10	$ 35.97
Limited Dental Services	$ 11,494	468	166	21	$ 24.55	$ 0.04
Optical	$ 229,609	3,217	2,035	145	$ 71.37	$ 0.86
Lab and X-Ray	$ 3,294,326	182,351	10,915	8,227	$ 18.07	$ 12.39
Transportation	$ 3,190,015	35,059	4,098	1,582	$ 90.99	$ 11.99
Subtotal (Medical)	$ 255,015,865	7,437,689	23,086			$ 958.77
CC4C LHD Payments	$ 2,122	470	N/A	21	$ 4.51	$ 0.01
OBCM LHD Payments	$ 215,412	43,873	N/A	1,979	$ 4.91	$ 0.81
Medical Home Payments	$ 1,055,887	226,172	N/A	10,204	$ 4.67	$ 3.97
Subtotal (LHD/Medical Home Payments)	$ 1,273,422	270,515	N/A			$ 4.79
Total (Medical + LHD/Medical Home)	$ 256,289,287	7,708,204	N/A			$ 963.55

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 8

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	147,905
Average Monthly Members/Deliveries:	12,325
Eligibles:	24,147

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 22,543,143	41,308	11,016	3,351	$ 545.74	$ 152.42
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,886,093	12,602	5,242	1,022	$ 149.67	$ 12.75
Emergency Room	$ 3,196,619	12,729	7,369	1,033	$ 251.13	$ 21.61
Physician	$ 10,165,211	122,217	20,585	9,916	$ 83.17	$ 68.73
FQHC/RHC	$ 571,259	5,220	1,340	423	$ 109.44	$ 3.86
Other Clinic	$ 5,576,307	54,182	19,221	4,396	$ 102.92	$ 37.70
Other Practitioner	$ 1,440	34	13	3	$ 42.30	$ 0.01
Therapies	$ 90,341	841	144	68	$ 107.47	$ 0.61
Prescribed Drugs	$ 1,686,718	43,580	12,060	3,536	$ 38.70	$ 11.40
Other BH Services	$ 6,402	273	54	22	$ 23.45	$ 0.04
LTSS Services	$ 173,286	14,131	119	1,146	$ 12.26	$ 1.17
Durable Medical Equipment	$ 968,409	48,192	1,783	3,910	$ 20.09	$ 6.55
Limited Dental Services	$ 357,285	14,429	6,074	1,171	$ 24.76	$ 2.42
Optical	$ 4,688	51	38	4	$ 91.89	$ 0.03
Lab and X-Ray	$ 111,634	8,204	3,909	666	$ 13.61	$ 0.75
Transportation	$ 144,799	1,498	711	121	$ 96.69	$ 0.98
Subtotal (Medical)	$ 47,483,633	379,490	22,433			$ 321.04
CC4C LHD Payments	$ 658,149	145,621	N/A	11,815	$ 4.52	$ 4.45
OBCM LHD Payments	$ 10	2	N/A	0	$ 4.94	$ 0.00
Medical Home Payments	$ 278,570	112,822	N/A	9,154	$ 2.47	$ 1.88
Subtotal (LHD/Medical Home Payments)	$ 936,729	258,445	N/A			$ 6.33
Total (Medical + LHD/Medical Home)	$ 48,420,362	637,935	N/A			$ 327.37

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 9

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,211,702
Average Monthly Members/Deliveries:	184,308
Eligibles:	216,119

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 9,910,920	7,935	1,859	43	$ 1,249.08	$ 4.48
Inpatient — BH	$ 2,050,152	3,076	490	17	$ 666.45	$ 0.93
Outpatient Hospital	$ 21,420,811	97,832	42,351	531	$ 218.96	$ 9.69
Emergency Room	$ 29,933,020	96,253	59,143	522	$ 310.98	$ 13.53
Physician	$ 41,004,876	612,460	151,606	3,323	$ 66.95	$ 18.54
FQHC/RHC	$ 2,741,954	25,439	12,228	138	$ 107.78	$ 1.24
Other Clinic	$ 13,199,664	124,161	101,404	674	$ 106.31	$ 5.97
Other Practitioner	$ 248,666	3,292	1,385	18	$ 75.53	$ 0.11
Therapies	$ 6,201,731	51,490	3,753	279	$ 120.45	$ 2.80
Prescribed Drugs	$ 76,749,940	849,725	128,693	4,610	$ 90.32	$ 34.70
Other BH Services	$ 9,856,914	135,954	12,698	738	$ 72.50	$ 4.46
LTSS Services	$ 314,012	32,585	103	177	$ 133.53	$ 0.14
Durable Medical Equipment	$ 4,026,763	1,414,058	11,181	7,672	$ 2.85	$ 1.82
Limited Dental Services	$ 934,170	37,626	14,186	204	$ 24.83	$ 0.42
Optical	$ 2,194,008	26,197	22,729	142	$ 83.75	$ 0.99
Lab and X-Ray	$ 4,162,080	234,768	41,416	1,274	$ 17.73	$ 1.88
Transportation	$ 915,674	9,929	3,994	54	$ 92.22	$ 0.41
Subtotal (Medical)	$ 225,865,354	3,762,781	177,918			$ 102.12
CC4C LHD Payments	$ 2,352,092	522,058	N/A	2,833	$ 4.51	$ 1.06
OBCM LHD Payments	$ 1,304,330	266,155	N/A	1,444	$ 4.90	$ 0.59
Medical Home Payments	$ 4,893,899	1,997,152	N/A	10,836	$ 2.45	$ 2.21
Subtotal (LHD/Medical Home Payments)	$ 8,550,322	2,785,365	N/A			$ 3.87
Total (Medical + LHD/Medical Home)	$ 234,415,675	6,548,146	N/A			$ 105.99

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 10

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	458,696
Average Monthly Members/Deliveries:	38,225
Eligibles:	56,407

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,383,199	10,526	2,253	275	$ 1,081.46	$ 24.82
Inpatient — BH	$ 1,001,470	1,435	382	38	$ 697.65	$ 2.18
Outpatient Hospital	$ 16,008,748	48,723	19,170	1,275	$ 328.56	$ 34.90
Emergency Room	$ 21,734,187	48,143	22,568	1,259	$ 451.45	$ 47.38
Physician	$ 22,293,837	205,138	37,613	5,367	$ 108.68	$ 48.60
FQHC/RHC	$ 322,203	3,026	1,270	79	$ 106.48	$ 0.70
Other Clinic	$ 3,704,218	16,437	13,051	430	$ 225.36	$ 8.08
Other Practitioner	$ 186,991	2,824	1,046	74	$ 66.22	$ 0.41
Therapies	$ 76	2	2	0	$ 37.96	$ 0.00
Prescribed Drugs	$ 45,602,993	542,304	34,295	14,187	$ 84.09	$ 99.42
Other BH Services	$ 3,167,099	43,239	5,095	1,131	$ 73.25	$ 6.90
LTSS Services	$ 900,145	159,622	295	4,176	$ 153.01	$ 1.96
Durable Medical Equipment	$ 2,350,540	1,067,373	4,033	27,924	$ 2.20	$ 5.12
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 198,761	2,959	1,410	77	$ 67.17	$ 0.43
Lab and X-Ray	$ 7,248,529	364,088	23,501	9,525	$ 19.91	$ 15.80
Transportation	$ 1,094,182	11,835	3,249	310	$ 92.45	$ 2.39
Subtotal (Medical)	$ 137,197,178	2,527,674	44,664			$ 299.10
CC4C LHD Payments	$ 31	7	N/A	0	$ 4.42	$ 0.00
OBCM LHD Payments	$ 1,643,881	336,202	N/A	8,795	$ 4.89	$ 3.58
Medical Home Payments	$ 739,829	314,517	N/A	8,228	$ 2.35	$ 1.61
Subtotal (LHD/Medical Home Payments)	$ 2,383,741	650,726	N/A			$ 5.20
Total (Medical + LHD/Medical Home)	$ 139,580,919	3,178,400	N/A			$ 304.30

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 11

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	9,229
Average Monthly Members/Deliveries:	769
Eligibles:	9,459

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 17,105,261	25,310	8,954	32,910	$ 675.82	$ 1,853.47
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,496,038	28,212	3,612	36,684	$ 123.92	$ 378.82
Emergency Room	$ 3,325,977	10,840	1,460	14,095	$ 306.82	$ 360.39
Physician	$ 15,821,943	68,707	9,073	89,339	$ 230.28	$ 1,714.41
FQHC/RHC	$ 64,073	470	37	612	$ 136.23	$ 6.94
Other Clinic	$ 605,022	4,201	2,196	5,463	$ 144.00	$ 65.56
Other Practitioner	$ 286	11	16	14	$ 26.00	$ 0.03
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 87	1	153	1	$ 87.19	$ 0.01
LTSS Services	$ 10,526	581	13	756	$ 18.12	$ 1.14
Durable Medical Equipment	$ 23,082	641	207	834	$ 35.99	$ 2.50
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 79	1	24	1	$ 78.45	$ 0.01
Lab and X-Ray	$ 250,289	15,088	2,205	19,619	$ 16.59	$ 27.12
Transportation	$ 104,097	1,085	520	1,410	$ 95.97	$ 11.28
Subtotal (Medical)	$ 40,806,760	155,150	9,401			$ 4,421.68
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 40,806,760	155,150	N/A			$ 4,421.68

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 12

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,084,286
Average Monthly Members/Deliveries:	257,024
Eligibles:	332,945

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 95,402,547	120,610	27,892	469	$ 791.00	$ 30.93
Inpatient — BH	$ 4,643,341	6,880	1,296	27	$ 674.94	$ 1.51
Outpatient Hospital	$ 72,230,360	248,402	82,903	966	$ 290.78	$ 23.42
Emergency Room	$ 74,890,358	200,734	102,425	781	$ 373.08	$ 24.28
Physician	$ 115,952,258	1,210,839	239,472	4,711	$ 95.76	$ 37.59
FQHC/RHC	$ 4,220,946	38,583	16,268	150	$ 109.40	$ 1.37
Other Clinic	$ 25,278,741	206,402	140,194	803	$ 122.47	$ 8.20
Other Practitioner	$ 637,719	8,821	3,529	34	$ 72.30	$ 0.21
Therapies	$ 7,005,720	58,312	4,293	227	$ 120.14	$ 2.27
Prescribed Drugs	$ 230,657,416	2,190,487	201,214	8,523	$ 105.30	$ 74.78
Other BH Services	$ 16,777,732	244,470	23,475	951	$ 68.63	$ 5.44
LTSS Services	$ 17,288,547	3,164,229	2,754	12,311	$ 161.55	$ 5.61
Durable Medical Equipment	$ 16,937,386	5,615,162	23,425	21,847	$ 3.02	$ 5.49
Limited Dental Services	$ 1,302,949	52,523	20,426	204	$ 24.81	$ 0.42
Optical	$ 2,627,144	32,425	26,236	126	$ 81.02	$ 0.85
Lab and X-Ray	$ 15,066,858	804,500	81,946	3,130	$ 18.73	$ 4.89
Transportation	$ 5,448,766	59,406	12,572	231	$ 91.72	$ 1.77
Subtotal (Medical)	$ 706,368,789	14,262,784	277,162			$ 229.02
CC4C LHD Payments	$ 3,012,394	668,156	N/A	2,600	$ 4.51	$ 0.98
OBCM LHD Payments	$ 3,163,634	646,232	N/A	2,514	$ 4.90	$ 1.03
Medical Home Payments	$ 6,968,186	2,650,663	N/A	10,313	$ 2.63	$ 2.26
Subtotal (LHD/Medical Home Payments)	$ 13,144,214	3,965,051	N/A			$ 4.26
Total (Medical + LHD/Medical Home)	$ 719,513,002	18,227,835	N/A			$ 233.28

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.3 SFY 2016 Region 3 Exhibits

Exhibit 13

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	325,282
Average Monthly Members/Deliveries:	27,107
Eligibles:	33,445

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 44,947,199	47,286	4,785	1,744	$ 950.54	$ 138.18
Inpatient — BH	$ 2,222,641	3,870	521	143	$ 574.31	$ 6.83
Outpatient Hospital	$ 32,951,616	75,421	16,183	2,782	$ 436.90	$ 101.30
Emergency Room	$ 22,924,088	44,473	15,197	1,641	$ 515.46	$ 70.47
Physician	$ 36,833,898	276,265	25,568	10,192	$ 133.33	$ 113.24
FQHC/RHC	$ 986,695	9,228	2,924	340	$ 106.92	$ 3.03
Other Clinic	$ 3,142,908	7,396	4,751	273	$ 424.97	$ 9.66
Other Practitioner	$ 304,312	4,082	1,380	151	$ 74.56	$ 0.94
Therapies	$ 1,247,469	11,050	630	408	$ 112.90	$ 3.84
Prescribed Drugs	$ 137,286,703	922,617	24,769	34,036	$ 148.80	$ 422.05
Other BH Services	$ 4,928,674	110,375	7,007	4,072	$ 44.65	$ 15.15
LTSS Services	$ 29,482,325	5,931,807	3,628	218,831	$ 163.66	$ 90.64
Durable Medical Equipment	$ 13,641,280	4,001,788	7,689	147,630	$ 3.41	$ 41.94
Limited Dental Services	$ 8,063	325	116	12	$ 24.80	$ 0.02
Optical	$ 226,009	3,221	1,847	119	$ 70.16	$ 0.69
Lab and X-Ray	$ 3,652,850	198,454	11,618	7,321	$ 18.41	$ 11.23
Transportation	$ 3,489,633	55,881	5,352	2,061	$ 62.45	$ 10.73
Subtotal (Medical)	$ 338,276,362	11,703,538	28,891			$ 1,039.95
CC4C LHD Payments	$ 1,763	391	N/A	14	$ 4.51	$ 0.01
OBCM LHD Payments	$ 260,916	53,141	N/A	1,960	$ 4.91	$ 0.80
Medical Home Payments	$ 1,278,833	268,380	N/A	9,901	$ 4.77	$ 3.93
Subtotal (LHD/Medical Home Payments)	$ 1,541,513	321,912	N/A			$ 4.74
Total (Medical + LHD/Medical Home)	$ 339,817,875	12,025,450	N/A			$ 1,044.69

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 14

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	217,948
Average Monthly Members/Deliveries:	18,162
Eligibles:	35,611

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 34,656,427	62,472	16,039	3,440	$ 554.75	$ 159.01
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 2,252,725	14,087	7,895	776	$ 159.91	$ 10.34
Emergency Room	$ 4,884,408	19,056	11,005	1,049	$ 256.32	$ 22.41
Physician	$ 15,509,201	181,531	30,438	9,995	$ 85.44	$ 71.16
FQHC/RHC	$ 325,282	3,006	786	166	$ 108.21	$ 1.49
Other Clinic	$ 7,577,368	77,930	27,844	4,291	$ 97.23	$ 34.77
Other Practitioner	$ 11,020	311	63	17	$ 35.41	$ 0.05
Therapies	$ 149,553	1,618	316	89	$ 92.42	$ 0.69
Prescribed Drugs	$ 3,143,156	66,879	17,577	3,682	$ 47.00	$ 14.42
Other BH Services	$ 7,836	447	14	25	$ 17.53	$ 0.04
LTSS Services	$ 375,197	26,734	277	1,472	$ 14.03	$ 1.72
Durable Medical Equipment	$ 1,504,729	61,167	2,782	3,368	$ 24.60	$ 6.90
Limited Dental Services	$ 402,377	16,242	6,807	894	$ 24.77	$ 1.85
Optical	$ 1,890	23	19	1	$ 83.97	$ 0.01
Lab and X-Ray	$ 326,604	11,588	3,917	638	$ 28.19	$ 1.50
Transportation	$ 188,842	2,084	1,006	115	$ 90.63	$ 0.87
Subtotal (Medical)	$ 71,316,613	545,175	32,642			$ 327.22
CC4C LHD Payments	$ 967,322	214,018	N/A	11,784	$ 4.52	$ 4.44
OBCM LHD Payments	$ 15	3	N/A	0	$ 4.85	$ 0.00
Medical Home Payments	$ 379,029	153,708	N/A	8,463	$ 2.47	$ 1.74
Subtotal (LHD/Medical Home Payments)	$ 1,346,366	367,729	N/A			$ 6.18
Total (Medical + LHD/Medical Home)	$ 72,662,979	912,904	N/A			$ 333.40

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 15

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	3,135,185
Average Monthly Members/Deliveries:	261,265
Eligibles:	311,208

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,829,192	10,815	2,432	41	$ 1,093.79	$ 3.77
Inpatient — BH	$ 2,101,819	3,698	543	14	$ 568.36	$ 0.67
Outpatient Hospital	$ 25,303,002	98,593	55,107	377	$ 256.64	$ 8.07
Emergency Room	$ 40,795,473	134,717	82,521	516	$ 302.82	$ 13.01
Physician	$ 65,482,259	874,336	217,046	3,347	$ 74.89	$ 20.89
FQHC/RHC	$ 1,754,241	16,222	6,655	62	$ 108.14	$ 0.56
Other Clinic	$ 17,279,207	173,069	143,265	662	$ 99.84	$ 5.51
Other Practitioner	$ 595,096	7,449	2,361	29	$ 79.89	$ 0.19
Therapies	$ 8,335,611	80,393	6,317	308	$ 103.69	$ 2.66
Prescribed Drugs	$ 108,757,643	1,158,392	176,790	4,434	$ 93.89	$ 34.69
Other BH Services	$ 15,497,836	212,892	19,931	815	$ 72.80	$ 4.94
LTSS Services	$ 845,706	130,962	232	501	$ 6.46	$ 0.27
Durable Medical Equipment	$ 5,614,221	1,617,871	16,386	6,192	$ 3.47	$ 1.79
Limited Dental Services	$ 947,407	38,340	14,894	147	$ 24.71	$ 0.30
Optical	$ 2,031,904	24,308	22,627	93	$ 83.59	$ 0.65
Lab and X-Ray	$ 4,238,985	252,883	45,724	968	$ 16.76	$ 1.35
Transportation	$ 1,276,706	17,385	6,432	67	$ 73.44	$ 0.41
Subtotal (Medical)	$ 312,686,309	4,852,327	248,053			$ 99.73
CC4C LHD Payments	$ 3,330,399	739,202	N/A	2,829	$ 4.51	$ 1.06
OBCM LHD Payments	$ 1,826,970	372,824	N/A	1,427	$ 4.90	$ 0.58
Medical Home Payments	$ 6,626,707	2,696,457	N/A	10,321	$ 2.46	$ 2.11
Subtotal (LHD/Medical Home Payments)	$ 11,784,076	3,808,483	N/A			$ 3.76
Total (Medical + LHD/Medical Home)	$ 324,470,385	8,660,810	N/A			$ 103.49

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 16

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	692,636
Average Monthly Members/Deliveries:	57,720
Eligibles:	85,395

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 14,127,689	13,080	2,828	227	$ 1,080.11	$ 20.40
Inpatient — BH	$ 1,348,824	2,233	432	39	$ 604.10	$ 1.95
Outpatient Hospital	$ 22,634,076	74,930	30,094	1,298	$ 302.07	$ 32.68
Emergency Room	$ 33,660,655	76,800	33,982	1,331	$ 438.29	$ 48.60
Physician	$ 31,986,827	292,460	54,068	5,067	$ 109.37	$ 46.18
FQHC/RHC	$ 955,471	9,164	3,673	159	$ 104.26	$ 1.38
Other Clinic	$ 4,851,825	23,088	18,618	400	$ 210.15	$ 7.00
Other Practitioner	$ 282,315	4,695	1,582	81	$ 60.13	$ 0.41
Therapies	$ 1,487	31	31	1	$ 47.89	$ 0.00
Prescribed Drugs	$ 61,141,743	741,867	50,424	12,853	$ 82.42	$ 88.27
Other BH Services	$ 4,851,614	87,596	7,403	1,518	$ 55.39	$ 7.00
LTSS Services	$ 1,648,739	342,972	517	5,942	$ 148.35	$ 2.38
Durable Medical Equipment	$ 3,919,781	1,550,837	5,579	26,868	$ 2.53	$ 5.66
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 141,413	2,118	1,128	37	$ 66.77	$ 0.20
Lab and X-Ray	$ 8,886,430	428,004	28,077	7,415	$ 20.76	$ 12.83
Transportation	$ 1,245,218	16,518	5,204	286	$ 75.38	$ 1.80
Subtotal (Medical)	$ 191,684,109	3,666,392	65,506			$ 276.75
CC4C LHD Payments	$ 164	38	N/A	1	$ 4.33	$ 0.00
OBCM LHD Payments	$ 2,485,588	508,368	N/A	8,808	$ 4.89	$ 3.59
Medical Home Payments	$ 1,102,731	457,965	N/A	7,934	$ 2.41	$ 1.59
Subtotal (LHD/Medical Home Payments)	$ 3,588,484	966,371	N/A			$ 5.18
Total (Medical + LHD/Medical Home)	$ 195,272,593	4,632,763	N/A			$ 281.93

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 17

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	13,143
Average Monthly Members/Deliveries:	1,095
Eligibles:	13,431

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 25,429,311	35,907	12,640	32,784	$ 708.21	$ 1,934.84
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 4,036,284	30,623	5,372	27,961	$ 131.80	$ 307.11
Emergency Room	$ 5,263,196	14,246	2,045	13,007	$ 369.45	$ 400.46
Physician	$ 20,059,949	85,503	12,818	78,068	$ 234.61	$ 1,526.30
FQHC/RHC	$ 47,046	401	14	366	$ 117.24	$ 3.58
Other Clinic	$ 2,706,459	16,181	3,197	14,774	$ 167.26	$ 205.93
Other Practitioner	$ 9,067	246	52	225	$ 36.85	$ 0.69
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ -	-	-	-	$ -	$ -
LTSS Services	$ 71,521	5,936	21	5,420	$ 12.05	$ 5.44
Durable Medical Equipment	$ 12,069	497	327	454	$ 24.27	$ 0.92
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ -	-	-	-	$ -	$ -
Lab and X-Ray	$ 354,777	15,021	2,024	13,715	$ 23.62	$ 26.99
Transportation	$ 166,153	1,818	750	1,660	$ 91.40	$ 12.64
Subtotal (Medical)	$ 58,155,832	206,380	13,380			$ 4,424.91
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 58,155,832	206,380	N/A			$ 4,424.91

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 18

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	4,371,052
Average Monthly Members/Deliveries:	364,254
Eligibles:	479,090

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 130,989,817	169,560	38,724	465	$ 772.53	$ 29.97
Inpatient — BH	$ 5,673,285	9,801	1,499	27	$ 578.85	$ 1.30
Outpatient Hospital	$ 87,177,702	293,655	114,651	806	$ 296.87	$ 19.94
Emergency Room	$ 107,527,820	289,291	144,750	794	$ 371.69	$ 24.60
Physician	$ 169,872,133	1,710,095	339,938	4,695	$ 99.33	$ 38.86
FQHC/RHC	$ 4,068,736	38,022	14,052	104	$ 107.01	$ 0.93
Other Clinic	$ 35,557,767	297,664	197,675	817	$ 119.46	$ 8.13
Other Practitioner	$ 1,201,811	16,783	5,438	46	$ 71.61	$ 0.27
Therapies	$ 9,734,120	93,092	7,294	256	$ 104.56	$ 2.23
Prescribed Drugs	$ 310,329,245	2,889,755	277,585	7,933	$ 107.39	$ 71.00
Other BH Services	$ 25,285,961	411,311	34,610	1,129	$ 61.48	$ 5.78
LTSS Services	$ 32,423,488	6,438,412	4,675	17,676	$ 161.73	$ 7.42
Durable Medical Equipment	$ 24,692,080	7,232,161	32,763	19,855	$ 3.41	$ 5.65
Limited Dental Services	$ 1,357,847	54,907	21,817	151	$ 24.73	$ 0.31
Optical	$ 2,401,215	29,669	25,641	81	$ 80.93	$ 0.55
Lab and X-Ray	$ 17,459,646	905,951	91,360	2,487	$ 19.27	$ 3.99
Transportation	$ 6,366,552	93,685	18,744	257	$ 67.96	$ 1.46
Subtotal (Medical)	$ 972,119,224	20,973,812	388,017			$ 222.40
CC4C LHD Payments	$ 4,299,649	953,649	N/A	2,618	$ 4.51	$ 0.98
OBCM LHD Payments	$ 4,573,489	934,336	N/A	2,565	$ 4.89	$ 1.05
Medical Home Payments	$ 9,387,301	3,576,510	N/A	9,819	$ 2.62	$ 2.15
Subtotal (LHD/Medical Home Payments)	$ 18,260,439	5,464,495	N/A			$ 4.18
Total (Medical + LHD/Medical Home)	$ 990,379,663	26,438,307	N/A			$ 226.58

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.4 SFY 2016 Region 4 Exhibits

Exhibit 19

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	276,093
Average Monthly Members/Deliveries:	23,008
Eligibles:	28,128

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 37,959,143	38,694	3,662	1,682	$ 981.01	$ 137.49
Inpatient — BH	$ 1,813,577	2,641	308	115	$ 686.66	$ 6.57
Outpatient Hospital	$ 25,967,271	54,081	12,082	2,351	$ 480.16	$ 94.05
Emergency Room	$ 15,184,312	30,722	11,967	1,335	$ 494.24	$ 55.00
Physician	$ 27,909,412	197,542	20,543	8,586	$ 141.28	$ 101.09
FQHC/RHC	$ 1,881,022	16,613	4,925	722	$ 113.22	$ 6.81
Other Clinic	$ 3,356,768	8,013	4,605	348	$ 418.90	$ 12.16
Other Practitioner	$ 171,847	2,181	980	95	$ 78.81	$ 0.62
Therapies	$ 1,375,705	12,029	699	523	$ 114.37	$ 4.98
Prescribed Drugs	$ 109,662,363	689,234	20,314	29,957	$ 159.11	$ 397.19
Other BH Services	$ 4,933,598	103,409	6,006	4,495	$ 47.71	$ 17.87
LTSS Services	$ 16,826,783	3,578,620	2,320	155,540	$ 163.31	$ 60.95
Durable Medical Equipment	$ 8,219,124	3,257,667	6,448	141,590	$ 2.52	$ 29.77
Limited Dental Services	$ 11,397	460	167	20	$ 24.77	$ 0.04
Optical	$ 279,585	3,943	2,444	171	$ 70.90	$ 1.01
Lab and X-Ray	$ 2,637,137	153,089	9,579	6,654	$ 17.23	$ 9.55
Transportation	$ 2,602,438	43,163	4,053	1,876	$ 60.29	$ 9.43
Subtotal (Medical)	$ 260,791,483	8,192,102	24,058			$ 944.58
CC4C LHD Payments	$ 1,963	435	N/A	19	$ 4.51	$ 0.01
OBCM LHD Payments	$ 213,426	43,470	N/A	1,889	$ 4.91	$ 0.77
Medical Home Payments	$ 1,087,407	227,397	N/A	9,884	$ 4.78	$ 3.94
Subtotal (LHD/Medical Home Payments)	$ 1,302,796	271,302	N/A			$ 4.72
Total (Medical + LHD/Medical Home)	$ 262,094,279	8,463,404	N/A			$ 949.30

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 20

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	176,685
Average Monthly Members/Deliveries:	14,724
Eligibles:	28,904

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 30,442,859	55,574	12,844	3,774	$ 547.79	$ 172.30
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,453,859	9,719	5,050	660	$ 149.59	$ 8.23
Emergency Room	$ 3,766,594	15,453	8,789	1,049	$ 243.75	$ 21.32
Physician	$ 13,570,959	148,528	23,981	10,088	$ 91.37	$ 76.81
FQHC/RHC	$ 1,293,410	12,386	2,990	841	$ 104.42	$ 7.32
Other Clinic	$ 6,331,693	65,558	21,845	4,453	$ 96.58	$ 35.84
Other Practitioner	$ 3,800	83	16	6	$ 45.75	$ 0.02
Therapies	$ 125,205	1,308	265	89	$ 95.72	$ 0.71
Prescribed Drugs	$ 2,466,439	46,285	13,261	3,144	$ 53.29	$ 13.96
Other BH Services	$ 6,358	192	23	13	$ 33.11	$ 0.04
LTSS Services	$ 100,995	6,928	23	471	$ 14.58	$ 0.57
Durable Medical Equipment	$ 513,155	81,363	1,870	5,526	$ 6.31	$ 2.90
Limited Dental Services	$ 367,652	14,825	6,261	1,007	$ 24.80	$ 2.08
Optical	$ 2,400	28	27	2	$ 85.71	$ 0.01
Lab and X-Ray	$ 105,238	7,805	3,444	530	$ 13.48	$ 0.60
Transportation	$ 184,550	1,819	844	124	$ 101.45	$ 1.04
Subtotal (Medical)	$ 60,735,166	467,853	26,562			$ 343.75
CC4C LHD Payments	$ 785,335	173,753	N/A	11,801	$ 4.52	$ 4.44
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 306,684	125,508	N/A	8,524	$ 2.44	$ 1.74
Subtotal (LHD/Medical Home Payments)	$ 1,092,019	299,261	N/A			$ 6.18
Total (Medical + LHD/Medical Home)	$ 61,827,185	767,114	N/A			$ 349.93

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 21

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,561,546
Average Monthly Members/Deliveries:	213,462
Eligibles:	255,071

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,021,676	8,698	2,056	41	$ 1,152.19	$ 3.91
Inpatient — BH	$ 2,369,461	3,695	422	17	$ 641.27	$ 0.93
Outpatient Hospital	$ 20,225,810	65,510	36,361	307	$ 308.75	$ 7.90
Emergency Room	$ 31,244,482	104,503	65,122	490	$ 298.98	$ 12.20
Physician	$ 48,721,156	610,010	163,973	2,858	$ 79.87	$ 19.02
FQHC/RHC	$ 5,550,833	53,532	23,023	251	$ 103.69	$ 2.17
Other Clinic	$ 14,120,485	140,583	112,040	659	$ 100.44	$ 5.51
Other Practitioner	$ 247,312	3,035	1,305	14	$ 81.48	$ 0.10
Therapies	$ 13,737,346	121,207	8,020	568	$ 113.34	$ 5.36
Prescribed Drugs	$ 76,171,672	775,889	135,031	3,635	$ 98.17	$ 29.74
Other BH Services	$ 14,658,536	182,631	16,403	856	$ 80.26	$ 5.72
LTSS Services	$ 267,248	33,717	99	158	$ 101.23	$ 0.10
Durable Medical Equipment	$ 4,673,169	1,632,429	15,827	7,647	$ 2.86	$ 1.82
Limited Dental Services	$ 880,838	35,641	13,953	167	$ 24.71	$ 0.34
Optical	$ 2,779,619	33,491	30,350	157	$ 83.00	$ 1.09
Lab and X-Ray	$ 3,152,389	216,303	39,998	1,013	$ 14.57	$ 1.23
Transportation	$ 813,013	9,735	4,894	46	$ 83.51	$ 0.32
Subtotal (Medical)	$ 249,635,045	4,030,610	203,876			$ 97.45
CC4C LHD Payments	$ 2,736,815	607,444	N/A	2,846	$ 4.51	$ 1.07
OBCM LHD Payments	$ 1,412,063	288,135	N/A	1,350	$ 4.90	$ 0.55
Medical Home Payments	$ 5,442,294	2,215,381	N/A	10,378	$ 2.46	$ 2.12
Subtotal (LHD/Medical Home Payments)	$ 9,591,172	3,110,960	N/A			$ 3.74
Total (Medical + LHD/Medical Home)	$ 259,226,217	7,141,570	N/A			$ 101.20

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 22

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	493,513
Average Monthly Members/Deliveries:	41,126
Eligibles:	64,794

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,652,638	9,808	2,027	238	$ 1,086.07	$ 21.59
Inpatient — BH	$ 737,019	1,015	209	25	$ 726.22	$ 1.49
Outpatient Hospital	$ 14,583,002	43,489	20,390	1,057	$ 335.32	$ 29.55
Emergency Room	$ 22,102,801	48,951	24,142	1,190	$ 451.53	$ 44.79
Physician	$ 21,578,124	184,335	38,681	4,482	$ 117.06	$ 43.72
FQHC/RHC	$ 1,707,792	15,848	6,223	385	$ 107.76	$ 3.46
Other Clinic	$ 4,156,204	25,403	17,805	618	$ 163.61	$ 8.42
Other Practitioner	$ 148,026	1,972	891	48	$ 75.05	$ 0.30
Therapies	$ 1,393	29	27	1	$ 47.96	$ 0.00
Prescribed Drugs	$ 39,655,962	478,426	35,233	11,633	$ 82.89	$ 80.35
Other BH Services	$ 4,085,791	52,573	5,804	1,278	$ 77.72	$ 8.28
LTSS Services	$ 862,968	160,316	309	3,898	$ 163.02	$ 1.75
Durable Medical Equipment	$ 2,133,831	1,049,049	4,612	25,508	$ 2.03	$ 4.32
Limited Dental Services	$ 77	4	3	0	$ 19.13	$ 0.00
Optical	$ 164,480	2,376	1,440	58	$ 69.23	$ 0.33
Lab and X-Ray	$ 6,366,443	330,133	23,901	8,027	$ 19.28	$ 12.90
Transportation	$ 736,771	9,568	3,414	233	$ 77.00	$ 1.49
Subtotal (Medical)	$ 129,673,324	2,413,297	49,345			$ 262.76
CC4C LHD Payments	$ 112	25	N/A	1	$ 4.47	$ 0.00
OBCM LHD Payments	$ 1,798,462	367,823	N/A	8,944	$ 4.89	$ 3.64
Medical Home Payments	$ 756,687	312,935	N/A	7,609	$ 2.42	$ 1.53
Subtotal (LHD/Medical Home Payments)	$ 2,555,261	680,783	N/A			$ 5.18
Total (Medical + LHD/Medical Home)	$ 132,228,585	3,094,080	N/A			$ 267.93

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 23

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	9,895
Average Monthly Members/Deliveries:	825
Eligibles:	10,183

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 19,460,479	27,881	9,627	33,814	$ 697.97	$ 1,966.78
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,959,874	27,345	3,723	33,163	$ 144.81	$ 400.21
Emergency Room	$ 4,249,729	11,649	1,470	14,128	$ 364.81	$ 429.50
Physician	$ 15,371,357	69,061	9,741	83,756	$ 222.58	$ 1,553.51
FQHC/RHC	$ 551,826	4,299	314	5,214	$ 128.36	$ 55.77
Other Clinic	$ 2,223,071	12,893	3,070	15,636	$ 172.43	$ 224.68
Other Practitioner	$ 120	3	16	4	$ 39.84	$ 0.01
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 889	14	199	17	$ 63.47	$ 0.09
LTSS Services	$ 24,929	6,100	19	7,398	$ 4.09	$ 2.52
Durable Medical Equipment	$ 21,990	722	260	876	$ 30.45	$ 2.22
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 114	2	19	2	$ 57.06	$ 0.01
Lab and X-Ray	$ 427,670	18,051	2,271	21,892	$ 23.69	$ 43.22
Transportation	$ 129,702	1,361	629	1,650	$ 95.32	$ 13.11
Subtotal (Medical)	$ 46,421,750	179,382	10,110			$ 4,691.63
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 46,421,750	179,382	N/A			$ 4,691.63

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 24

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,507,837
Average Monthly Members/Deliveries:	292,320
Eligibles:	387,080

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 108,536,794	140,656	30,216	481	$ 771.65	$ 30.94
Inpatient — BH	$ 4,920,057	7,351	939	25	$ 669.31	$ 1.40
Outpatient Hospital	$ 66,189,817	200,143	77,606	685	$ 330.71	$ 18.87
Emergency Room	$ 76,547,919	211,278	111,490	723	$ 362.31	$ 21.82
Physician	$ 127,151,009	1,209,477	256,919	4,138	$ 105.13	$ 36.25
FQHC/RHC	$ 10,984,883	102,679	37,475	351	$ 106.98	$ 3.13
Other Clinic	$ 30,188,223	252,450	159,365	864	$ 119.58	$ 8.61
Other Practitioner	$ 571,105	7,274	3,208	25	$ 78.51	$ 0.16
Therapies	$ 15,239,649	134,573	9,011	460	$ 113.24	$ 4.34
Prescribed Drugs	$ 227,956,436	1,989,834	209,164	6,807	$ 114.56	$ 64.98
Other BH Services	$ 23,685,173	338,819	28,435	1,159	$ 69.91	$ 6.75
LTSS Services	$ 18,082,923	3,785,682	2,770	12,950	$ 164.79	$ 5.16
Durable Medical Equipment	$ 15,561,269	6,021,230	29,017	20,598	$ 2.58	$ 4.44
Limited Dental Services	$ 1,259,963	50,931	20,384	174	$ 24.74	$ 0.36
Optical	$ 3,226,198	39,840	34,280	136	$ 80.98	$ 0.92
Lab and X-Ray	$ 12,688,878	725,381	79,193	2,481	$ 17.49	$ 3.62
Transportation	$ 4,466,473	65,646	13,834	225	$ 68.04	$ 1.27
Subtotal (Medical)	$ 747,256,769	15,283,244	313,396			$ 213.02
CC4C LHD Payments	$ 3,524,224	781,657	N/A	2,674	$ 4.51	$ 1.00
OBCM LHD Payments	$ 3,423,952	699,428	N/A	2,393	$ 4.90	$ 0.98
Medical Home Payments	$ 7,593,072	2,881,221	N/A	9,856	$ 2.64	$ 2.16
Subtotal (LHD/Medical Home Payments)	$ 14,541,248	4,362,306	N/A			$ 4.15
Total (Medical + LHD/Medical Home)	$ 761,798,016	19,645,550	N/A			$ 217.17

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.5 SFY 2016 Region 5 Exhibits

Exhibit 25

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	312,103
Average Monthly Members/Deliveries:	26,009
Eligibles:	31,124

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 42,980,100	47,378	4,516	1,822	$ 907.18	$ 137.71
Inpatient — BH	$ 1,383,726	2,116	372	81	$ 653.89	$ 4.43
Outpatient Hospital	$ 26,374,888	53,612	13,698	2,061	$ 491.96	$ 84.51
Emergency Room	$ 17,104,032	39,021	14,405	1,500	$ 438.33	$ 54.80
Physician	$ 35,678,291	252,643	23,588	9,714	$ 141.22	$ 114.32
FQHC/RHC	$ 2,016,353	20,506	4,975	788	$ 98.33	$ 6.46
Other Clinic	$ 3,243,299	7,287	4,596	280	$ 445.05	$ 10.39
Other Practitioner	$ 271,106	3,666	1,283	141	$ 73.96	$ 0.87
Therapies	$ 2,029,014	18,785	958	722	$ 108.02	$ 6.50
Prescribed Drugs	$ 116,567,756	872,775	23,493	33,557	$ 133.56	$ 373.49
Other BH Services	$ 4,728,085	66,653	6,058	2,563	$ 70.94	$ 15.15
LTSS Services	$ 20,646,580	4,522,069	2,937	173,869	$ 161.39	$ 66.15
Durable Medical Equipment	$ 9,173,715	3,694,744	7,288	142,059	$ 2.48	$ 29.39
Limited Dental Services	$ 8,320	336	129	13	$ 24.75	$ 0.03
Optical	$ 496,667	7,642	3,602	294	$ 65.00	$ 1.59
Lab and X-Ray	$ 3,915,422	217,209	11,915	8,351	$ 18.03	$ 12.55
Transportation	$ 2,060,412	28,966	5,435	1,114	$ 71.13	$ 6.60
Subtotal (Medical)	$ 288,677,766	9,855,407	26,943			$ 924.95
CC4C LHD Payments	$ 2,257	500	N/A	19	$ 4.51	$ 0.01
OBCM LHD Payments	$ 245,000	49,899	N/A	1,919	$ 4.91	$ 0.78
Medical Home Payments	$ 1,237,466	259,007	N/A	9,959	$ 4.78	$ 3.96
Subtotal (LHD/Medical Home Payments)	$ 1,484,723	309,406	N/A			$ 4.76
Total (Medical + LHD/Medical Home)	$ 290,162,489	10,164,813	N/A			$ 929.70

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 26

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	140,711
Average Monthly Members/Deliveries:	11,726
Eligibles:	23,094

Category of Service		Incurred Claims	Utilization	Users	Utilization Per 1,000		Unit Cost		PMPM/ Payment
Inpatient — PH	$	24,601,998	46,618	10,363	3,976	$	527.74	$	174.84
Inpatient — BH	$	-	-	-	-	$	-	$	-
Outpatient Hospital	$	998,951	8,397	4,281	716	$	118.97	$	7.10
Emergency Room	$	2,754,046	14,025	7,748	1,196	$	196.37	$	19.57
Physician	$	11,455,591	119,505	19,799	10,192	$	95.86	$	81.41
FQHC/RHC	$	460,136	4,621	1,079	394	$	99.58	$	3.27
Other Clinic	$	5,219,250	51,899	18,109	4,426	$	100.57	$	37.09
Other Practitioner	$	3,873	52	16	4	$	74.42	$	0.03
Therapies	$	81,601	971	178	83	$	84.06	$	0.58
Prescribed Drugs	$	2,046,215	50,954	12,371	4,345	$	40.16	$	14.54
Other BH Services	$	2,552	138	7	12	$	18.49	$	0.02
LTSS Services	$	54,472	1,997	65	170	$	27.27	$	0.39
Durable Medical Equipment	$	480,535	109,985	1,766	9,380	$	4.37	$	3.42
Limited Dental Services	$	343,593	13,872	5,738	1,183	$	24.77	$	2.44
Optical	$	12,352	157	123	13	$	78.65	$	0.09
Lab and X-Ray	$	113,524	5,526	2,322	471	$	20.54	$	0.81
Transportation	$	185,427	1,324	785	113	$	140.05	$	1.32
Subtotal (Medical)	$	48,814,117	430,040	21,241				$	346.91
CC4C LHD Payments	$	628,182	138,989	N/A	11,853	$	4.52	$	4.46
OBCM LHD Payments	$	-	-	N/A	-	$	-	$	-
Medical Home Payments	$	254,644	104,969	N/A	8,952	$	2.43	$	1.81
Subtotal (LHD/Medical Home Payments)	$	882,826	243,958	N/A				$	6.27
Total (Medical + LHD/Medical Home)	$	49,696,943	673,998	N/A				$	353.19

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 27

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,122,571
Average Monthly Members/Deliveries:	176,881
Eligibles:	207,787

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 9,713,159	9,013	2,273	51	$ 1,077.73	$ 4.58
Inpatient — BH	$ 1,394,564	2,214	311	13	$ 629.78	$ 0.66
Outpatient Hospital	$ 15,722,919	59,014	33,568	334	$ 266.43	$ 7.41
Emergency Room	$ 26,005,939	105,950	63,131	599	$ 245.46	$ 12.25
Physician	$ 42,463,907	575,829	142,263	3,255	$ 73.74	$ 20.01
FQHC/RHC	$ 2,875,787	31,068	12,475	176	$ 92.56	$ 1.35
Other Clinic	$ 12,267,363	116,685	93,129	660	$ 105.13	$ 5.78
Other Practitioner	$ 245,584	3,374	1,227	19	$ 72.79	$ 0.12
Therapies	$ 12,480,599	115,042	7,036	650	$ 108.49	$ 5.88
Prescribed Drugs	$ 75,677,720	850,321	125,255	4,807	$ 89.00	$ 35.65
Other BH Services	$ 11,344,267	155,995	14,877	882	$ 72.72	$ 5.34
LTSS Services	$ 190,433	37,810	126	214	$ 93.59	$ 0.09
Durable Medical Equipment	$ 3,042,897	1,188,599	10,573	6,720	$ 2.56	$ 1.43
Limited Dental Services	$ 951,522	38,629	14,324	218	$ 24.63	$ 0.45
Optical	$ 2,928,708	36,044	30,515	204	$ 81.25	$ 1.38
Lab and X-Ray	$ 2,659,638	151,971	29,719	859	$ 17.50	$ 1.25
Transportation	$ 903,051	9,793	5,159	55	$ 92.21	$ 0.43
Subtotal (Medical)	$ 220,868,056	3,487,350	169,878			$ 104.06
CC4C LHD Payments	$ 2,230,710	495,131	N/A	2,799	$ 4.51	$ 1.05
OBCM LHD Payments	$ 1,316,151	268,567	N/A	1,518	$ 4.90	$ 0.62
Medical Home Payments	$ 4,510,956	1,848,289	N/A	10,449	$ 2.44	$ 2.13
Subtotal (LHD/Medical Home Payments)	$ 8,057,817	2,611,987	N/A			$ 3.80
Total (Medical + LHD/Medical Home)	$ 228,925,873	6,099,337	N/A			$ 107.85

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 28

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	533,376
Average Monthly Members/Deliveries:	44,448
Eligibles:	63,876

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 13,190,539	13,170	2,766	296	$ 1,001.58	$ 24.73
Inpatient — BH	$ 870,327	1,242	303	28	$ 700.58	$ 1.63
Outpatient Hospital	$ 15,827,870	46,231	21,128	1,040	$ 342.36	$ 29.67
Emergency Room	$ 22,626,252	58,408	26,693	1,314	$ 387.38	$ 42.42
Physician	$ 29,900,583	247,480	41,517	5,568	$ 120.82	$ 56.06
FQHC/RHC	$ 2,057,504	21,229	6,844	478	$ 96.92	$ 3.86
Other Clinic	$ 3,793,640	18,112	14,944	407	$ 209.46	$ 7.11
Other Practitioner	$ 197,667	2,653	1,044	60	$ 74.52	$ 0.37
Therapies	$ 3,636	64	56	1	$ 56.71	$ 0.01
Prescribed Drugs	$ 52,581,046	650,801	39,900	14,642	$ 80.79	$ 98.58
Other BH Services	$ 3,906,403	60,112	6,310	1,352	$ 64.99	$ 7.32
LTSS Services	$ 1,145,454	216,046	375	4,861	$ 156.03	$ 2.15
Durable Medical Equipment	$ 2,453,672	1,116,800	5,338	25,126	$ 2.20	$ 4.60
Limited Dental Services	$ 15	1	1	0	$ 15.10	$ 0.00
Optical	$ 295,388	4,579	2,208	103	$ 64.51	$ 0.55
Lab and X-Ray	$ 8,172,080	403,936	26,022	9,088	$ 20.23	$ 15.32
Transportation	$ 861,529	9,719	4,740	219	$ 88.65	$ 1.62
Subtotal (Medical)	$ 157,883,606	2,870,584	50,297			$ 296.01
CC4C LHD Payments	$ 322	75	N/A	2	$ 4.29	$ 0.00
OBCM LHD Payments	$ 1,938,417	396,455	N/A	8,920	$ 4.89	$ 3.63
Medical Home Payments	$ 892,039	369,982	N/A	8,324	$ 2.41	$ 1.67
Subtotal (LHD/Medical Home Payments)	$ 2,830,777	766,512	N/A			$ 5.31
Total (Medical + LHD/Medical Home)	$ 160,714,383	3,637,096	N/A			$ 301.32

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 29

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	8,788
Average Monthly Members/Deliveries:	732
Eligibles:	8,964

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 18,036,806	26,193	8,539	35,767	$ 688.61	$ 2,052.45
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,131,933	27,019	3,709	36,895	$ 115.92	$ 356.39
Emergency Room	$ 3,128,692	9,950	1,145	13,587	$ 314.45	$ 356.02
Physician	$ 15,632,406	63,245	8,681	86,362	$ 247.17	$ 1,778.85
FQHC/RHC	$ 465,819	3,216	299	4,392	$ 144.84	$ 53.01
Other Clinic	$ 970,427	6,891	1,764	9,410	$ 140.82	$ 110.43
Other Practitioner	$ 39	1	14	1	$ 38.73	$ 0.00
Therapies	$ 61	1	1	1	$ 61.21	$ 0.01
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 219	4	185	5	$ 54.68	$ 0.02
LTSS Services	$ 29,229	5,508	15	7,522	$ 5.31	$ 3.33
Durable Medical Equipment	$ 31,789	644	604	880	$ 49.35	$ 3.62
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 194	3	20	4	$ 64.58	$ 0.02
Lab and X-Ray	$ 345,324	14,963	1,806	20,433	$ 23.08	$ 39.30
Transportation	$ 176,420	1,690	648	2,308	$ 104.37	$ 20.08
Subtotal (Medical)	$ 41,949,358	159,330	8,927			$ 4,773.52
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 41,949,358	159,330	N/A			$ 4,773.52

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 30

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,108,760
Average Monthly Members/Deliveries:	259,063
Eligibles:	334,845

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 108,522,603	142,371	28,457	550	$ 762.25	$ 34.91
Inpatient — BH	$ 3,648,617	5,573	987	22	$ 654.72	$ 1.17
Outpatient Hospital	$ 62,056,562	194,273	76,384	750	$ 319.43	$ 19.96
Emergency Room	$ 71,618,962	227,354	113,122	878	$ 315.01	$ 23.04
Physician	$ 135,130,778	1,258,702	235,848	4,859	$ 107.36	$ 43.47
FQHC/RHC	$ 7,875,598	80,640	25,672	311	$ 97.66	$ 2.53
Other Clinic	$ 25,493,979	200,875	132,542	775	$ 126.91	$ 8.20
Other Practitioner	$ 718,268	9,745	3,584	38	$ 73.70	$ 0.23
Therapies	$ 14,594,911	134,862	8,229	521	$ 108.22	$ 4.69
Prescribed Drugs	$ 246,872,736	2,424,851	206,747	9,360	$ 101.81	$ 79.41
Other BH Services	$ 19,981,526	282,902	27,437	1,092	$ 70.63	$ 6.43
LTSS Services	$ 22,066,168	4,783,431	3,519	18,464	$ 158.33	$ 7.10
Durable Medical Equipment	$ 15,182,608	6,110,772	25,569	23,588	$ 2.48	$ 4.88
Limited Dental Services	$ 1,303,450	52,838	20,192	204	$ 24.67	$ 0.42
Optical	$ 3,733,310	48,424	36,468	187	$ 77.10	$ 1.20
Lab and X-Ray	$ 15,205,989	793,605	71,784	3,063	$ 19.16	$ 4.89
Transportation	$ 4,186,839	51,493	16,767	199	$ 81.31	$ 1.35
Subtotal (Medical)	$ 758,192,903	16,802,710	276,945			$ 243.89
CC4C LHD Payments	$ 2,861,471	634,695	N/A	2,450	$ 4.51	$ 0.92
OBCM LHD Payments	$ 3,499,567	714,921	N/A	2,760	$ 4.90	$ 1.13
Medical Home Payments	$ 6,895,105	2,582,247	N/A	9,968	$ 2.67	$ 2.22
Subtotal (LHD/Medical Home Payments)	$ 13,256,142	3,931,863	N/A			$ 4.26
Total (Medical + LHD/Medical Home)	$ 771,449,045	20,734,573	N/A			$ 248.15

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.6 SFY 2016 Region 6 Exhibits

Exhibit 31

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	271,768
Average Monthly Members/Deliveries:	22,647
Eligibles:	27,187

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 33,746,462	33,582	3,497	1,483	$ 1,004.89	$ 124.17
Inpatient — BH	$ 2,041,020	2,925	381	129	$ 697.69	$ 7.51
Outpatient Hospital	$ 18,007,561	35,785	10,613	1,580	$ 503.22	$ 66.26
Emergency Room	$ 15,518,336	32,035	12,348	1,414	$ 484.42	$ 57.10
Physician	$ 27,413,637	188,235	20,024	8,312	$ 145.63	$ 100.87
FQHC/RHC	$ 1,987,124	19,232	5,328	849	$ 103.32	$ 7.31
Other Clinic	$ 3,558,962	7,844	4,459	346	$ 453.73	$ 13.10
Other Practitioner	$ 231,660	3,202	1,216	141	$ 72.35	$ 0.85
Therapies	$ 1,416,161	12,220	613	540	$ 115.89	$ 5.21
Prescribed Drugs	$ 95,090,588	696,518	20,453	30,755	$ 136.52	$ 349.90
Other BH Services	$ 3,391,052	58,654	5,772	2,590	$ 57.81	$ 12.48
LTSS Services	$ 17,109,712	3,489,771	2,090	154,092	$ 164.84	$ 62.96
Durable Medical Equipment	$ 9,274,550	3,136,402	6,108	138,489	$ 2.96	$ 34.13
Limited Dental Services	$ 6,713	274	99	12	$ 24.49	$ 0.02
Optical	$ 338,362	4,874	3,082	215	$ 69.43	$ 1.25
Lab and X-Ray	$ 2,617,835	149,366	10,766	6,595	$ 17.53	$ 9.63
Transportation	$ 2,639,256	41,632	4,335	1,838	$ 63.39	$ 9.71
Subtotal (Medical)	$ 234,388,990	7,912,551	23,632			$ 862.46
CC4C LHD Payments	$ 1,581	350	N/A	15	$ 4.52	$ 0.01
OBCM LHD Payments	$ 214,584	43,705	N/A	1,930	$ 4.91	$ 0.79
Medical Home Payments	$ 1,093,735	229,616	N/A	10,139	$ 4.76	$ 4.02
Subtotal (LHD/Medical Home Payments)	$ 1,309,900	273,671	N/A			$ 4.82
Total (Medical + LHD/Medical Home)	$ 235,698,890	8,186,222	N/A			$ 867.28

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 32

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	114,678
Average Monthly Members/Deliveries:	9,556
Eligibles:	18,758

Category of Service		Incurred Claims	Utilization	Users	Utilization Per 1,000		Unit Cost		PMPM/ Payment
Inpatient — PH	$	19,176,688	34,213	8,324	3,580	$	560.51	$	167.22
Inpatient — BH	$	-	-	-	-	$	-	$	-
Outpatient Hospital	$	932,170	5,729	3,373	600	$	162.71	$	8.13
Emergency Room	$	2,602,548	10,661	5,956	1,116	$	244.11	$	22.69
Physician	$	8,026,720	88,860	15,709	9,298	$	90.33	$	69.99
FQHC/RHC	$	667,309	6,408	1,484	671	$	104.13	$	5.82
Other Clinic	$	4,640,715	41,615	14,369	4,355	$	111.51	$	40.47
Other Practitioner	$	1,567	25	15	3	$	62.62	$	0.01
Therapies	$	102,872	903	145	94	$	113.97	$	0.90
Prescribed Drugs	$	1,547,167	33,986	9,379	3,556	$	45.52	$	13.49
Other BH Services	$	5,516	339	9	35	$	16.27	$	0.05
LTSS Services	$	9,048	547	9	57	$	16.54	$	0.08
Durable Medical Equipment	$	209,818	22,958	1,066	2,402	$	9.14	$	1.83
Limited Dental Services	$	308,066	12,428	5,098	1,301	$	24.79	$	2.69
Optical	$	6,295	73	68	8	$	86.20	$	0.05
Lab and X-Ray	$	52,726	3,312	1,615	347	$	15.92	$	0.46
Transportation	$	252,244	1,990	724	208	$	126.76	$	2.20
Subtotal (Medical)	$	38,541,467	264,049	17,306				$	336.08
CC4C LHD Payments	$	510,941	113,049	N/A	11,830	$	4.52	$	4.46
OBCM LHD Payments	$	-	-	N/A	-	$	-	$	-
Medical Home Payments	$	212,887	87,084	N/A	9,113	$	2.44	$	1.86
Subtotal (LHD/Medical Home Payments)	$	723,828	200,133	N/A				$	6.31
Total (Medical + LHD/Medical Home)	$	39,265,296	464,182	N/A				$	342.40

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 33

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	1,683,919
Average Monthly Members/Deliveries:	140,327
Eligibles:	166,388

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 7,145,189	5,875	1,281	42	$ 1,216.16	$ 4.24
Inpatient — BH	$ 1,367,229	2,342	289	17	$ 583.88	$ 0.81
Outpatient Hospital	$ 11,778,648	35,556	21,302	253	$ 331.27	$ 6.99
Emergency Room	$ 22,751,995	82,296	49,499	586	$ 276.47	$ 13.51
Physician	$ 28,818,468	417,336	110,112	2,974	$ 69.05	$ 17.11
FQHC/RHC	$ 3,289,015	32,669	13,162	233	$ 100.68	$ 1.95
Other Clinic	$ 10,505,924	96,433	76,729	687	$ 108.95	$ 6.24
Other Practitioner	$ 185,005	2,491	950	18	$ 74.28	$ 0.11
Therapies	$ 5,294,784	46,445	3,658	331	$ 114.00	$ 3.14
Prescribed Drugs	$ 60,404,898	636,860	95,451	4,538	$ 94.85	$ 35.87
Other BH Services	$ 7,096,542	103,600	12,382	738	$ 68.50	$ 4.21
LTSS Services	$ 456,631	54,259	61	387	$ 97.08	$ 0.27
Durable Medical Equipment	$ 2,638,242	986,319	8,081	7,029	$ 2.67	$ 1.57
Limited Dental Services	$ 826,732	33,501	12,044	239	$ 24.68	$ 0.49
Optical	$ 2,235,342	26,873	24,723	192	$ 83.18	$ 1.33
Lab and X-Ray	$ 1,968,925	115,805	22,208	825	$ 17.00	$ 1.17
Transportation	$ 867,571	10,676	3,929	76	$ 81.26	$ 0.52
Subtotal (Medical)	$ 167,631,139	2,689,334	135,612			$ 99.55
CC4C LHD Payments	$ 1,789,238	397,139	N/A	2,830	$ 4.51	$ 1.06
OBCM LHD Payments	$ 1,014,494	207,016	N/A	1,475	$ 4.90	$ 0.60
Medical Home Payments	$ 3,673,284	1,501,853	N/A	10,703	$ 2.45	$ 2.18
Subtotal (LHD/Medical Home Payments)	$ 6,477,016	2,106,008	N/A			$ 3.85
Total (Medical + LHD/Medical Home)	$ 174,108,155	4,795,342	N/A			$ 103.39

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 34

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	401,299
Average Monthly Members/Deliveries:	33,442
Eligibles:	49,451

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 9,613,378	7,721	1,659	231	$ 1,245.02	$ 23.96
Inpatient — BH	$ 1,007,650	1,374	246	41	$ 733.50	$ 2.51
Outpatient Hospital	$ 10,378,550	26,984	14,510	807	$ 384.62	$ 25.86
Emergency Room	$ 19,093,129	47,274	21,335	1,414	$ 403.88	$ 47.58
Physician	$ 16,536,882	149,024	30,089	4,456	$ 110.97	$ 41.21
FQHC/RHC	$ 1,716,029	17,262	6,018	516	$ 99.41	$ 4.28
Other Clinic	$ 3,838,973	21,268	13,785	636	$ 180.51	$ 9.57
Other Practitioner	$ 182,124	2,510	1,001	75	$ 72.57	$ 0.45
Therapies	$ 120	2	2	0	$ 59.72	$ 0.00
Prescribed Drugs	$ 35,015,197	424,751	29,947	12,701	$ 82.44	$ 87.25
Other BH Services	$ 2,732,287	41,433	5,428	1,239	$ 65.95	$ 6.81
LTSS Services	$ 637,940	112,513	214	3,364	$ 108.78	$ 1.59
Durable Medical Equipment	$ 1,830,965	817,160	3,597	24,435	$ 2.24	$ 4.56
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 155,921	2,256	1,481	67	$ 69.12	$ 0.39
Lab and X-Ray	$ 5,238,306	254,812	19,930	7,620	$ 20.56	$ 13.05
Transportation	$ 693,643	8,812	3,043	264	$ 78.72	$ 1.73
Subtotal (Medical)	$ 108,671,094	1,935,154	38,739			$ 270.80
CC4C LHD Payments	$ 507	118	N/A	4	$ 4.30	$ 0.00
OBCM LHD Payments	$ 1,491,982	305,139	N/A	9,125	$ 4.89	$ 3.72
Medical Home Payments	$ 694,052	291,057	N/A	8,703	$ 2.38	$ 1.73
Subtotal (LHD/Medical Home Payments)	$ 2,186,541	596,314	N/A			$ 5.45
Total (Medical + LHD/Medical Home)	$ 110,857,635	2,531,468	N/A			$ 276.25

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 35

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	7,457
Average Monthly Members/Deliveries:	621
Eligibles:	7,632

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 15,473,680	20,211	7,284	32,522	$ 765.61	$ 2,074.93
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,810,873	13,975	2,735	22,487	$ 129.58	$ 242.83
Emergency Room	$ 2,903,617	10,194	1,413	16,403	$ 284.84	$ 389.36
Physician	$ 12,212,921	48,927	7,194	78,729	$ 249.62	$ 1,637.68
FQHC/RHC	$ 1,006,079	6,656	525	10,710	$ 151.16	$ 134.91
Other Clinic	$ 1,630,980	12,154	2,393	19,557	$ 134.20	$ 218.70
Other Practitioner	$ 271	4	12	6	$ 67.77	$ 0.04
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 88	1	177	2	$ 88.00	$ 0.01
LTSS Services	$ 20,591	2,134	9	3,434	$ 9.65	$ 2.76
Durable Medical Equipment	$ 25,608	339	163	546	$ 75.53	$ 3.43
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 576	6	14	10	$ 96.02	$ 0.08
Lab and X-Ray	$ 315,511	12,163	1,964	19,572	$ 25.94	$ 42.31
Transportation	$ 151,602	1,426	566	2,295	$ 106.30	$ 20.33
Subtotal (Medical)	$ 35,552,399	128,189	7,582			$ 4,767.37
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 35,552,399	128,189	N/A			$ 4,767.37

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 36

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	2,471,664
Average Monthly Members/Deliveries:	205,972
Eligibles:	269,416

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 85,155,397	101,603	22,045	493	$ 838.12	$ 34.45
Inpatient — BH	$ 4,415,899	6,641	918	32	$ 664.97	$ 1.79
Outpatient Hospital	$ 42,907,801	118,028	52,533	573	$ 363.54	$ 17.36
Emergency Room	$ 62,869,623	182,459	90,551	886	$ 344.57	$ 25.44
Physician	$ 93,008,627	892,381	183,128	4,333	$ 104.23	$ 37.63
FQHC/RHC	$ 8,665,556	82,227	26,517	399	$ 105.39	$ 3.51
Other Clinic	$ 24,175,554	179,313	111,735	871	$ 134.82	$ 9.78
Other Practitioner	$ 600,627	8,231	3,194	40	$ 72.97	$ 0.24
Therapies	$ 6,813,937	59,570	4,418	289	$ 114.39	$ 2.76
Prescribed Drugs	$ 192,057,850	1,792,115	159,980	8,701	$ 107.17	$ 77.70
Other BH Services	$ 13,225,485	204,027	23,768	991	$ 64.82	$ 5.35
LTSS Services	$ 18,233,922	3,659,223	2,383	17,766	$ 160.19	$ 7.38
Durable Medical Equipment	$ 13,979,184	4,963,178	19,015	24,096	$ 2.82	$ 5.66
Limited Dental Services	$ 1,141,510	46,203	17,241	224	$ 24.71	$ 0.46
Optical	$ 2,736,497	34,081	29,368	165	$ 80.29	$ 1.11
Lab and X-Ray	$ 10,193,303	535,458	56,483	2,600	$ 19.04	$ 4.12
Transportation	$ 4,604,316	64,536	12,597	313	$ 71.34	$ 1.86
Subtotal (Medical)	$ 584,785,089	12,929,276	222,587			$ 236.60
CC4C LHD Payments	$ 2,302,267	510,656	N/A	2,479	$ 4.51	$ 0.93
OBCM LHD Payments	$ 2,721,061	555,860	N/A	2,699	$ 4.90	$ 1.10
Medical Home Payments	$ 5,673,958	2,109,610	N/A	10,242	$ 2.69	$ 2.30
Subtotal (LHD/Medical Home Payments)	$ 10,697,286	3,176,126	N/A			$ 4.33
Total (Medical + LHD/Medical Home)	$ 595,482,375	16,105,402	N/A			$ 240.92

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2 SFY 2017 Exhibits

Cost and utilization information for the July 1, 2016 through June 30, 2017 (SFY 2017) time period is illustrated in Section 7.2.

7.2.1 SFY 2017 Region 1 Exhibits

Exhibit 37

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	146,847
Average Monthly Members/Deliveries:	12,237
Eligibles:	14,853

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 18,994,504	18,663	2,226	1,525	$ 1,017.76	$ 129.35
Inpatient — BH	$ 1,338,873	1,901	275	155	$ 704.19	$ 9.12
Outpatient Hospital	$ 18,296,270	40,731	8,523	3,328	$ 449.20	$ 124.59
Emergency Room	$ 9,346,567	18,051	6,512	1,475	$ 517.80	$ 63.65
Physician	$ 15,556,490	115,987	11,575	9,478	$ 134.12	$ 105.94
FQHC/RHC	$ 2,218,513	17,279	3,821	1,412	$ 128.40	$ 15.11
Other Clinic	$ 1,166,583	3,710	2,170	303	$ 314.47	$ 7.94
Other Practitioner	$ 180,776	2,318	653	189	$ 78.00	$ 1.23
Therapies	$ 486,461	4,406	263	360	$ 110.40	$ 3.31
Prescribed Drugs	$ 61,440,392	491,070	11,706	40,129	$ 125.12	$ 418.40
Other BH Services	$ 2,094,097	37,746	2,879	3,085	$ 55.48	$ 14.26
LTSS Services	$ 7,210,950	850,972	1,068	69,539	$ 189.60	$ 49.11
Durable Medical Equipment	$ 5,723,376	2,063,918	3,815	168,658	$ 2.77	$ 38.97
Limited Dental Services	$ 3,342	137	50	11	$ 24.43	$ 0.02
Optical	$ 132,996	1,897	1,174	155	$ 70.11	$ 0.91
Lab and X-Ray	$ 1,088,692	37,872	4,843	3,095	$ 28.75	$ 7.41
Transportation	$ 1,676,927	27,938	2,706	2,283	$ 60.02	$ 11.42
Subtotal (Medical)	$ 146,955,808	3,734,595	13,178			$ 1,000.74
CC4C LHD Payments	$ 397	88	N/A	7	$ 4.54	$ 0.00
OBCM LHD Payments	$ 101,345	20,523	N/A	1,677	$ 4.94	$ 0.69
Medical Home Payments	$ 621,927	133,474	N/A	10,907	$ 4.66	$ 4.24
Subtotal (LHD/Medical Home Payments)	$ 723,669	154,084	N/A			$ 4.93
Total (Medical + LHD/Medical Home)	$ 147,679,478	3,888,679	N/A			$ 1,005.67

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 38

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	78,257
Average Monthly Members/Deliveries:	6,521
Eligibles:	12,641

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 15,525,719	24,261	5,804	3,720	$ 639.95	$ 198.39
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,728,925	11,443	3,805	1,755	$ 151.10	$ 22.09
Emergency Room	$ 1,316,140	5,521	3,212	847	$ 238.40	$ 16.82
Physician	$ 6,695,472	73,367	10,474	11,250	$ 91.26	$ 85.56
FQHC/RHC	$ 779,884	5,972	1,367	916	$ 130.59	$ 9.97
Other Clinic	$ 2,464,658	27,935	9,257	4,284	$ 88.23	$ 31.49
Other Practitioner	$ 2,393	60	24	9	$ 39.69	$ 0.03
Therapies	$ 85,974	915	187	140	$ 93.91	$ 1.10
Prescribed Drugs	$ 1,101,993	23,586	6,177	3,617	$ 46.72	$ 14.08
Other BH Services	$ 5,128	257	11	39	$ 19.93	$ 0.07
LTSS Services	$ 163,499	1,914	246	293	$ 85.44	$ 2.09
Durable Medical Equipment	$ 822,414	182,332	1,251	27,959	$ 4.51	$ 10.51
Limited Dental Services	$ 122,046	4,930	2,027	756	$ 24.75	$ 1.56
Optical	$ 2,257	29	19	4	$ 77.33	$ 0.03
Lab and X-Ray	$ 43,797	2,096	646	321	$ 20.89	$ 0.56
Transportation	$ 109,478	1,300	389	199	$ 84.19	$ 1.40
Subtotal (Medical)	$ 30,969,776	365,919	11,576			$ 395.75
CC4C LHD Payments	$ 323,152	70,918	N/A	10,875	$ 4.56	$ 4.13
OBCM LHD Payments	$ 15	3	N/A	0	$ 4.96	$ 0.00
Medical Home Payments	$ 163,036	66,160	N/A	10,145	$ 2.46	$ 2.08
Subtotal (LHD/Medical Home Payments)	$ 486,203	137,081	N/A			$ 6.21
Total (Medical + LHD/Medical Home)	$ 31,455,979	503,000	N/A			$ 401.96

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 39

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	1,220,080
Average Monthly Members/Deliveries:	101,673
Eligibles:	116,531

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 5,297,873	4,396	991	43	$ 1,205.11	$ 4.34
Inpatient — BH	$ 1,431,364	1,575	214	15	$ 909.02	$ 1.17
Outpatient Hospital	$ 22,147,849	93,938	34,648	924	$ 235.77	$ 18.15
Emergency Room	$ 15,014,302	49,887	29,704	491	$ 300.97	$ 12.31
Physician	$ 27,760,868	383,658	83,775	3,773	$ 72.36	$ 22.75
FQHC/RHC	$ 5,694,160	41,304	13,839	406	$ 137.86	$ 4.67
Other Clinic	$ 6,516,181	65,219	53,472	641	$ 99.91	$ 5.34
Other Practitioner	$ 215,180	4,152	1,149	41	$ 51.83	$ 0.18
Therapies	$ 4,634,703	46,289	3,434	455	$ 100.13	$ 3.80
Prescribed Drugs	$ 49,955,652	501,953	72,628	4,937	$ 99.52	$ 40.94
Other BH Services	$ 8,956,123	119,215	9,894	1,173	$ 75.13	$ 7.34
LTSS Services	$ 327,992	29,662	53	292	$ 25.08	$ 0.27
Durable Medical Equipment	$ 3,334,257	999,037	6,621	9,826	$ 3.34	$ 2.73
Limited Dental Services	$ 382,494	15,519	5,648	153	$ 24.65	$ 0.31
Optical	$ 1,175,104	14,300	12,815	141	$ 82.17	$ 0.96
Lab and X-Ray	$ 732,355	36,994	9,426	364	$ 19.80	$ 0.60
Transportation	$ 631,403	8,983	2,230	88	$ 70.29	$ 0.52
Subtotal (Medical)	$ 154,207,860	2,416,081	98,966			$ 126.39
CC4C LHD Payments	$ 1,179,912	260,803	N/A	2,565	$ 4.52	$ 0.97
OBCM LHD Payments	$ 658,366	133,787	N/A	1,316	$ 4.92	$ 0.54
Medical Home Payments	$ 2,796,550	1,143,143	N/A	11,243	$ 2.45	$ 2.29
Subtotal (LHD/Medical Home Payments)	$ 4,634,828	1,537,733	N/A			$ 3.80
Total (Medical + LHD/Medical Home)	$ 158,842,688	3,953,814	N/A			$ 130.19

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 40

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	270,425
Average Monthly Members/Deliveries:	22,535
Eligibles:	33,192

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 7,923,909	6,445	1,290	286	$ 1,229.50	$ 29.30
Inpatient — BH	$ 798,181	1,015	203	45	$ 786.59	$ 2.95
Outpatient Hospital	$ 14,339,387	45,065	14,113	2,000	$ 318.19	$ 53.03
Emergency Room	$ 11,885,273	26,596	12,069	1,180	$ 446.88	$ 43.95
Physician	$ 11,407,559	109,837	20,943	4,874	$ 103.86	$ 42.18
FQHC/RHC	$ 2,082,077	16,108	5,354	715	$ 129.26	$ 7.70
Other Clinic	$ 2,241,069	7,958	7,512	353	$ 281.61	$ 8.29
Other Practitioner	$ 128,946	2,276	722	101	$ 56.66	$ 0.48
Therapies	$ 5,759	96	61	4	$ 60.20	$ 0.02
Prescribed Drugs	$ 23,691,831	318,126	20,038	14,117	$ 74.47	$ 87.61
Other BH Services	$ 1,977,560	27,475	3,698	1,219	$ 71.98	$ 7.31
LTSS Services	$ 317,349	18,616	150	826	$ 172.95	$ 1.17
Durable Medical Equipment	$ 1,592,017	686,886	2,671	30,480	$ 2.32	$ 5.89
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 95,213	1,380	843	61	$ 68.99	$ 0.35
Lab and X-Ray	$ 2,284,452	65,669	9,654	2,914	$ 34.79	$ 8.45
Transportation	$ 517,694	7,405	1,797	329	$ 69.91	$ 1.91
Subtotal (Medical)	$ 81,288,275	1,340,954	26,354			$ 300.59
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ 853,983	173,769	N/A	7,711	$ 4.91	$ 3.16
Medical Home Payments	$ 456,639	192,396	N/A	8,537	$ 2.37	$ 1.69
Subtotal (LHD/Medical Home Payments)	$ 1,310,621	366,164	N/A			$ 4.85
Total (Medical + LHD/Medical Home)	$ 82,598,896	1,707,119	N/A			$ 305.44

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 41

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	5,230
Average Monthly Members/Deliveries:	436
Eligibles:	5,361

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,196,571	14,204	4,806	32,587	$ 788.30	$ 2,140.69
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,988,804	15,334	2,412	35,180	$ 129.70	$ 380.24
Emergency Room	$ 1,719,165	5,102	683	11,706	$ 336.95	$ 328.69
Physician	$ 8,069,159	44,448	4,938	101,978	$ 181.54	$ 1,542.75
FQHC/RHC	$ 1,101,462	7,373	602	16,917	$ 149.38	$ 210.59
Other Clinic	$ 1,075,068	8,221	1,217	18,861	$ 130.77	$ 205.54
Other Practitioner	$ 616	6	19	14	$ 98.69	$ 0.12
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 87	1	144	2	$ 87.29	$ 0.02
LTSS Services	$ 7,547	987	5	2,264	$ 7.65	$ 1.44
Durable Medical Equipment	$ 45,075	590	179	1,354	$ 76.40	$ 8.62
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 127	1	3	2	$ 121.79	$ 0.02
Lab and X-Ray	$ 199,971	7,563	533	17,353	$ 26.44	$ 38.23
Transportation	$ 66,700	645	263	1,480	$ 103.41	$ 12.75
Subtotal (Medical)	$ 25,470,353	104,476	5,323			$ 4,869.71
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 25,470,353	104,476	N/A			$ 4,869.71

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 42

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	1,715,609
Average Monthly Members/Deliveries:	142,967
Eligibles:	182,578

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 58,938,575	67,968	15,117	475	$ 867.15	$ 34.35
Inpatient — BH	$ 3,568,417	4,491	697	31	$ 794.63	$ 2.08
Outpatient Hospital	$ 58,501,235	206,511	63,501	1,444	$ 283.28	$ 34.10
Emergency Room	$ 39,281,447	105,157	52,180	736	$ 373.55	$ 22.90
Physician	$ 69,489,547	727,298	131,705	5,087	$ 95.54	$ 40.50
FQHC/RHC	$ 11,876,095	88,035	24,983	616	$ 134.90	$ 6.92
Other Clinic	$ 13,463,559	113,043	73,628	791	$ 119.10	$ 7.85
Other Practitioner	$ 527,911	8,812	2,567	62	$ 59.91	$ 0.31
Therapies	$ 5,212,896	51,706	3,946	362	$ 100.82	$ 3.04
Prescribed Drugs	$ 136,189,868	1,334,735	113,718	9,336	$ 102.04	$ 79.38
Other BH Services	$ 13,032,996	184,695	16,626	1,292	$ 70.56	$ 7.60
LTSS Services	$ 8,027,337	902,150	1,522	6,310	$ 189.51	$ 4.68
Durable Medical Equipment	$ 11,517,139	3,932,762	14,537	27,508	$ 2.93	$ 6.71
Limited Dental Services	$ 507,883	20,586	7,725	144	$ 24.67	$ 0.30
Optical	$ 1,405,697	17,607	14,854	123	$ 79.84	$ 0.82
Lab and X-Ray	$ 4,349,267	150,195	25,102	1,051	$ 28.96	$ 2.54
Transportation	$ 3,002,202	46,271	7,385	324	$ 64.88	$ 1.75
Subtotal (Medical)	$ 438,892,071	7,962,025	155,271			$ 255.82
CC4C LHD Payments	$ 1,503,461	331,809	N/A	2,321	$ 4.53	$ 0.88
OBCM LHD Payments	$ 1,613,708	328,082	N/A	2,295	$ 4.92	$ 0.94
Medical Home Payments	$ 4,038,152	1,535,172	N/A	10,738	$ 2.63	$ 2.35
Subtotal (LHD/Medical Home Payments)	$ 7,155,321	2,195,063	N/A			$ 4.17
Total (Medical + LHD/Medical Home)	$ 446,047,392	10,157,087	N/A			$ 259.99

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.2 SFY 2017 Region 2 Exhibits

Exhibit 43

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	263,136
Average Monthly Members/Deliveries:	21,928
Eligibles:	25,937

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 33,083,387	33,435	3,631	1,525	$ 989.49	$ 125.73
Inpatient — BH	$ 1,581,726	2,275	441	104	$ 695.42	$ 6.01
Outpatient Hospital	$ 31,459,577	62,331	12,516	2,843	$ 504.72	$ 119.56
Emergency Room	$ 16,949,675	32,514	11,717	1,483	$ 521.31	$ 64.41
Physician	$ 26,481,959	204,381	20,426	9,321	$ 129.57	$ 100.64
FQHC/RHC	$ 526,521	4,249	1,282	194	$ 123.91	$ 2.00
Other Clinic	$ 2,287,971	6,835	4,055	312	$ 334.72	$ 8.70
Other Practitioner	$ 208,798	2,803	1,077	128	$ 74.48	$ 0.79
Therapies	$ 819,074	7,765	458	354	$ 105.48	$ 3.11
Prescribed Drugs	$ 103,369,743	765,152	20,070	34,894	$ 135.10	$ 392.84
Other BH Services	$ 4,094,563	62,861	5,480	2,867	$ 65.14	$ 15.56
LTSS Services	$ 17,626,213	3,058,087	2,099	139,461	$ 169.55	$ 66.99
Durable Medical Equipment	$ 10,831,764	3,708,218	6,231	169,109	$ 2.92	$ 41.16
Limited Dental Services	$ 10,381	412	143	19	$ 25.21	$ 0.04
Optical	$ 248,853	3,518	2,010	160	$ 70.75	$ 0.95
Lab and X-Ray	$ 2,735,269	109,014	10,867	4,971	$ 25.09	$ 10.39
Transportation	$ 3,308,251	37,263	4,850	1,699	$ 88.78	$ 12.57
Subtotal (Medical)	$ 255,623,725	8,101,112	22,727			$ 971.45
CC4C LHD Payments	$ 1,114	245	N/A	11	$ 4.54	$ 0.00
OBCM LHD Payments	$ 196,065	39,704	N/A	1,811	$ 4.94	$ 0.75
Medical Home Payments	$ 1,139,481	243,996	N/A	11,127	$ 4.67	$ 4.33
Subtotal (LHD/Medical Home Payments)	$ 1,336,660	283,945	N/A			$ 5.08
Total (Medical + LHD/Medical Home)	$ 256,960,385	8,385,058	N/A			$ 976.53

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 44

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	144,528
Average Monthly Members/Deliveries:	12,044
Eligibles:	23,173

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 26,576,128	47,242	11,050	3,922	$ 562.55	$ 183.88
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 2,106,834	13,525	5,393	1,123	$ 155.78	$ 14.58
Emergency Room	$ 3,182,994	11,942	6,874	991	$ 266.55	$ 22.02
Physician	$ 12,150,122	133,359	19,705	11,073	$ 91.11	$ 84.07
FQHC/RHC	$ 641,465	5,569	1,225	462	$ 115.19	$ 4.44
Other Clinic	$ 5,142,516	53,297	17,927	4,425	$ 96.49	$ 35.58
Other Practitioner	$ 1,191	37	12	3	$ 32.17	$ 0.01
Therapies	$ 112,191	1,144	157	95	$ 98.08	$ 0.78
Prescribed Drugs	$ 1,946,504	41,817	11,502	3,472	$ 46.55	$ 13.47
Other BH Services	$ 8,618	376	62	31	$ 22.89	$ 0.06
LTSS Services	$ 35,172	546	65	45	$ 64.47	$ 0.24
Durable Medical Equipment	$ 1,128,812	39,504	1,701	3,280	$ 28.57	$ 7.81
Limited Dental Services	$ 312,710	12,578	5,100	1,044	$ 24.86	$ 2.16
Optical	$ 3,409	35	30	3	$ 97.60	$ 0.02
Lab and X-Ray	$ 118,304	6,993	2,524	581	$ 16.92	$ 0.82
Transportation	$ 135,618	1,503	721	125	$ 90.22	$ 0.94
Subtotal (Medical)	$ 53,602,588	369,466	21,347			$ 370.88
CC4C LHD Payments	$ 595,268	130,636	N/A	10,847	$ 4.56	$ 4.12
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 302,478	122,332	N/A	10,157	$ 2.47	$ 2.09
Subtotal (LHD/Medical Home Payments)	$ 897,746	252,967	N/A			$ 6.21
Total (Medical + LHD/Medical Home)	$ 54,500,334	622,433	N/A			$ 377.09

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 45

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,297,179
Average Monthly Members/Deliveries:	191,432
Eligibles:	216,277

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,752,091	8,205	1,852	43	$ 1,310.38	$ 4.68
Inpatient — BH	$ 2,114,694	3,235	524	17	$ 653.76	$ 0.92
Outpatient Hospital	$ 24,844,015	105,826	44,807	553	$ 234.76	$ 10.82
Emergency Room	$ 31,493,396	97,184	58,948	508	$ 324.06	$ 13.71
Physician	$ 45,315,943	655,747	155,015	3,425	$ 69.11	$ 19.73
FQHC/RHC	$ 2,928,078	25,853	11,590	135	$ 113.26	$ 1.27
Other Clinic	$ 13,436,188	131,296	103,554	686	$ 102.33	$ 5.85
Other Practitioner	$ 234,925	2,965	1,369	15	$ 79.23	$ 0.10
Therapies	$ 6,837,795	59,661	3,997	312	$ 114.61	$ 2.98
Prescribed Drugs	$ 84,692,324	875,933	131,257	4,576	$ 96.69	$ 36.87
Other BH Services	$ 10,839,718	140,832	13,430	736	$ 76.97	$ 4.72
LTSS Services	$ 174,936	26,924	85	141	$ 6.50	$ 0.08
Durable Medical Equipment	$ 5,217,783	2,011,476	11,540	10,508	$ 2.59	$ 2.27
Limited Dental Services	$ 1,005,121	40,739	13,961	213	$ 24.67	$ 0.44
Optical	$ 2,395,843	28,838	23,135	151	$ 83.08	$ 1.04
Lab and X-Ray	$ 3,364,513	178,466	42,564	932	$ 18.85	$ 1.46
Transportation	$ 958,910	10,649	4,449	56	$ 90.05	$ 0.42
Subtotal (Medical)	$ 246,606,272	4,403,829	180,636			$ 107.35
CC4C LHD Payments	$ 2,230,258	492,968	N/A	2,575	$ 4.52	$ 0.97
OBCM LHD Payments	$ 1,263,793	256,816	N/A	1,342	$ 4.92	$ 0.55
Medical Home Payments	$ 5,345,660	2,179,810	N/A	11,387	$ 2.45	$ 2.33
Subtotal (LHD/Medical Home Payments)	$ 8,839,710	2,929,593	N/A			$ 3.85
Total (Medical + LHD/Medical Home)	$ 255,445,982	7,333,422	N/A			$ 111.20

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 46

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	468,569
Average Monthly Members/Deliveries:	39,047
Eligibles:	56,420

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,971,337	11,199	2,262	287	$ 1,068.94	$ 25.55
Inpatient — BH	$ 1,014,168	1,495	382	38	$ 678.22	$ 2.16
Outpatient Hospital	$ 17,998,181	51,707	19,704	1,324	$ 348.08	$ 38.41
Emergency Room	$ 20,552,237	44,736	22,136	1,146	$ 459.42	$ 43.86
Physician	$ 22,478,323	208,375	37,935	5,336	$ 107.87	$ 47.97
FQHC/RHC	$ 324,957	2,701	1,193	69	$ 120.31	$ 0.69
Other Clinic	$ 3,651,840	14,503	12,615	371	$ 251.80	$ 7.79
Other Practitioner	$ 176,221	2,613	1,043	67	$ 67.45	$ 0.38
Therapies	$ 6,918	125	98	3	$ 55.20	$ 0.01
Prescribed Drugs	$ 51,201,429	542,420	34,564	13,891	$ 94.39	$ 109.27
Other BH Services	$ 3,523,543	45,048	5,294	1,154	$ 78.22	$ 7.52
LTSS Services	$ 1,109,248	163,970	298	4,199	$ 172.43	$ 2.37
Durable Medical Equipment	$ 2,716,156	1,264,152	4,234	32,375	$ 2.15	$ 5.80
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 250,399	3,797	1,565	97	$ 65.95	$ 0.53
Lab and X-Ray	$ 6,453,854	227,736	23,592	5,832	$ 28.34	$ 13.77
Transportation	$ 1,146,516	12,345	3,507	316	$ 92.88	$ 2.45
Subtotal (Medical)	$ 144,575,328	2,596,921	44,687			$ 308.55
CC4C LHD Payments	$ 18	4	N/A	0	$ 4.52	$ 0.00
OBCM LHD Payments	$ 1,579,767	321,452	N/A	8,232	$ 4.91	$ 3.37
Medical Home Payments	$ 795,630	336,586	N/A	8,620	$ 2.36	$ 1.70
Subtotal (LHD/Medical Home Payments)	$ 2,375,415	658,041	N/A			$ 5.07
Total (Medical + LHD/Medical Home)	$ 146,950,743	3,254,963	N/A			$ 313.62

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 47

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	9,264
Average Monthly Members/Deliveries:	772
Eligibles:	9,406

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 18,484,926	26,525	8,734	34,361	$ 696.87	$ 1,995.43
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 4,001,893	31,395	3,775	40,669	$ 127.47	$ 432.00
Emergency Room	$ 4,737,924	13,907	1,445	18,016	$ 340.67	$ 511.46
Physician	$ 16,582,118	75,117	9,064	97,306	$ 220.75	$ 1,790.03
FQHC/RHC	$ 64,871	517	38	670	$ 125.40	$ 7.00
Other Clinic	$ 1,041,576	7,139	2,368	9,247	$ 145.91	$ 112.44
Other Practitioner	$ -	-	-	-	$ -	$ -
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 215	5	174	7	$ 42.19	$ 0.02
LTSS Services	$ 23,955	4,764	7	6,172	$ 5.03	$ 2.59
Durable Medical Equipment	$ 16,373	619	256	802	$ 26.45	$ 1.77
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 247	3	20	4	$ 80.26	$ 0.03
Lab and X-Ray	$ 367,249	18,967	2,042	24,570	$ 19.36	$ 39.64
Transportation	$ 97,926	982	487	1,272	$ 99.69	$ 10.57
Subtotal (Medical)	$ 45,419,272	179,942	9,364			$ 4,902.97
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 45,419,272	179,942	N/A			$ 4,902.97

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 48

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,173,411
Average Monthly Members/Deliveries:	264,451
Eligibles:	331,213

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 100,867,870	126,607	27,529	479	$ 796.70	$ 31.79
Inpatient — BH	$ 4,710,589	7,005	1,349	26	$ 672.51	$ 1.48
Outpatient Hospital	$ 80,410,499	264,783	86,195	1,001	$ 303.68	$ 25.34
Emergency Room	$ 76,916,227	200,282	101,120	757	$ 384.04	$ 24.24
Physician	$ 123,008,465	1,276,979	242,145	4,829	$ 96.33	$ 38.76
FQHC/RHC	$ 4,485,892	38,890	15,328	147	$ 115.35	$ 1.41
Other Clinic	$ 25,560,091	213,070	140,519	806	$ 119.96	$ 8.05
Other Practitioner	$ 621,135	8,418	3,509	32	$ 73.79	$ 0.20
Therapies	$ 7,775,978	68,695	4,710	260	$ 113.20	$ 2.45
Prescribed Drugs	$ 241,209,999	2,225,322	203,600	8,415	$ 108.39	$ 76.01
Other BH Services	$ 18,466,657	249,122	24,440	942	$ 74.13	$ 5.82
LTSS Services	$ 18,969,525	3,254,292	2,554	12,306	$ 170.88	$ 5.98
Durable Medical Equipment	$ 19,910,887	7,023,969	23,962	26,561	$ 2.83	$ 6.27
Limited Dental Services	$ 1,328,212	53,729	19,204	203	$ 24.72	$ 0.42
Optical	$ 2,898,750	36,190	26,760	137	$ 80.10	$ 0.91
Lab and X-Ray	$ 13,039,190	541,176	81,589	2,046	$ 24.09	$ 4.11
Transportation	$ 5,647,221	62,742	14,014	237	$ 90.01	$ 1.78
Subtotal (Medical)	$ 745,827,186	15,651,270	278,326			$ 235.02
CC4C LHD Payments	$ 2,826,658	623,853	N/A	2,359	$ 4.53	$ 0.89
OBCM LHD Payments	$ 3,039,624	617,972	N/A	2,337	$ 4.92	$ 0.96
Medical Home Payments	$ 7,583,248	2,882,723	N/A	10,901	$ 2.63	$ 2.39
Subtotal (LHD/Medical Home Payments)	$ 13,449,531	4,124,547	N/A			$ 4.24
Total (Medical + LHD/Medical Home)	$ 759,276,717	19,775,818	N/A			$ 239.26

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.3 SFY 2017 Region 3 Exhibits

Exhibit 49

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	328,525
Average Monthly Members/Deliveries:	27,377
Eligibles:	32,778

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 41,598,028	42,685	4,608	1,559	$ 974.53	$ 126.62
Inpatient — BH	$ 2,290,834	4,096	454	150	$ 559.29	$ 6.97
Outpatient Hospital	$ 35,546,505	73,931	15,775	2,700	$ 480.81	$ 108.20
Emergency Room	$ 22,891,149	45,627	15,006	1,667	$ 501.70	$ 69.68
Physician	$ 37,974,265	282,103	25,581	10,304	$ 134.61	$ 115.59
FQHC/RHC	$ 1,081,821	9,709	2,908	355	$ 111.43	$ 3.29
Other Clinic	$ 3,723,798	8,149	4,961	298	$ 456.95	$ 11.33
Other Practitioner	$ 284,035	3,766	1,323	138	$ 75.42	$ 0.86
Therapies	$ 1,780,683	16,327	1,037	596	$ 109.07	$ 5.42
Prescribed Drugs	$ 153,170,308	942,292	24,965	34,419	$ 162.55	$ 466.24
Other BH Services	$ 5,135,458	104,727	6,843	3,825	$ 49.04	$ 15.63
LTSS Services	$ 31,801,162	6,153,530	3,492	224,769	$ 168.18	$ 96.80
Durable Medical Equipment	$ 15,590,300	4,925,689	7,927	179,920	$ 3.17	$ 47.46
Limited Dental Services	$ 9,796	386	145	14	$ 25.41	$ 0.03
Optical	$ 219,763	3,083	1,816	113	$ 71.28	$ 0.67
Lab and X-Ray	$ 3,124,896	123,251	11,636	4,502	$ 25.35	$ 9.51
Transportation	$ 3,542,680	61,309	6,189	2,239	$ 57.78	$ 10.78
Subtotal (Medical)	$ 359,765,481	12,800,659	28,564			$ 1,095.09
CC4C LHD Payments	$ 1,416	312	N/A	11	$ 4.54	$ 0.00
OBCM LHD Payments	$ 238,983	48,396	N/A	1,768	$ 4.94	$ 0.73
Medical Home Payments	$ 1,453,939	302,679	N/A	11,056	$ 4.80	$ 4.43
Subtotal (LHD/Medical Home Payments)	$ 1,694,338	351,387	N/A			$ 5.16
Total (Medical + LHD/Medical Home)	$ 361,459,819	13,152,046	N/A			$ 1,100.25

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 50

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	211,433
Average Monthly Members/Deliveries:	17,619
Eligibles:	33,933

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 39,150,106	67,642	15,412	3,839	$ 578.78	$ 185.17
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 2,291,442	13,526	7,212	768	$ 169.41	$ 10.84
Emergency Room	$ 4,503,473	18,120	10,252	1,028	$ 248.53	$ 21.30
Physician	$ 18,382,371	195,045	28,890	11,070	$ 94.25	$ 86.94
FQHC/RHC	$ 327,502	2,924	659	166	$ 112.01	$ 1.55
Other Clinic	$ 7,106,897	75,519	25,720	4,286	$ 94.11	$ 33.61
Other Practitioner	$ 16,794	446	73	25	$ 37.64	$ 0.08
Therapies	$ 238,573	2,634	361	149	$ 90.58	$ 1.13
Prescribed Drugs	$ 3,245,173	62,943	16,361	3,572	$ 51.56	$ 15.35
Other BH Services	$ 18,984	1,151	41	65	$ 16.49	$ 0.09
LTSS Services	$ 375,745	25,068	270	1,423	$ 14.99	$ 1.78
Durable Medical Equipment	$ 1,891,641	71,498	2,717	4,058	$ 26.46	$ 8.95
Limited Dental Services	$ 356,162	14,319	5,745	813	$ 24.87	$ 1.68
Optical	$ 890	9	8	0	$ 102.46	$ 0.00
Lab and X-Ray	$ 362,383	10,187	2,748	578	$ 35.57	$ 1.71
Transportation	$ 188,556	1,943	975	110	$ 97.04	$ 0.89
Subtotal (Medical)	$ 78,456,691	562,974	30,794			$ 371.07
CC4C LHD Payments	$ 867,157	190,304	N/A	10,801	$ 4.56	$ 4.10
OBCM LHD Payments	$ 5	1	N/A	0	$ 4.96	$ 0.00
Medical Home Payments	$ 418,634	169,083	N/A	9,596	$ 2.48	$ 1.98
Subtotal (LHD/Medical Home Payments)	$ 1,285,797	359,387	N/A			$ 6.08
Total (Medical + LHD/Medical Home)	$ 79,742,487	922,361	N/A			$ 377.15

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 51

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	3,243,949
Average Monthly Members/Deliveries:	270,329
Eligibles:	308,878

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 12,385,404	11,265	2,430	42	$ 1,099.48	$ 3.82
Inpatient — BH	$ 2,072,143	3,875	578	14	$ 534.69	$ 0.64
Outpatient Hospital	$ 25,456,020	95,720	53,076	354	$ 265.94	$ 7.85
Emergency Room	$ 40,944,054	138,951	82,366	514	$ 294.67	$ 12.62
Physician	$ 70,311,450	927,875	219,935	3,432	$ 75.78	$ 21.67
FQHC/RHC	$ 1,785,329	15,073	6,462	56	$ 118.45	$ 0.55
Other Clinic	$ 19,078,107	193,462	148,634	716	$ 98.61	$ 5.88
Other Practitioner	$ 646,166	7,977	2,263	30	$ 81.01	$ 0.20
Therapies	$ 10,137,948	102,097	7,207	378	$ 99.30	$ 3.13
Prescribed Drugs	$ 114,284,540	1,177,481	179,354	4,356	$ 97.06	$ 35.23
Other BH Services	$ 17,461,990	231,775	20,559	857	$ 75.34	$ 5.38
LTSS Services	$ 933,047	113,486	219	420	$ 22.25	$ 0.29
Durable Medical Equipment	$ 7,018,183	2,132,100	16,249	7,887	$ 3.29	$ 2.16
Limited Dental Services	$ 1,012,572	40,951	14,558	151	$ 24.73	$ 0.31
Optical	$ 2,033,644	24,224	22,053	90	$ 83.95	$ 0.63
Lab and X-Ray	$ 5,428,344	247,962	45,200	917	$ 21.89	$ 1.67
Transportation	$ 1,228,715	17,417	6,352	64	$ 70.55	$ 0.38
Subtotal (Medical)	$ 332,217,656	5,481,690	250,681			$ 102.41
CC4C LHD Payments	$ 3,184,269	703,839	N/A	2,604	$ 4.52	$ 0.98
OBCM LHD Payments	$ 1,735,278	352,627	N/A	1,304	$ 4.92	$ 0.53
Medical Home Payments	$ 7,385,222	2,996,840	N/A	11,086	$ 2.46	$ 2.28
Subtotal (LHD/Medical Home Payments)	$ 12,304,769	4,053,305	N/A			$ 3.79
Total (Medical + LHD/Medical Home)	$ 344,522,425	9,534,995	N/A			$ 106.20

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 52

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	711,903
Average Monthly Members/Deliveries:	59,325
Eligibles:	84,698

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 15,322,830	13,791	2,684	232	$ 1,111.10	$ 21.52
Inpatient — BH	$ 1,236,429	2,212	382	37	$ 558.94	$ 1.74
Outpatient Hospital	$ 22,025,205	69,568	27,879	1,173	$ 316.60	$ 30.94
Emergency Room	$ 32,641,030	73,873	33,311	1,245	$ 441.85	$ 45.85
Physician	$ 32,474,178	295,608	54,292	4,983	$ 109.86	$ 45.62
FQHC/RHC	$ 964,134	8,969	3,531	151	$ 107.49	$ 1.35
Other Clinic	$ 4,865,419	21,997	18,253	371	$ 221.19	$ 6.83
Other Practitioner	$ 263,606	4,308	1,494	73	$ 61.19	$ 0.37
Therapies	$ 25,581	452	401	8	$ 56.63	$ 0.04
Prescribed Drugs	$ 64,644,468	733,296	50,217	12,361	$ 88.16	$ 90.81
Other BH Services	$ 4,875,878	75,615	7,176	1,275	$ 64.48	$ 6.85
LTSS Services	$ 1,977,810	332,526	502	5,605	$ 160.13	$ 2.78
Durable Medical Equipment	$ 4,169,468	1,749,357	5,681	29,488	$ 2.38	$ 5.86
Limited Dental Services	$ 30	2	1	0	$ 15.06	$ 0.00
Optical	$ 145,795	2,102	1,167	35	$ 69.35	$ 0.20
Lab and X-Ray	$ 8,241,625	270,613	27,708	4,562	$ 30.46	$ 11.58
Transportation	$ 1,275,756	17,486	5,143	295	$ 72.96	$ 1.79
Subtotal (Medical)	$ 195,149,244	3,671,775	65,333			$ 274.12
CC4C LHD Payments	$ 5	1	N/A	0	$ 4.52	$ 0.00
OBCM LHD Payments	$ 2,376,978	483,668	N/A	8,153	$ 4.91	$ 3.34
Medical Home Payments	$ 1,252,574	514,790	N/A	8,677	$ 2.43	$ 1.76
Subtotal (LHD/Medical Home Payments)	$ 3,629,556	998,459	N/A			$ 5.10
Total (Medical + LHD/Medical Home)	$ 198,778,800	4,670,234	N/A			$ 279.22

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 53

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	13,078
Average Monthly Members/Deliveries:	1,090
Eligibles:	13,259

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 26,477,511	36,076	11,977	33,103	$ 733.93	$ 2,024.61
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,228,461	23,951	4,613	21,977	$ 134.80	$ 246.87
Emergency Room	$ 6,100,174	16,495	2,258	15,136	$ 369.81	$ 466.45
Physician	$ 21,653,244	93,486	12,698	85,781	$ 231.62	$ 1,655.72
FQHC/RHC	$ 100,569	767	42	704	$ 131.16	$ 7.69
Other Clinic	$ 3,065,443	15,434	2,973	14,162	$ 198.62	$ 234.40
Other Practitioner	$ 1,775	40	27	37	$ 44.05	$ 0.14
Therapies	$ 387	4	2	4	$ 89.84	$ 0.03
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ -	-	-	-	$ -	$ -
LTSS Services	$ 46,500	57,529	20	52,788	$ 0.81	$ 3.56
Durable Medical Equipment	$ 26,774	1,037	351	952	$ 25.81	$ 2.05
Limited Dental Services	$ 51	2	-	2	$ 24.71	$ 0.00
Optical	$ 144	2	15	2	$ 69.74	$ 0.01
Lab and X-Ray	$ 619,157	21,757	1,957	19,964	$ 28.46	$ 47.34
Transportation	$ 127,393	1,396	668	1,281	$ 91.28	$ 9.74
Subtotal (Medical)	$ 61,447,583	267,977	13,221			$ 4,698.62
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 61,447,583	267,977	N/A			$ 4,698.62

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 54

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	4,495,811
Average Monthly Members/Deliveries:	374,651
Eligibles:	473,546

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 134,933,879	171,459	37,111	458	$ 786.98	$ 30.01
Inpatient — BH	$ 5,599,406	10,183	1,416	27	$ 549.85	$ 1.25
Outpatient Hospital	$ 88,547,633	276,696	108,555	739	$ 320.02	$ 19.70
Emergency Room	$ 107,079,880	293,067	143,193	782	$ 365.38	$ 23.82
Physician	$ 180,795,507	1,794,117	341,396	4,789	$ 100.77	$ 40.21
FQHC/RHC	$ 4,259,355	37,441	13,602	100	$ 113.76	$ 0.95
Other Clinic	$ 37,839,664	314,561	200,541	840	$ 120.29	$ 8.42
Other Practitioner	$ 1,212,375	16,537	5,180	44	$ 73.31	$ 0.27
Therapies	$ 12,183,172	121,514	9,008	324	$ 100.26	$ 2.71
Prescribed Drugs	$ 335,344,488	2,916,011	278,989	7,783	$ 115.00	$ 74.59
Other BH Services	$ 27,492,311	413,268	34,870	1,103	$ 66.52	$ 6.12
LTSS Services	$ 35,134,265	6,682,139	4,503	17,836	$ 167.51	$ 7.81
Durable Medical Equipment	$ 28,696,365	8,879,681	32,925	23,701	$ 3.23	$ 6.38
Limited Dental Services	$ 1,378,611	55,659	20,449	149	$ 24.77	$ 0.31
Optical	$ 2,400,237	29,421	25,059	79	$ 81.58	$ 0.53
Lab and X-Ray	$ 17,776,406	673,770	89,249	1,798	$ 26.38	$ 3.95
Transportation	$ 6,363,100	99,551	19,327	266	$ 63.92	$ 1.42
Subtotal (Medical)	$ 1,027,036,654	22,785,075	388,116			$ 228.44
CC4C LHD Payments	$ 4,052,847	894,455	N/A	2,387	$ 4.53	$ 0.90
OBCM LHD Payments	$ 4,351,244	884,692	N/A	2,361	$ 4.92	$ 0.97
Medical Home Payments	$ 10,510,370	3,983,391	N/A	10,632	$ 2.64	$ 2.34
Subtotal (LHD/Medical Home Payments)	$ 18,914,461	5,762,538	N/A			$ 4.21
Total (Medical + LHD/Medical Home)	$ 1,045,951,115	28,547,613	N/A			$ 232.65

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.4 SFY 2017 Region 4 Exhibits

Exhibit 55

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	278,511
Average Monthly Members/Deliveries:	23,209
Eligibles:	27,445

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 38,729,867	39,670	3,610	1,709	$ 976.30	$ 139.06
Inpatient — BH	$ 2,067,638	2,586	304	111	$ 799.57	$ 7.42
Outpatient Hospital	$ 27,936,179	54,068	11,740	2,330	$ 516.68	$ 100.31
Emergency Room	$ 17,085,084	33,138	12,223	1,428	$ 515.57	$ 61.34
Physician	$ 28,552,620	204,806	20,445	8,824	$ 139.41	$ 102.52
FQHC/RHC	$ 2,013,794	17,215	4,840	742	$ 116.98	$ 7.23
Other Clinic	$ 4,031,634	8,133	4,302	350	$ 495.74	$ 14.48
Other Practitioner	$ 174,698	2,215	917	95	$ 78.86	$ 0.63
Therapies	$ 1,820,760	15,897	929	685	$ 114.53	$ 6.54
Prescribed Drugs	$ 121,607,990	703,312	20,431	30,303	$ 172.91	$ 436.64
Other BH Services	$ 5,974,538	101,786	5,806	4,386	$ 58.70	$ 21.45
LTSS Services	$ 17,890,751	3,563,752	2,243	153,549	$ 171.36	$ 64.24
Durable Medical Equipment	$ 10,148,598	3,845,988	6,547	165,710	$ 2.64	$ 36.44
Limited Dental Services	$ 9,625	390	144	17	$ 24.66	$ 0.03
Optical	$ 283,386	4,041	2,392	174	$ 70.14	$ 1.02
Lab and X-Ray	$ 2,448,064	105,268	9,564	4,536	$ 23.26	$ 8.79
Transportation	$ 2,707,501	46,364	4,592	1,998	$ 58.40	$ 9.72
Subtotal (Medical)	$ 283,482,727	8,748,629	23,855			$ 1,017.85
CC4C LHD Payments	$ 1,087	240	N/A	10	$ 4.54	$ 0.00
OBCM LHD Payments	$ 194,270	39,341	N/A	1,695	$ 4.94	$ 0.70
Medical Home Payments	$ 1,234,620	256,154	N/A	11,037	$ 4.82	$ 4.43
Subtotal (LHD/Medical Home Payments)	$ 1,429,978	295,734	N/A			$ 5.13
Total (Medical + LHD/Medical Home)	$ 284,912,705	9,044,364	N/A			$ 1,022.99

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 56

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	171,144
Average Monthly Members/Deliveries:	14,262
Eligibles:	27,550

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 33,192,884	59,628	12,717	4,181	$ 556.67	$ 193.95
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,558,689	10,016	4,852	702	$ 155.62	$ 9.11
Emergency Room	$ 4,032,465	15,019	8,330	1,053	$ 268.50	$ 23.56
Physician	$ 16,249,014	159,947	22,675	11,215	$ 101.59	$ 94.94
FQHC/RHC	$ 1,331,168	12,586	2,728	883	$ 105.76	$ 7.78
Other Clinic	$ 5,670,995	60,423	19,861	4,237	$ 93.85	$ 33.14
Other Practitioner	$ 3,714	80	24	6	$ 46.54	$ 0.02
Therapies	$ 146,961	1,450	319	102	$ 101.37	$ 0.86
Prescribed Drugs	$ 2,326,991	42,297	12,393	2,966	$ 55.01	$ 13.60
Other BH Services	$ 16,882	377	68	26	$ 44.81	$ 0.10
LTSS Services	$ 138,232	9,368	22	657	$ 14.76	$ 0.81
Durable Medical Equipment	$ 592,898	108,736	1,677	7,624	$ 5.45	$ 3.46
Limited Dental Services	$ 328,860	13,198	5,322	925	$ 24.92	$ 1.92
Optical	$ 4,012	46	39	3	$ 86.63	$ 0.02
Lab and X-Ray	$ 150,471	6,704	2,203	470	$ 22.44	$ 0.88
Transportation	$ 205,431	2,190	904	154	$ 93.79	$ 1.20
Subtotal (Medical)	$ 65,949,665	502,066	25,034			$ 385.35
CC4C LHD Payments	$ 703,766	154,446	N/A	10,829	$ 4.56	$ 4.11
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 340,825	138,895	N/A	9,739	$ 2.45	$ 1.99
Subtotal (LHD/Medical Home Payments)	$ 1,044,591	293,341	N/A			$ 6.10
Total (Medical + LHD/Medical Home)	$ 66,994,257	795,408	N/A			$ 391.45

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 57

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,661,605
Average Monthly Members/Deliveries:	221,800
Eligibles:	254,570

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,743,316	9,464	2,049	43	$ 1,135.22	$ 4.04
Inpatient — BH	$ 3,347,145	4,904	512	22	$ 682.59	$ 1.26
Outpatient Hospital	$ 21,664,568	68,578	36,951	309	$ 315.91	$ 8.14
Emergency Room	$ 35,537,128	110,945	67,270	500	$ 320.31	$ 13.35
Physician	$ 51,877,982	642,506	167,275	2,897	$ 80.74	$ 19.49
FQHC/RHC	$ 5,883,863	56,555	23,375	255	$ 104.04	$ 2.21
Other Clinic	$ 14,767,935	146,571	107,852	661	$ 100.76	$ 5.55
Other Practitioner	$ 254,872	3,144	1,356	14	$ 81.08	$ 0.10
Therapies	$ 15,642,186	140,175	9,534	632	$ 111.59	$ 5.88
Prescribed Drugs	$ 83,094,773	793,826	138,203	3,579	$ 104.68	$ 31.22
Other BH Services	$ 16,490,885	201,086	16,840	907	$ 82.01	$ 6.20
LTSS Services	$ 506,994	55,059	88	248	$ 100.42	$ 0.19
Durable Medical Equipment	$ 5,323,569	1,843,198	16,064	8,310	$ 2.89	$ 2.00
Limited Dental Services	$ 1,006,920	40,769	14,218	184	$ 24.70	$ 0.38
Optical	$ 2,858,250	35,190	29,914	159	$ 81.22	$ 1.07
Lab and X-Ray	$ 3,539,940	221,569	41,038	999	$ 15.98	$ 1.33
Transportation	$ 928,882	12,288	5,462	55	$ 75.59	$ 0.35
Subtotal (Medical)	$ 273,469,208	4,385,825	207,373			$ 102.75
CC4C LHD Payments	$ 2,601,271	574,975	N/A	2,592	$ 4.52	$ 0.98
OBCM LHD Payments	$ 1,373,290	279,067	N/A	1,258	$ 4.92	$ 0.52
Medical Home Payments	$ 6,100,387	2,481,210	N/A	11,187	$ 2.46	$ 2.29
Subtotal (LHD/Medical Home Payments)	$ 10,074,948	3,335,253	N/A			$ 3.79
Total (Medical + LHD/Medical Home)	$ 283,544,156	7,721,078	N/A			$ 106.53

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 58

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	509,487
Average Monthly Members/Deliveries:	42,457
Eligibles:	63,865

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,795,791	11,082	2,048	261	$ 1,064.42	$ 23.15
Inpatient — BH	$ 776,246	979	206	23	$ 792.51	$ 1.52
Outpatient Hospital	$ 16,897,404	45,563	19,957	1,073	$ 370.86	$ 33.17
Emergency Room	$ 24,056,553	49,941	24,093	1,176	$ 481.70	$ 47.22
Physician	$ 21,895,235	193,964	39,057	4,568	$ 112.88	$ 42.98
FQHC/RHC	$ 1,859,431	16,940	6,144	399	$ 109.77	$ 3.65
Other Clinic	$ 4,116,851	23,515	17,253	554	$ 175.07	$ 8.08
Other Practitioner	$ 155,717	2,046	856	48	$ 76.12	$ 0.31
Therapies	$ 14,062	252	187	6	$ 55.91	$ 0.03
Prescribed Drugs	$ 43,540,709	481,193	35,552	11,334	$ 90.48	$ 85.46
Other BH Services	$ 4,241,961	53,394	5,626	1,258	$ 79.45	$ 8.33
LTSS Services	$ 962,875	164,580	311	3,876	$ 161.73	$ 1.89
Durable Medical Equipment	$ 2,316,258	1,165,421	4,649	27,449	$ 1.99	$ 4.55
Limited Dental Services	$ 16	1	1	0	$ 15.11	$ 0.00
Optical	$ 182,097	2,654	1,541	63	$ 68.61	$ 0.36
Lab and X-Ray	$ 5,662,928	223,143	23,527	5,256	$ 25.38	$ 11.11
Transportation	$ 848,431	11,709	3,769	276	$ 72.46	$ 1.67
Subtotal (Medical)	$ 139,322,565	2,446,376	49,408			$ 273.46
CC4C LHD Payments	$ 59	13	N/A	0	$ 4.52	$ 0.00
OBCM LHD Payments	$ 1,726,213	351,250	N/A	8,273	$ 4.91	$ 3.39
Medical Home Payments	$ 852,336	350,290	N/A	8,250	$ 2.43	$ 1.67
Subtotal (LHD/Medical Home Payments)	$ 2,578,607	701,554	N/A			$ 5.06
Total (Medical + LHD/Medical Home)	$ 141,901,172	3,147,930	N/A			$ 278.52

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 59

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	9,785
Average Monthly Members/Deliveries:	815
Eligibles:	9,978

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 20,698,110	27,700	9,171	33,970	$ 747.23	$ 2,115.28
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 4,185,698	26,015	3,533	31,904	$ 160.90	$ 427.77
Emergency Room	$ 5,781,685	14,018	1,737	17,191	$ 412.46	$ 590.87
Physician	$ 15,890,268	73,835	9,536	90,548	$ 215.21	$ 1,623.93
FQHC/RHC	$ 540,150	4,280	311	5,248	$ 126.21	$ 55.20
Other Clinic	$ 2,723,339	16,916	3,107	20,746	$ 160.99	$ 278.32
Other Practitioner	$ -	-	-	-	$ -	$ -
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 1,015	17	192	21	$ 58.47	$ 0.10
LTSS Services	$ 16,604	3,655	20	4,482	$ 4.54	$ 1.70
Durable Medical Equipment	$ 11,888	184	280	226	$ 64.53	$ 1.21
Limited Dental Services	$ 106	4	-	5	$ 25.18	$ 0.01
Optical	$ -	-	-	-	$ -	$ -
Lab and X-Ray	$ 742,268	27,079	2,088	33,208	$ 27.41	$ 75.86
Transportation	$ 137,693	1,535	653	1,883	$ 89.70	$ 14.07
Subtotal (Medical)	$ 50,728,824	195,238	9,909			$ 5,184.32
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 50,728,824	195,238	N/A			$ 5,184.32

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 60

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,620,746
Average Monthly Members/Deliveries:	301,729
Eligibles:	383,408

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 115,159,968	147,543	29,595	489	$ 780.52	$ 31.81
Inpatient — BH	$ 6,191,029	8,469	1,025	28	$ 731.02	$ 1.71
Outpatient Hospital	$ 72,242,539	204,240	77,033	677	$ 353.71	$ 19.95
Emergency Room	$ 86,492,915	223,060	113,653	739	$ 387.76	$ 23.89
Physician	$ 134,465,119	1,275,058	258,988	4,226	$ 105.46	$ 37.14
FQHC/RHC	$ 11,628,405	107,575	37,398	357	$ 108.10	$ 3.21
Other Clinic	$ 31,310,754	255,559	152,375	847	$ 122.52	$ 8.65
Other Practitioner	$ 589,000	7,484	3,161	25	$ 78.70	$ 0.16
Therapies	$ 17,623,969	157,773	10,969	523	$ 111.70	$ 4.87
Prescribed Drugs	$ 250,570,463	2,020,628	211,979	6,697	$ 124.01	$ 69.20
Other BH Services	$ 26,725,280	356,659	28,532	1,182	$ 74.93	$ 7.38
LTSS Services	$ 19,515,455	3,796,414	2,684	12,582	$ 170.40	$ 5.39
Durable Medical Equipment	$ 18,393,211	6,963,527	29,217	23,079	$ 2.64	$ 5.08
Limited Dental Services	$ 1,345,527	54,363	19,685	180	$ 24.75	$ 0.37
Optical	$ 3,327,746	41,931	33,903	139	$ 79.36	$ 0.92
Lab and X-Ray	$ 12,543,671	583,764	78,420	1,935	$ 21.49	$ 3.46
Transportation	$ 4,827,938	74,087	15,380	246	$ 65.17	$ 1.33
Subtotal (Medical)	$ 812,952,989	16,278,134	315,007			$ 224.53
CC4C LHD Payments	$ 3,306,184	729,674	N/A	2,418	$ 4.53	$ 0.91
OBCM LHD Payments	$ 3,293,773	669,658	N/A	2,219	$ 4.92	$ 0.91
Medical Home Payments	$ 8,528,168	3,226,550	N/A	10,694	$ 2.64	$ 2.36
Subtotal (LHD/Medical Home Payments)	$ 15,128,124	4,625,882	N/A			$ 4.18
Total (Medical + LHD/Medical Home)	$ 828,081,113	20,904,016	N/A			$ 228.70

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.5 SFY 2017 Region 5 Exhibits

Exhibit 61

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	309,639
Average Monthly Members/Deliveries:	25,803
Eligibles:	30,210

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 40,612,383	42,084	4,313	1,631	$ 965.03	$ 131.16
Inpatient — BH	$ 1,864,503	2,693	379	104	$ 692.36	$ 6.02
Outpatient Hospital	$ 27,508,819	52,609	13,244	2,039	$ 522.90	$ 88.84
Emergency Room	$ 18,961,621	39,224	14,102	1,520	$ 483.42	$ 61.24
Physician	$ 33,875,195	248,340	23,159	9,624	$ 136.41	$ 109.40
FQHC/RHC	$ 1,866,205	18,500	4,747	717	$ 100.87	$ 6.03
Other Clinic	$ 3,299,232	7,614	4,659	295	$ 433.34	$ 10.66
Other Practitioner	$ 276,665	3,624	1,216	140	$ 76.35	$ 0.89
Therapies	$ 2,451,168	22,859	1,171	886	$ 107.23	$ 7.92
Prescribed Drugs	$ 118,183,541	870,596	23,351	33,740	$ 135.75	$ 381.68
Other BH Services	$ 5,304,737	74,299	6,109	2,879	$ 71.40	$ 17.13
LTSS Services	$ 19,007,888	3,980,340	2,569	154,257	$ 183.98	$ 61.39
Durable Medical Equipment	$ 10,628,755	3,778,000	7,348	146,416	$ 2.81	$ 34.33
Limited Dental Services	$ 11,350	458	167	18	$ 24.78	$ 0.04
Optical	$ 495,088	7,574	3,415	294	$ 65.36	$ 1.60
Lab and X-Ray	$ 3,483,305	128,141	11,730	4,966	$ 27.18	$ 11.25
Transportation	$ 2,165,704	29,698	5,503	1,151	$ 72.93	$ 6.99
Subtotal (Medical)	$ 289,996,157	9,306,652	26,375			$ 936.56
CC4C LHD Payments	$ 1,393	307	N/A	12	$ 4.54	$ 0.00
OBCM LHD Payments	$ 227,324	46,035	N/A	1,784	$ 4.94	$ 0.73
Medical Home Payments	$ 1,375,299	288,824	N/A	11,193	$ 4.76	$ 4.44
Subtotal (LHD/Medical Home Payments)	$ 1,604,016	335,165	N/A			$ 5.18
Total (Medical + LHD/Medical Home)	$ 291,600,174	9,641,817	N/A			$ 941.74

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 62

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	135,338
Average Monthly Members/Deliveries:	11,278
Eligibles:	21,970

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 27,527,584	50,762	10,306	4,501	$ 542.29	$ 203.40
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,082,010	8,301	4,063	736	$ 130.34	$ 7.99
Emergency Room	$ 2,916,943	13,428	7,304	1,191	$ 217.22	$ 21.55
Physician	$ 13,689,167	130,796	18,720	11,597	$ 104.66	$ 101.15
FQHC/RHC	$ 423,789	4,260	1,008	378	$ 99.48	$ 3.13
Other Clinic	$ 4,623,649	50,617	16,743	4,488	$ 91.35	$ 34.16
Other Practitioner	$ 3,178	45	12	4	$ 70.51	$ 0.02
Therapies	$ 131,091	1,633	250	145	$ 80.29	$ 0.97
Prescribed Drugs	$ 2,203,710	47,463	11,603	4,208	$ 46.43	$ 16.28
Other BH Services	$ 23,757	977	26	87	$ 24.32	$ 0.18
LTSS Services	$ 47,343	2,743	50	243	$ 17.26	$ 0.35
Durable Medical Equipment	$ 538,442	154,897	1,631	13,734	$ 3.48	$ 3.98
Limited Dental Services	$ 304,063	12,224	4,974	1,084	$ 24.87	$ 2.25
Optical	$ 10,944	140	100	12	$ 77.89	$ 0.08
Lab and X-Ray	$ 121,307	4,449	1,298	395	$ 27.26	$ 0.90
Transportation	$ 239,493	1,459	776	129	$ 164.11	$ 1.77
Subtotal (Medical)	$ 53,886,470	484,195	20,079			$ 398.16
CC4C LHD Payments	$ 557,110	122,261	N/A	10,841	$ 4.56	$ 4.12
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 273,894	111,246	N/A	9,864	$ 2.46	$ 2.02
Subtotal (LHD/Medical Home Payments)	$ 831,004	233,508	N/A			$ 6.14
Total (Medical + LHD/Medical Home)	$ 54,717,474	717,703	N/A			$ 404.30

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 63

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,183,299
Average Monthly Members/Deliveries:	181,942
Eligibles:	206,833

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,636,909	9,854	2,270	54	$ 1,180.90	$ 5.33
Inpatient — BH	$ 1,883,430	2,838	340	16	$ 663.67	$ 0.86
Outpatient Hospital	$ 16,688,669	58,785	32,333	323	$ 283.90	$ 7.64
Emergency Room	$ 29,730,660	109,861	63,656	604	$ 270.62	$ 13.62
Physician	$ 45,810,665	605,763	143,958	3,329	$ 75.62	$ 20.98
FQHC/RHC	$ 2,962,837	31,615	12,412	174	$ 93.72	$ 1.36
Other Clinic	$ 12,237,362	122,028	93,960	671	$ 100.28	$ 5.60
Other Practitioner	$ 201,271	2,305	1,041	13	$ 87.33	$ 0.09
Therapies	$ 13,751,741	132,724	7,670	729	$ 103.61	$ 6.30
Prescribed Drugs	$ 79,259,858	859,738	126,619	4,725	$ 92.19	$ 36.30
Other BH Services	$ 12,831,228	165,675	15,127	911	$ 77.45	$ 5.88
LTSS Services	$ 285,805	35,577	118	196	$ 98.42	$ 0.13
Durable Medical Equipment	$ 3,747,091	1,494,775	10,436	8,216	$ 2.51	$ 1.72
Limited Dental Services	$ 1,003,780	40,617	14,034	223	$ 24.71	$ 0.46
Optical	$ 2,925,673	35,965	29,624	198	$ 81.35	$ 1.34
Lab and X-Ray	$ 2,800,306	128,611	28,381	707	$ 21.77	$ 1.28
Transportation	$ 1,028,192	10,494	5,365	58	$ 97.98	$ 0.47
Subtotal (Medical)	$ 238,785,477	3,847,224	170,371			$ 109.37
CC4C LHD Payments	$ 2,096,343	463,368	N/A	2,547	$ 4.52	$ 0.96
OBCM LHD Payments	$ 1,250,632	254,142	N/A	1,397	$ 4.92	$ 0.57
Medical Home Payments	$ 5,066,409	2,066,633	N/A	11,359	$ 2.45	$ 2.32
Subtotal (LHD/Medical Home Payments)	$ 8,413,384	2,784,143	N/A			$ 3.85
Total (Medical + LHD/Medical Home)	$ 247,198,861	6,631,367	N/A			$ 113.22

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 64

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	540,587
Average Monthly Members/Deliveries:	45,049
Eligibles:	63,298

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 13,865,660	13,012	2,651	289	$ 1,065.61	$ 25.65
Inpatient — BH	$ 1,245,868	1,728	355	38	$ 721.16	$ 2.30
Outpatient Hospital	$ 16,250,251	47,359	20,793	1,051	$ 343.13	$ 30.06
Emergency Room	$ 25,088,335	57,415	26,535	1,275	$ 436.97	$ 46.41
Physician	$ 28,709,294	250,471	41,412	5,560	$ 114.62	$ 53.11
FQHC/RHC	$ 1,869,126	19,086	6,283	424	$ 97.93	$ 3.46
Other Clinic	$ 3,739,911	16,035	14,756	356	$ 233.23	$ 6.92
Other Practitioner	$ 179,258	2,442	967	54	$ 73.42	$ 0.33
Therapies	$ 18,778	331	248	7	$ 56.65	$ 0.03
Prescribed Drugs	$ 54,429,473	643,955	39,716	14,295	$ 84.52	$ 100.69
Other BH Services	$ 4,372,906	57,473	6,681	1,276	$ 76.09	$ 8.09
LTSS Services	$ 1,112,868	223,543	335	4,962	$ 167.29	$ 2.06
Durable Medical Equipment	$ 2,901,484	1,157,933	5,315	25,704	$ 2.51	$ 5.37
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 292,396	4,521	2,118	100	$ 64.67	$ 0.54
Lab and X-Ray	$ 7,635,268	249,732	24,812	5,544	$ 30.57	$ 14.12
Transportation	$ 990,173	10,918	4,868	242	$ 90.69	$ 1.83
Subtotal (Medical)	$ 162,701,048	2,755,954	49,986			$ 300.97
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ 1,832,484	372,875	N/A	8,277	$ 4.91	$ 3.39
Medical Home Payments	$ 1,006,669	418,439	N/A	9,289	$ 2.41	$ 1.86
Subtotal (LHD/Medical Home Payments)	$ 2,839,153	791,313	N/A			$ 5.25
Total (Medical + LHD/Medical Home)	$ 165,540,201	3,547,268	N/A			$ 306.22

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 65

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	8,871
Average Monthly Members/Deliveries:	739
Eligibles:	9,011

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 19,682,422	26,759	8,406	36,196	$ 735.55	$ 2,218.66
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,239,525	25,977	3,633	35,138	$ 124.71	$ 365.17
Emergency Room	$ 4,679,384	12,736	1,161	17,228	$ 367.41	$ 527.47
Physician	$ 16,393,306	67,776	8,711	91,679	$ 241.87	$ 1,847.90
FQHC/RHC	$ 413,497	2,799	264	3,787	$ 147.71	$ 46.61
Other Clinic	$ 1,096,469	8,583	1,573	11,610	$ 127.74	$ 123.60
Other Practitioner	$ -	-	-	-	$ -	$ -
Therapies	$ 362	7	2	10	$ 50.11	$ 0.04
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 105	2	232	3	$ 51.19	$ 0.01
LTSS Services	$ 23,398	5,171	23	6,994	$ 4.53	$ 2.64
Durable Medical Equipment	$ 38,881	817	698	1,105	$ 47.59	$ 4.38
Limited Dental Services	$ 54	2	-	3	$ 24.88	$ 0.01
Optical	$ 81	1	14	1	$ 80.59	$ 0.01
Lab and X-Ray	$ 501,977	17,910	1,679	24,227	$ 28.03	$ 56.58
Transportation	$ 169,899	1,510	677	2,042	$ 112.53	$ 19.15
Subtotal (Medical)	$ 46,239,360	170,050	8,964			$ 5,212.24
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 46,239,360	170,050	N/A			$ 5,212.24

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 66

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,168,863
Average Monthly Members/Deliveries:	264,072
Eligibles:	331,322

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 113,324,958	142,471	27,946	540	$ 795.43	$ 35.76
Inpatient — BH	$ 4,993,801	7,258	1,075	27	$ 688.00	$ 1.58
Outpatient Hospital	$ 64,769,273	193,030	74,066	731	$ 335.54	$ 20.44
Emergency Room	$ 81,376,943	232,664	112,758	881	$ 349.76	$ 25.68
Physician	$ 138,477,627	1,303,147	235,960	4,935	$ 106.26	$ 43.70
FQHC/RHC	$ 7,535,453	76,261	24,714	289	$ 98.81	$ 2.38
Other Clinic	$ 24,996,624	204,877	131,691	776	$ 122.01	$ 7.89
Other Practitioner	$ 660,373	8,415	3,243	32	$ 78.47	$ 0.21
Therapies	$ 16,353,139	157,554	9,341	597	$ 103.79	$ 5.16
Prescribed Drugs	$ 254,076,583	2,421,752	207,026	9,171	$ 104.91	$ 80.18
Other BH Services	$ 22,532,732	298,425	28,175	1,130	$ 75.51	$ 7.11
LTSS Services	$ 20,477,302	4,247,373	3,095	16,084	$ 181.97	$ 6.46
Durable Medical Equipment	$ 17,854,652	6,586,422	25,428	24,942	$ 2.71	$ 5.63
Limited Dental Services	$ 1,319,246	53,301	19,175	202	$ 24.75	$ 0.42
Optical	$ 3,724,182	48,202	35,271	183	$ 77.26	$ 1.18
Lab and X-Ray	$ 14,542,162	528,844	67,900	2,003	$ 27.50	$ 4.59
Transportation	$ 4,593,461	54,078	17,189	205	$ 84.94	$ 1.45
Subtotal (Medical)	$ 791,608,513	16,564,075	275,352			$ 249.81
CC4C LHD Payments	$ 2,654,845	585,936	N/A	2,219	$ 4.53	$ 0.84
OBCM LHD Payments	$ 3,310,441	673,051	N/A	2,549	$ 4.92	$ 1.04
Medical Home Payments	$ 7,722,271	2,885,143	N/A	10,926	$ 2.68	$ 2.44
Subtotal (LHD/Medical Home Payments)	$ 13,687,557	4,144,130	N/A			$ 4.32
Total (Medical + LHD/Medical Home)	$ 805,296,070	20,708,205	N/A			$ 254.13

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.6 SFY 2017 Region 6 Exhibits

Exhibit 67

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	267,136
Average Monthly Members/Deliveries:	22,261
Eligibles:	26,250

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 33,908,853	34,770	3,445	1,562	$ 975.23	$ 126.93
Inpatient — BH	$ 2,181,274	2,921	372	131	$ 746.83	$ 8.17
Outpatient Hospital	$ 20,092,525	35,463	10,317	1,593	$ 566.57	$ 75.21
Emergency Room	$ 16,221,364	32,182	12,109	1,446	$ 504.05	$ 60.72
Physician	$ 27,327,152	191,382	19,642	8,597	$ 142.79	$ 102.30
FQHC/RHC	$ 2,032,962	19,316	5,292	868	$ 105.25	$ 7.61
Other Clinic	$ 3,642,048	7,529	4,317	338	$ 483.75	$ 13.63
Other Practitioner	$ 250,262	3,395	1,203	153	$ 73.71	$ 0.94
Therapies	$ 1,278,108	11,240	660	505	$ 113.71	$ 4.78
Prescribed Drugs	$ 96,667,525	702,485	20,214	31,556	$ 137.61	$ 361.87
Other BH Services	$ 3,109,256	53,752	5,567	2,415	$ 57.85	$ 11.64
LTSS Services	$ 17,007,737	3,253,079	2,030	146,132	$ 182.17	$ 63.67
Durable Medical Equipment	$ 9,592,168	3,371,875	6,021	151,468	$ 2.84	$ 35.91
Limited Dental Services	$ 9,836	397	128	18	$ 24.76	$ 0.04
Optical	$ 362,636	5,181	3,151	233	$ 70.00	$ 1.36
Lab and X-Ray	$ 2,491,765	109,950	10,797	4,939	$ 22.66	$ 9.33
Transportation	$ 2,475,349	41,715	4,783	1,874	$ 59.34	$ 9.27
Subtotal (Medical)	$ 238,650,822	7,876,632	22,943			$ 893.37
CC4C LHD Payments	$ 1,091	240	N/A	11	$ 4.54	$ 0.00
OBCM LHD Payments	$ 193,836	39,253	N/A	1,763	$ 4.94	$ 0.73
Medical Home Payments	$ 1,210,762	252,617	N/A	11,348	$ 4.79	$ 4.53
Subtotal (LHD/Medical Home Payments)	$ 1,405,688	292,110	N/A			$ 5.26
Total (Medical + LHD/Medical Home)	$ 240,056,510	8,168,742	N/A			$ 898.63

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 68

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	108,992
Average Monthly Members/Deliveries:	9,083
Eligibles:	17,762

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 20,773,693	36,954	8,077	4,069	$ 562.14	$ 190.60
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,062,514	5,906	3,306	650	$ 179.90	$ 9.75
Emergency Room	$ 2,578,938	10,276	5,565	1,131	$ 250.97	$ 23.66
Physician	$ 9,710,719	96,348	14,546	10,608	$ 100.79	$ 89.10
FQHC/RHC	$ 645,160	6,198	1,382	682	$ 104.10	$ 5.92
Other Clinic	$ 4,202,945	39,555	13,116	4,355	$ 106.26	$ 38.56
Other Practitioner	$ 2,043	48	15	5	$ 42.88	$ 0.02
Therapies	$ 101,548	976	169	108	$ 103.99	$ 0.93
Prescribed Drugs	$ 1,631,998	31,402	8,681	3,457	$ 51.97	$ 14.97
Other BH Services	$ 11,417	625	8	69	$ 18.27	$ 0.10
LTSS Services	$ 70,376	1,048	7	115	$ 67.16	$ 0.65
Durable Medical Equipment	$ 298,073	53,417	1,044	5,881	$ 5.58	$ 2.73
Limited Dental Services	$ 271,630	10,897	4,303	1,200	$ 24.93	$ 2.49
Optical	$ 7,233	89	69	10	$ 81.68	$ 0.07
Lab and X-Ray	$ 64,975	3,118	978	343	$ 20.84	$ 0.60
Transportation	$ 273,848	2,284	772	251	$ 119.91	$ 2.51
Subtotal (Medical)	$ 41,707,110	299,140	16,085			$ 382.66
CC4C LHD Payments	$ 448,412	98,407	N/A	10,835	$ 4.56	$ 4.11
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 219,774	89,579	N/A	9,863	$ 2.45	$ 2.02
Subtotal (LHD/Medical Home Payments)	$ 668,186	187,986	N/A			$ 6.13
Total (Medical + LHD/Medical Home)	$ 42,375,296	487,126	N/A			$ 388.79

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 69

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	1,733,723
Average Monthly Members/Deliveries:	144,477
Eligibles:	164,827

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 6,922,858	5,524	1,238	38	$ 1,253.21	$ 3.99
Inpatient — BH	$ 1,361,232	2,319	265	16	$ 586.97	$ 0.79
Outpatient Hospital	$ 12,996,332	37,526	21,281	260	$ 346.33	$ 7.50
Emergency Room	$ 23,892,199	84,304	49,404	584	$ 283.40	$ 13.78
Physician	$ 31,089,086	437,138	110,576	3,026	$ 71.12	$ 17.93
FQHC/RHC	$ 3,316,828	32,743	12,981	227	$ 101.30	$ 1.91
Other Clinic	$ 10,472,431	99,358	76,957	688	$ 105.40	$ 6.04
Other Practitioner	$ 178,352	2,450	927	17	$ 72.81	$ 0.10
Therapies	$ 5,944,391	51,738	4,338	358	$ 114.89	$ 3.43
Prescribed Drugs	$ 64,058,923	645,147	95,278	4,465	$ 99.29	$ 36.95
Other BH Services	$ 7,845,836	104,811	12,584	725	$ 74.86	$ 4.53
LTSS Services	$ 257,952	20,979	44	145	$ 100.85	$ 0.15
Durable Medical Equipment	$ 2,911,911	1,079,420	8,057	7,471	$ 2.70	$ 1.68
Limited Dental Services	$ 909,824	36,814	12,054	255	$ 24.71	$ 0.52
Optical	$ 2,336,482	28,135	25,400	195	$ 83.05	$ 1.35
Lab and X-Ray	$ 2,092,395	110,151	21,902	762	$ 19.00	$ 1.21
Transportation	$ 875,144	11,298	4,147	78	$ 77.46	$ 0.50
Subtotal (Medical)	$ 177,462,176	2,789,854	135,358			$ 102.36
CC4C LHD Payments	$ 1,691,277	373,833	N/A	2,587	$ 4.52	$ 0.98
OBCM LHD Payments	$ 974,781	198,086	N/A	1,371	$ 4.92	$ 0.56
Medical Home Payments	$ 4,024,743	1,642,587	N/A	11,369	$ 2.45	$ 2.32
Subtotal (LHD/Medical Home Payments)	$ 6,690,801	2,214,507	N/A			$ 3.86
Total (Medical + LHD/Medical Home)	$ 184,152,977	5,004,360	N/A			$ 106.22

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 70

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	407,775
Average Monthly Members/Deliveries:	33,981
Eligibles:	48,504

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 9,328,294	8,085	1,625	238	$ 1,153.71	$ 22.88
Inpatient — BH	$ 954,536	1,153	221	34	$ 827.64	$ 2.34
Outpatient Hospital	$ 11,099,675	28,181	14,061	829	$ 393.87	$ 27.22
Emergency Room	$ 19,013,960	45,809	21,066	1,348	$ 415.07	$ 46.63
Physician	$ 17,249,518	152,651	29,685	4,492	$ 113.00	$ 42.30
FQHC/RHC	$ 1,737,885	17,224	5,889	507	$ 100.90	$ 4.26
Other Clinic	$ 3,231,879	16,812	13,144	495	$ 192.23	$ 7.93
Other Practitioner	$ 157,965	2,285	929	67	$ 69.12	$ 0.39
Therapies	$ 4,959	101	83	3	$ 49.00	$ 0.01
Prescribed Drugs	$ 37,976,488	425,052	29,509	12,508	$ 89.35	$ 93.13
Other BH Services	$ 2,785,498	41,492	5,344	1,221	$ 67.13	$ 6.83
LTSS Services	$ 569,700	106,364	206	3,130	$ 173.22	$ 1.40
Durable Medical Equipment	$ 2,089,279	921,812	3,731	27,127	$ 2.27	$ 5.12
Limited Dental Services	$ 15	1	1	0	$ 15.11	$ 0.00
Optical	$ 148,446	2,118	1,394	62	$ 70.10	$ 0.36
Lab and X-Ray	$ 4,928,565	183,312	19,404	5,395	$ 26.89	$ 12.09
Transportation	$ 721,889	9,660	3,164	284	$ 74.73	$ 1.77
Subtotal (Medical)	$ 111,998,551	1,962,113	38,188			$ 274.66
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ 1,409,970	286,901	N/A	8,443	$ 4.91	$ 3.46
Medical Home Payments	$ 756,316	316,367	N/A	9,310	$ 2.39	$ 1.85
Subtotal (LHD/Medical Home Payments)	$ 2,166,286	603,268	N/A			$ 5.31
Total (Medical + LHD/Medical Home)	$ 114,164,837	2,565,381	N/A			$ 279.97

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 71

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	7,245
Average Monthly Members/Deliveries:	604
Eligibles:	7,365

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 16,577,058	20,705	6,964	34,296	$ 800.63	$ 2,288.19
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,824,891	12,591	2,691	20,856	$ 144.93	$ 251.90
Emergency Room	$ 3,213,442	10,590	1,369	17,542	$ 303.44	$ 443.56
Physician	$ 12,376,813	51,708	6,877	85,649	$ 239.36	$ 1,708.42
FQHC/RHC	$ 980,384	6,217	527	10,298	$ 157.69	$ 135.33
Other Clinic	$ 2,051,707	15,842	1,978	26,241	$ 129.51	$ 283.21
Other Practitioner	$ -	-	-	-	$ -	$ -
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ -	-	-	-	$ -	$ -
LTSS Services	$ 31,081	2,216	7	3,671	$ 14.02	$ 4.29
Durable Medical Equipment	$ 7,087	119	195	197	$ 59.53	$ 0.98
Limited Dental Services	$ 50	2	-	3	$ 24.79	$ 0.01
Optical	$ 81	1	14	2	$ 80.59	$ 0.01
Lab and X-Ray	$ 399,774	15,469	1,961	25,623	$ 25.84	$ 55.18
Transportation	$ 155,300	1,367	576	2,264	$ 113.62	$ 21.44
Subtotal (Medical)	$ 37,617,668	136,828	7,316			$ 5,192.51
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 37,617,668	136,828	N/A			$ 5,192.51

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 72

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	2,517,626
Average Monthly Members/Deliveries:	209,802
Eligibles:	264,708

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 87,510,757	106,039	21,349	505	$ 825.27	$ 34.76
Inpatient — BH	$ 4,497,042	6,393	859	30	$ 703.42	$ 1.79
Outpatient Hospital	$ 47,075,937	119,668	51,656	570	$ 393.39	$ 18.70
Emergency Room	$ 64,919,904	183,161	89,513	873	$ 354.44	$ 25.79
Physician	$ 97,753,287	929,228	181,326	4,429	$ 105.20	$ 38.83
FQHC/RHC	$ 8,713,219	81,697	26,071	389	$ 106.65	$ 3.46
Other Clinic	$ 23,601,011	179,096	109,512	854	$ 131.78	$ 9.37
Other Practitioner	$ 588,622	8,178	3,075	39	$ 71.98	$ 0.23
Therapies	$ 7,329,005	64,056	5,250	305	$ 114.42	$ 2.91
Prescribed Drugs	$ 200,334,934	1,804,087	158,208	8,599	$ 111.05	$ 79.57
Other BH Services	$ 13,752,008	200,679	23,688	957	$ 68.53	$ 5.46
LTSS Services	$ 17,936,846	3,383,686	2,294	16,128	$ 181.75	$ 7.12
Durable Medical Equipment	$ 14,898,518	5,426,643	19,048	25,866	$ 2.75	$ 5.92
Limited Dental Services	$ 1,191,355	48,111	16,486	229	$ 24.76	$ 0.47
Optical	$ 2,854,879	35,523	30,028	169	$ 80.37	$ 1.13
Lab and X-Ray	$ 9,977,474	422,000	55,042	2,011	$ 23.64	$ 3.96
Transportation	$ 4,501,528	66,324	13,442	316	$ 67.87	$ 1.79
Subtotal (Medical)	$ 607,436,327	13,064,567	219,576			$ 241.27
CC4C LHD Payments	$ 2,140,779	472,481	N/A	2,252	$ 4.53	$ 0.85
OBCM LHD Payments	$ 2,578,587	524,240	N/A	2,499	$ 4.92	$ 1.02
Medical Home Payments	$ 6,211,595	2,301,150	N/A	10,968	$ 2.70	$ 2.47
Subtotal (LHD/Medical Home Payments)	$ 10,930,961	3,297,871	N/A			$ 4.34
Total (Medical + LHD/Medical Home)	$ 618,367,288	16,362,437	N/A			$ 245.62

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

8 CAPITATION RATE DEVELOPMENT

The rate-setting methodology is based on generally accepted actuarial principles and best practices and approaches from other state Medicaid managed care programs. The rate-setting process and related documentation comply with CMS regulations outlined in 42 CFR 438.4 and were developed in accordance with applicable law and regulations, including the ASOPs. The process was developed in a way that supports the financial-related objectives of the new program to:

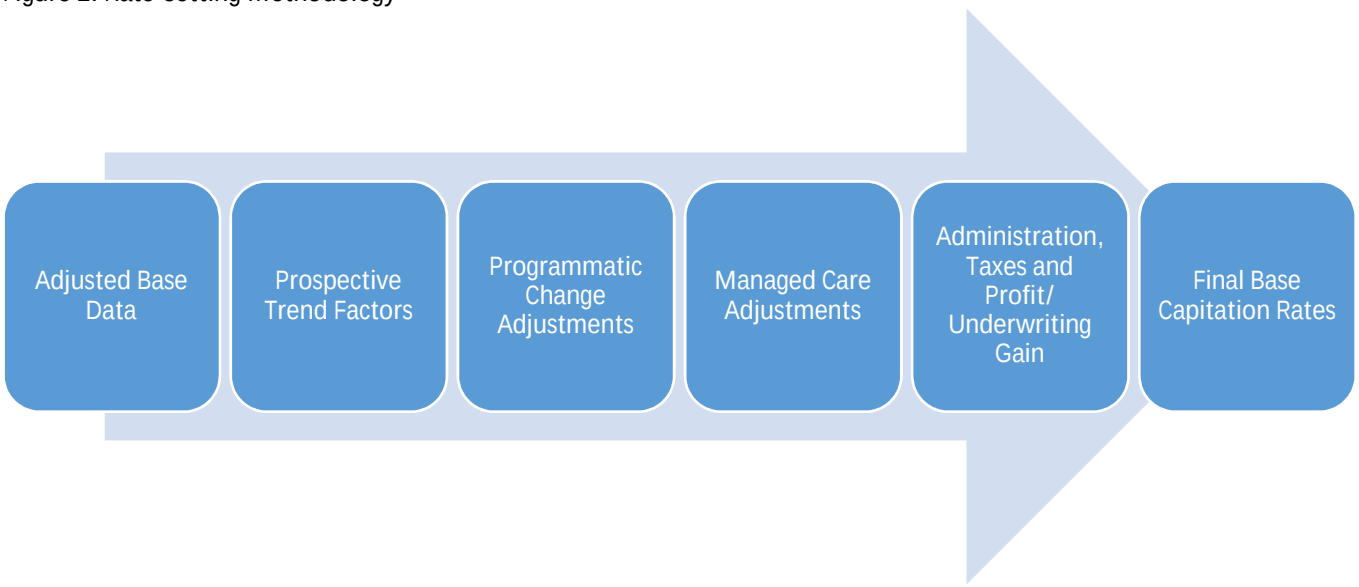
- Advance high-value care, and
- Establish a sustainable program with predictable costs.

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 State Medicaid and NC Health Choice populations. Under managed care, the capitation payments will be made by DHHS to the PHPs who will administer the contractually-required services to the populations covered under the program. Capitation payments differ from FFS payments where DHHS pays providers for each service rendered. Under capitation payments, a monthly payment for each member is made to a PHP to cover a defined set of services. Under managed care, PHPs will contract and reimburse providers for services rendered to their enrollees.

The rate-setting process is the means for determining the PMPM capitation payments DHHS will pay to the PHPs 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 2 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. Mercer has refined the approach to best match the proposed Medicaid managed care program design and North Carolina's health care landscape.

Figure 2: Rate-Setting Methodology



9 BASE DATA DEVELOPMENT

Capitation rates were developed starting with a 20.0%/80.0% blend of SFY 2016 and SFY 2017 base data experience, respectively (with the exception of pharmacy as described below). Prior to blending the base data experience into a single base year, Mercer trended SFY 2016 data forward one year so that the SFY 2016 and SFY 2017 experience was on the same basis.

Mercer reviewed SFY 2015 through SFY 2017 historical experience to develop retrospective trend assumptions, which are used to trend SFY 2016 to SFY 2017 prior to blending. Retrospective trend assumptions were developed by major COS groupings, and were developed in aggregate across all regions and COA. This approach helps create a more credible level of data, smooth data anomalies and mitigate volatility for smaller COS within a rate cell. Since retrospective trend was developed and applied on an aggregate basis this allows for annual regional, COA and/or detailed COS variances to be mitigated by trending SFY 2016 to SFY 2017 and blending the two years of experience.

The table below provides an outline of how the detailed COS included in the base data summaries (Section 7) are aggregated for trend analyses (same COS groupings used for prospective trend in Section 10) along with the retrospective trend factors used to trend SFY 2016 onto a SFY 2017 time period basis.

Table 14: Retrospective Trend Factors for SFY 2016 to SFY 2017 by COS

Aggregate COS	Detailed COS	Trend Factors for SFY 2016 to SFY 2017
Inpatient Hospital	Inpatient Hospital — PH Inpatient Hospital — BH	2.0%
Outpatient Hospital	Outpatient Hospital	2.0%
Emergency Room	Emergency Room	2.0%
Physician	Physician FQHC/RHC Other Clinic Other Practitioner Therapies	2.5%
Prescribed Drugs	Prescribed Drugs	Not Applicable
Other BH Services	Other BH Services	6.5%
LTSS Services	LTSS Services	2.0%
Other Acute Care	Durable Medical Equipment Limited Dental Services Optical Lab and X-Ray	2.0%
Transportation	Transportation	0.0%

After trending SFY 2016 to a common SFY 2017 time period, Mercer smoothed the claims data by blending the multiple years of available data into a single base year (SFY 2017), placing higher credibility on the most recent year. The goal of this process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially sound capitation rates. For all populations and services, except for pharmacy, 20.0% weight was given to SFY 2016 and 80.0% weight was given to SFY 2017. For pharmacy, effective January 1, 2016, DHHS implemented a new reimbursement methodology based on Actual Acquisition Cost (AAC). Given this change is not fully reflected in the SFY 2016 base data, Mercer placed 100.0% weight on the SFY 2017 experience.

Please note the base data development will be refreshed to include data through SFY 2018 in advance of managed care implementation and final capitation rate development.

10 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 SFY 2020 rating period. Per 42 CFR 438.5(b)(2) of the CMS Managed Care Final Rule (Final Rule), in setting actuarially sound rates, the actuary must "develop and apply trend factors, including cost and utilization, to base data that are developed from actual experience of the Medicaid population or a similar population in accordance with generally accepted actuarial practices and principles."

10.1 Trend Development Methodology

Mercer reviewed historical FFS and BH LME/MCO claims and enrollment data during the SFY 2015, SFY 2016 and SFY 2017 time periods for the proposed Standard Plan population. The data was analyzed on a rolling average basis (12-months, 9-months, 3-months and single month) 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 region and service category. The slope of the fitted line from the historical data informed prospective trend assumptions. 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 on a statewide and regional basis. Rate cell specific variations were also evaluated and informed further delineation where warranted for certain COS; assumptions vary by rate cell for Inpatient and Prescription Drugs which make up over 40.0% of the total Standard Plan base expenditures. Since each rate cell has a different distribution of services, the trend assumption percentages translate to a different PMPM impact by rate cell. The trend assumptions were applied from the midpoint of the credibility-blended SFY 2017 base data period to the midpoint of the SFY 2020 rating period, a total of 36 months.

10.2 Overall Trend Assumptions

Mercer developed an annual trend assumption of approximately 3.0% to project the SFY 2017 base data to the SFY 2020 rate period. The impact varies by COS and is captured in the table below. Specific details about unique service considerations are provided below the trend tables.

Table 15: Overall Annual Trend Projections by Major Service Category

COS	Unit Cost Trend	Utilization Trend	Total PMPM Trend	SFY 2017 Base PMPM[13]
Inpatient Hospital	0.5%	0.7%	1.2%	$34.25
Outpatient Hospital	0.5%	1.4%	1.9%	$22.02
Emergency Room	0.5%	1.5%	2.0%	$24.40
Physician[14]	0.5%	1.7%	2.2%	$54.57
Prescription Drugs	5.2%	0.4%	5.7%	$75.85
Other BH Services	1.0%	1.6%	2.7%	$6.53
LTSS Services	0.5%	0.2%	0.7%	$6.42
Other Acute Care	0.5%	1.1%	1.6%	$11.08

[13] Overall base data PMPM provided for reference to scale of overall COS relative to the total across all services.

[14] Physician trend projections were applied to the primary and specialty care physician, FQHCs/RHCs, Therapies and Other Clinics and Practitioners service lines. Other acute care trend projections were applied to the Durable Medical Equipment, Optical and Lab and X-ray service lines.

COS	Unit Cost Trend	Utilization Trend	Total PMPM Trend	SFY 2017 Base PMPM[13]
Transportation	0.5%	-0.5%	0.0%	$1.55
Medical Home/LHD Payments	0.0%	0.0%	0.0%	$4.24
Total Standard Plan	2.0%	1.0%	3.0%	$240.91

Note: The transportation COS is comprised of both Ambulance and NEMT cost and utilization; negative prospective utilization trend is a result of historical decreases observed for the Ambulance COS.

The table below shows the trend factors by region. The impact of trend is generally consistent across the regions; differences are driven by the variation in the utilization of services within each region.

Table 16: Overall Annual Trend Projections by PHP Region

Region	Unit Cost Trend	Utilization Trend	Total PMPM Trend
Region 1	1.9%	1.2%	3.1%
Region 2	2.0%	1.0%	3.0%
Region 3	2.2%	0.8%	3.0%
Region 4	2.2%	1.1%	3.3%
Region 5	1.9%	1.0%	2.8%
Region 6	2.1%	1.0%	3.1%
Total Standard Plan	2.0%	1.0%	3.0%

The sections below provide additional commentary for service categories with trend differences by rate cell or observations within the base data. For detailed trend assumptions by rate cell, see the Capitation Rate Development Exhibits included in Section 14 of this Draft Rate Book.

10.2.1 Inpatient Hospital

Mercer evaluated the inpatient hospital service trends by rate cell to assess whether trend should be varied across the rate cells. Historical experience for this service line is comprised of over 90.0% physical health services. This service line captures approximately 15.0% of the total Standard Plan expenditures. Historical trends have been highest for the TANF — Adult (21+) and Maternity Event rate cells, resulting in the higher trend projections for these rate cells. Conversely, historical trends have been lowest for the ABD population, resulting in lower trend projections. Trend projections for the TANF — Newborn (<1) and TANF — Child (1-20) populations fall between these levels. Variation was included by rate cell for the Inpatient Hospital service line. The same assumptions were applied across all regions.

Specific to Inpatient Hospital — PH services, DHHS is requiring PHPs to reimburse hospitals per the DHHS-determined DRG base rates, Medicaid FFS case weights and outlier methodologies. DHHS will increase the DRG base rate annually by the Medicare Inpatient Hospital Prospective Payment System (PPS) market basket update less the productivity adjustment, as published in the Medicare Hospital Inpatient PPS and Long Term Acute Care Hospital PPS Final Rule. This trend index will be reviewed as a part of annual rate development, and will be addressed in the final capitation rates per consideration of final hospital reimbursement requirements (Section 11.1).

10.2.2 Prescription Drugs

Prescription drugs have the highest prospective trend assumptions in the capitation rates. Recent publications pertaining to the National Drug Trend and Pipeline suggest overall trends across specialty and traditional drug classes are expected to increase in the coming years. Further, prescription drug growth is expected to accelerate between 2017 – 2019 due to price growth and fewer brand name drugs losing patent protection.

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 projections for specialty and traditional pharmacy trends by rate cell to account for the varying impact of prescription drugs for each population. Some of the underlying reasons for the higher specialty trends include: expanded indications, direct to consumer advertising and new drugs entering the market faster due to breakthrough therapy approvals granted by the Food and Drug Administration (FDA).

Pipeline drugs, which are drugs that are still under development or discovery, may not be reflected in the historical claims data, but are known to impact utilization and cost beyond the base data period. These types of drugs were evaluated and accounted for in the pharmacy trend development. There may also be significant growth in other drug classes such as diabetes (traditional), asthma (traditional), rheumatoid arthritis (specialty), oncology (specialty), HIV (specialty) and other new and emerging therapeutic drugs. Some recent examples of emerging drugs that have impacted expected pharmacy costs are treatments for hypercholesterolemia, cystic fibrosis and hepatitis C. Pharmacy-specific trend models utilize this information along with historical utilization data to develop pharmacy trends for each rate cell.

Please note the trend assumptions will be re-evaluated when more recent base data experience becomes available in advance of managed care implementation and final capitation rate development. Pharmacy trends will be specifically reviewed to account for industry emerging trends, along with State-specific changes that may impact pharmacy trends (e.g., 2017 Opioid policy changes).

11 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 claims data as well as information provided by DHHS to assess the impact of known programmatic changes to the capitation rates. Note that these programmatic changes currently assume no changes to proposed covered benefits, and any changes (e.g., changes to address the opioid crisis) will be evaluated and accounted for in the final capitation rate development process.

11.1 Hospital Reimbursement Methodology

DHHS has historically reimbursed hospitals using a mix of claims payments and supplemental payments. In the initial contract years, rate floors will apply for PHP payments to hospitals that incorporate a portion of these supplemental payments into hospital base rates. For additional information on hospital reimbursement methodology, see Appendix G.

For purposes of the draft rates, the hospital reimbursement adjustment has been modeled based on the historical supplemental payment levels. To account for the historical supplemental payments made to hospitals outside of the claims system, Mercer utilized supplemental payment information for the federal fiscal year (FFY) 2016 time period to calculate a rate adjustment. Mercer evaluated the supplemental payments for Inpatient Hospital and Outpatient Hospital services, including Emergency Room services, by provider number (National Provider Identifier [NPI]). Mercer then distributed these payments across the Standard Plan population by region and by rate cell based on the population-specific claim costs by hospital captured in the FFS data.

DHHS will make GME payments directly to eligible hospitals, and thus PHPs will not be required to reimburse hospitals for GME. The hospital reimbursement methodology adjustment reflects the reclassification of historical supplemental payments as GME per the hospital reimbursement methodology; the total amount of historical supplemental payments reclassified as GME in the draft rates is around $140 million for all populations (including those excluded from PHPs). This $140 million is in addition to the $85 million removed from historical FFS claims expenditures, reflecting the GME add-on currently included in the hospital base rates (see Section 6.4 of this Draft Rate Book). In total, $225 million in GME, representing the base rate add-on and portion of supplemental payments attributable to GME, was removed from the draft capitation rates.

The tables below represents the total regional supplemental payment amounts across all populations and then the amount allocated to the Standard Plan population and the overall impact by COA to the Standard Plan capitation rates. As mentioned above, the figures below reflect adjusted historical supplemental payment information for the GME reclassification.

Table 17: Calculated Historical Supplemental Payments by Region

	Inpatient Hospital		Outpatient Hospital (Includes Emergency Room)	
Region	Total Supplemental Payments for All Populations	Supplemental Payments for the Standard Plan Population	Total Supplemental Payments for All Populations	Supplemental Payments for the Standard Plan Population
Region 1	$146.9M	$112.8M	$32.0M	$24.2M
Region 2	$256.1M	$204.4M	$61.9M	$49.2M
Region 3	$339.3M	$267.8M	$92.9M	$73.8M
Region 4	$255.7M	$190.9M	$53.8M	$41.4M
Region 5	$251.0M	$196.7M	$51.4M	$41.5M
Region 6	$118.1M	$91.4M	$31.1M	$24.9M
Total	$1,367.1M	$1,064.0M	$323.1M	$255.0M

Table 18: Impact of Hospital Reimbursement Requirements by COA

COA	PMPM/Payment Impact	Percent Impact
ABD	$241.95	21.9%
TANF, Newborn (<1)	$306.44	76.6%
TANF, Children (1-20)	$12.85	10.7%
TANF, Adults (21+)	$66.42	20.5%
Maternity Event	$3,756.83	73.0%
Total Standard Plan	$64.81	24.7%

Final capitation rates will reflect the final hospital base rates developed using the methodology described in Appendix G. Note as part of the hospital reimbursement design, DHHS will apply the new reimbursement rates to the NC Health Choice population. The capitation rate adjustment outlined above does not reflect this impact for the NC Health Choice population. DHHS is also requiring PHPs to make additional, utilization based, directed payments to hospitals owned by UNC Health Care and Vidant Medical Center. DHHS will reimburse PHPs for these additional payments outside of the prospective PMPM and maternity event capitated payments. The historical supplemental payments for UNC and Vidant are included in the supplemental payments incorporated into the draft rates. The final rates will be adjusted downward to account for the directed payments to UNC Health Care and Vidant Medical Center that will be removed from the risk pool.

11.2 Maternity Enhanced Rate

Under the current FFS program, providers offering coverage to beneficiaries enrolled in the PMH are reimbursed at an enhanced rate for vaginal deliveries (approximately 85.0% of total vaginal births). Under managed care, DHHS is requiring that PHPs reimburse all providers at the enhanced payment rate on all vaginal deliveries. Given that a portion of the historical FFS deliveries occurred outside of the PMH, Mercer evaluated an adjustment to ensure all vaginal deliveries in the base experience reflected the enhanced rate consistent with future PHP reimbursement requirements. To calculate this adjustment, Mercer identified the vaginal deliveries with a unit cost corresponding to the fee schedule rate and repriced at the enhanced vaginal delivery unit cost represented in the data. Claims and utilization data for this adjustment was based on the Calendar Year 2016 time period to ensure adequate runout in order to capture all deliveries within a year. This adjustment represented an overall 0.3%, or approximately $784,000 overall, upward adjustment to the Maternity Event rate cell (0.8% upward adjustment to the Physician COS).

11.3 Long-Term Nursing Home Stay Beneficiaries

The base data currently excludes beneficiaries with long-term nursing home stays (90 days or greater) from the Standard Plan population. Under the proposed program design, PHPs are responsible for short-term nursing home stays along with the first 90 days of a long-term nursing home stay for new admissions to the nursing home (after which they would be dis-enrolled from the PHP). Beneficiaries accessing services in State-owned neuro-medical centers or State-owned veteran homes will be excluded from PHP coverage upon entry to one of those facilities. Since the summarized base experience does not include long-term nursing home stay beneficiaries, Mercer modeled an assumption to calculate an upward adjustment to account for the additional cost and membership associated with new nursing home admissions during the first 90 days of a long-term nursing home stay. Mercer applied this adjustment on a PMPM basis to account for both the additional costs and MMs associated with these beneficiaries. Note that this adjustment is subject to change pending final approach to the long-term nursing home stay population.

Table 19: Impact of Initial 90 Days of Long-term Nursing Home Stays

COA	PMPM/Payment Impact
ABD	0.8%
TANF, Newborn (<1)	0.0%
TANF, Children (1-20)	0.0%
TANF, Adults (21+)	0.0%
Maternity Event	0.0%
Total Standard Plan	0.3%

11.4 Other Provider Reimbursement Considerations

11.4.1 Provider Rate Floors

DHHS will establish rate floors set at FFS levels as allowed by 438.6(c)(1)(iii)(A) for in-network physicians, physician extenders, hospitals and nursing facilities. The rate floor for in-network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) will be set at 100.0% of the Medicaid FFS rate. For a period of time to be defined by DHHS, PHPs shall be required to reimburse nursing facilities (excluding those owned and operated by the State) at a rate that is no less than the Medicaid FFS rate in effect six months prior to the start of the capitation rating year. As such, the capitation rates assume the current FFS levels will be maintained as the payment level for these providers.

11.4.2 LME/MCO Services Reimbursement

The current proposed Standard Plan program design includes service offerings for a subset of BH services historically covered through the LME/MCOs (see Section 5, Table 4 for a listing of these services). However, proposed program design dictates that services historically covered by LME/MCOs should not be subject to a rate floor requirement. While most LME/MCOs adhere to the State per diem fee schedule published for State-Operated ICF/IIDs, the LME/MCOs generally negotiate rates for other services. As such, the base encounter experience reflects provider-negotiated rates for LME/MCO BH services covered under the Standard Plan. No adjustments, other than trend, have been made in capitation rate development to alter the historical LME/MCO provider rates.

11.4.3 FQHC/RHC Providers

DHHS is currently working with FQHCs/RHCs on appropriate reimbursement rates under the PHP contracts. For purposes of draft rate development, similar reimbursement levels as FFS for these providers have been assumed, with anticipated wrap payments as required. The historical cost settlements for FQHCs/RHCs were $10,039,949 and $17,211,997 for SFY 2015 and SFY 2016, respectively. Final rates will reflect PHP requirements related to FQHC/RHC reimbursement.

11.4.4 Historical Cost Settlements

DHHS has historically cost settled certain providers in the FFS program. Interim payments are made based on a defined fee schedule and providers subsequently settled to actual cost. While cost settlements cannot continue in a managed care environment, DHHS is working with CMS to get approval for converting current cost settlements for certain providers to directed payments per 42 CFR 438.6(c). These are additional payments made by PHPs to certain providers for a particular service, for which DHHS would reimburse PHPs outside of the prospective PMPM and maternity event capitated rates based on utilization of that particular service. As such, the capitation rates assume continuation of reimbursement consistent with current fee schedules. Any changes to this approach will be reflected in final rates.

Table 20: Historical Cost Settlement Amounts for Proposed Additional Payments Outside of the Prospective PMPM and Maternity Event Capitated Rates

Provider Type	SFY 2015 Settlement Amount	SFY 2016 Settlement Amount
Public Ambulance	$58,665,724	$60,800,909
LHDs	$66,453,787	Not Available
Certain faculty physicians affiliated with the University of North Carolina and East Carolina University schools of medicine	$85,954,097	$82,465,468

11.5 Additional Programmatic Considerations

There are additional programmatic considerations that must be evaluated as final rates are developed for the SFY 2020 time period. These items include but are not limited to:

- Any revisions in BH I/DD Tailored Plan eligibility criteria from that assumed herein, including known changes in recent legislation not reflected in these draft rates.
- Beneficiaries shifting between the Standard Plan and BH I/DD Tailored Plan (outlined in Appendix F).
- Potential impact of extended coverage for services delivered in an IMD on the Standard Plan population. DHHS is still in negotiations with CMS on this provision. To date, Mercer's analysis has indicated that this provision will have minimal impact to the Standard Plan member costs, as the majority of individuals utilizing these services are expected to meet BH I/DD Tailored Plan criteria. As such, no adjustment has been included in the draft RFP rates, but Mercer will continue to evaluate for final rate development.
- Potential impact of SUD service array expansion. The State is working on updates to the SUD service array. Changes are under development and may require updates to the State Plan. No adjustment is currently reflected in the draft rates, but as the State Plan amendments are submitted and the changes determined the final rates will consider implications of updates to the SUD service array.
- Future fee schedule changes that impact rate floors prior to July 2019 go-live date will need to be monitored and evaluated for incorporation into the final rates.
- Other changes in covered benefits and provider reimbursement requirements will be reflected in the final rates.

12 MANAGED CARE ASSUMPTIONS

Managed care adjustments are intended to capture expected future changes in the utilization of certain services as a result of care management initiatives by the PHPs. Mercer conducted a managed care opportunity analysis as part of the rate development process. The following components were analyzed as part of the managed care opportunity assessment and were specifically evaluated in the development of the Standard Plan capitation rate development:

- Comparison of North Carolina 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
- Low Acuity Non-Emergent (LANE) analysis related to avoidable visits to the Emergency Room in NC Medicaid data
- Potentially Preventable Admissions (PPA) analysis in NC Medicaid data for Inpatient Hospital visits
- Analysis of Inpatient Hospital readmissions

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

12.1 Overall Managed Care Findings

Mercer applied managed care assumptions in the Contract year 1 capitation rate development for the Standard Plan population. 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, pharmacy clinical edits analysis and potential PHP rebate analysis. Assumed reductions in provider services spend are offset by non-benefit expenses incorporated into PHP capitation rates as outlined in Section 13.

Mercer assumes it will take approximately three years for each population under managed care to realize the full extent of expected savings. Furthermore, Mercer assumes approximately 75.0% of managed care savings to be realized in year 1 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. Mercer also expects the pharmacy clinical edits savings adjustment to ramp up to account for a potential continuity of care period where patients continue with the same prescribed drugs as when they were under FFS for a period of time. In the instance the year 1 rating period is not twelve months, Mercer will reevaluate the appropriateness of the 75.0% assumption.

The table below illustrates the overall impact of the year 1 managed care assumptions by rate cell. Overall, these amount to approximately a -8.4% impact to the cost of Standard Plan medical benefits. Regional variations are driven by varying assumptions for the Outpatient Hospital COS since observed utilization varied greatly by region; all other assumptions by COS were applied consistently by region.

Table 21: Year 1 Standard Plan Savings Factors to Medical Costs

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	-11.8%	-11.3%	-10.3%	-10.2%	-10.4%	-9.4%
TANF, Newborn (<1)	-12.9%	-12.5%	-12.6%	-12.2%	-12.5%	-11.6%
TANF, Children (1-20)	-7.2%	-5.9%	-5.8%	-5.9%	-5.9%	-5.2%
TANF, Adults (21+)	-10.9%	-8.3%	-8.4%	-8.4%	-8.1%	-7.4%
Maternity Event	-2.6%	-2.6%	-2.2%	-2.7%	-2.4%	-2.0%

Assumptions above are based on a review of current programmatic experience. The appropriateness of these factors will be re-evaluated as the base experience is updated upon calculation of final capitation rates for Contract Year 1.

12.2 Non-Pharmacy Benefits

This section gives an overview of the available information utilized in development of the managed care factors for non-pharmacy benefits. Section 12.3 overviews the specific analyses used to develop pharmacy-specific opportunity assumptions.

Mercer reviewed a number of data sources in order to arrive at reasonable managed care expectations for the Standard Plan population. These reviews largely focused on a comparison to other state Medicaid managed care experience along with results of managed care efficiency analyses run on the current program experience. Additionally, a review of other state Medicaid managed care assumptions helped inform expectations for other medical services not compared in Section 12.2.1.

In general, PHPs 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. It is important to note that the Physician service line for rate setting purposes was summarized to include both the attending physician claims for Outpatient Hospital visits as well as primary care and specialist physician office visits. Mercer considered each component of physician utilization to arrive at the overall managed care assumption by rate cell. For the portion of the utilization associated with the attending physician for Outpatient Hospital claims, Mercer assumed the same level of utilization savings as was assumed for the Outpatient Hospital facility claims. 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 PHPs 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 PHP preventative care efforts coupled with beneficiaries being diverted from more high-cost and high-intensity services.

Note that Maternity Event managed care expectations were developed based on the TANF Adult (21+) rate cell observations given the majority of beneficiaries receiving maternity care also fall in the TANF Adult (21+) rate cell. However, the factors were tailored to target non-Physician services outside of the month of delivery. Moreover, the factor noted in the table above reflects a prorated factor adjusted for the portion of the Maternity Event payment attributable to costs outside of the month of delivery. The expectation is that through care management, the PHPs should be able to reduce hospital and Emergency Room utilization during the prenatal and postpartum periods of the maternity episode.

12.2.1 Other State Medicaid Experience

Mercer collected information from ten state Medicaid programs to serve as a comparison to North Carolina data and provide context regarding potential savings under managed care. Based on Mercer's review of the North Carolina experience compared to other state Medicaid programs, Mercer observes TANF and Other Related Children and Adult PMPM costs for North Carolina are generally in the range of other state Medicaid programs.

However, the utilization per 1,000 members statistics for some services (e.g., Inpatient Hospital — PH) are on the higher end of the range for other state Medicaid programs. For the ABD population, costs and utilization are above other state Medicaid program experience; even without prescription drug considerations, most other services fall towards the top of the PMPM and utilization per 1,000 range.

It is important to note that in North Carolina a number of services and populations are already receiving some coordinated care and management through (1) the CCNC/CA program, which is an enhanced Primary Care Case Management model and (2) the BH managed care program run by the LME/MCOs. Since DHHS already operates under a "managed" FFS model with CCNC/CA and has BH managed care, DHHS may observe less managed care savings opportunities due to the implementation of capitated managed care as compared to other states, given that the effect of some care management is already being realized.

12.2.2 Efficiency Analysis

Mercer completed efficiency analyses that further evaluated potential savings to support the general managed care assumptions related to Inpatient Hospital and Emergency Room services. The analyses detailed below include analysis of inpatient claims for PPA and Inpatient Hospital readmission analysis along with LANE analysis related to avoidable visits to the Emergency Room.

PPA Analysis

Mercer performed a PPA analysis to identify opportunities for managed care impact on inpatient admissions that could be achieved through PHP management of PPAs. Mercer's PPA analysis identifies inpatient admissions that could have been avoided through high quality outpatient care and/or reflects conditions that could be less severe and not warrant an inpatient level of care if treated early and appropriately. The PPA analysis can help identify potential reductions of health care inefficiencies in the inpatient hospital setting and support DHHS' desire for a more value focused purchasing strategy.

In total, Mercer found that around 3.0% for TANF and 10.0% for ABD of Inpatient Hospital spend is related to Pediatric Quality Indicators/Prevention Quality Indicators (PDI/PQI) flagged conditions. After a series of exclusions for high-risk beneficiaries and enrollment duration considerations around the time to reasonably manage care, the refined proportion of PPA dollars drops to approximately 2.0% for TANF and 7.0% for ABD as a percentage of Inpatient Hospital spend. Note that results of the full PPA efficiency adjustment analysis from other state Medicaid programs generally impact Inpatient by 2.0% to 7.0%; state variations are generally a result of different underlying populations.

Inpatient Readmission Analysis

Like PPA admissions, hospital readmissions represent health care expenditures that could possibly be avoided through high-quality outpatient care and post-discharge transition planning. Mercer's readmission analysis focused on hospital admissions within 30 days of a previous discharge for the same recipient at any facility and for any diagnosis-related group. A readmission within 30 days can be a result of a breakdown in discharge planning or outpatient care subsequent to the original admission.

The observed experience based on the raw Inpatient readmission analysis is approximately 5.5% readmission rate for TANF and above 20.0% readmission rate for ABD beneficiaries. Note that results of other state Inpatient readmission analyses equate to approximately a 7.0% to 10.0% inpatient readmission rate.

LANE Analysis

Mercer performed a LANE analysis as part of the managed care opportunities analysis to support the managed care assumptions related to Emergency Room utilization. The LANE analysis identifies instances when Medicaid eligibles may not have needed to make a trip to the Emergency Room if they had received effective outreach, care coordination and/or access to preventative care. The management of the identified LANE visits is an

effective cost-containment strategy that can help reduce health care inefficiencies in the Emergency Room setting; and therefore, supports DHHS' desire for a more value-focused purchasing strategy.

The overall results illustrate that on average LANE dollars represented approximately 50.0% of total Emergency Room costs. When looking specifically at less intensive LANE visits (as defined by attending physician code of 99281-99283), Mercer observes that these constitute approximately 9.0% for TANF and 4.0% for ABD of total Emergency Room, variable by population. Results of the full LANE efficiency adjustment analysis from other state Medicaid programs generally range from 5.0% to 10.0%; state variations are generally a result of different underlying populations and different state methodology assumptions.

12.2.3 Other Medical Services

Mercer reviewed other state Medicaid experience to also understand the level of potential savings on other COS. In general, Mercer noted that other states applied savings adjustments and/or realized savings on Durable Medical Equipment. Mercer assumed all Standard Plan rate cells (other than the Maternity Event payment) would generate savings.

Savings on State Plan LTSS services including personal care is expected to take time to materialize through longer term management of patient conditions, thus a minimal savings assumption was put forth for these community LTSS services. Also, since the majority of spend for LTSS services is for the ABD population, Mercer only applied a savings factor to the ABD rate cell.

12.3 Pharmacy Benefits

Reimbursement and utilization management strategies play an important role in controlling pharmacy costs. Effective management of federal and supplemental rebates also contributes to decreasing the overall net drug costs to the Medicaid program. Along with other medical services, DHHS will move the management of the pharmacy benefit under the control of the PHPs.

Mercer performed a retrospective analysis of pharmacy claims data to identify inappropriate prescribing and/or dispensing patterns, using a customized series of clinical rules-based, pharmacy utilization management edits. These edits are developed by Mercer's managed pharmacy practice based on various states' pharmacy policies, published literature, industry standard practices, clinical appropriateness review, professional expertise and information gathered during the review of several Medicaid MCO pharmacy programs across the country. This analysis resulted in an estimated total savings opportunity of approximately -2.4%.

Additionally, under FFS, DHHS has developed a strong pharmacy benefit program, which includes a Preferred Drug List (PDL) that generates significant pharmacy rebates to DHHS on the prescription drugs administered to Medicaid beneficiaries. As a part of Medicaid Transformation efforts, the State is requiring that PHPs adhere to the State PDL. By requiring PHPs to follow the PDL, DHHS should expect to receive similar rebates on the drugs administered to PHP beneficiaries. Additionally, DHHS is mandating in the contract that the PHPs shall not negotiate rebates for drugs on the State PDL. As such, Mercer does not anticipate the PHPs will be able to negotiate further material rebates with the manufacturers under managed care, and no additional adjustment was assumed related to PHP rebate opportunities.

13 NON-BENEFIT EXPENSE CONSIDERATIONS

The final component of the capitation rates is the non-benefit expense load. This portion of the capitation rate accounts for PHP administration costs incurred to operate the Medicaid managed care program. Per 42 CFR 438.5(e) of the Final Rule, "The development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP, or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs associated with the provision of services identified in §438.3(c)(1)(ii) to the populations covered under the contract." Additional guidance specific to non-benefit expense load development in Medicaid Managed Care Capitation Rate Development is included in ASOP 49 excerpt 3.2.12.

The non-benefit expense load includes consideration for general administration (including program management, administrative operations and utilization management personnel), care management personnel, non-personnel costs, profit/underwriting gain and premium taxes imposed on the PHPs. The considerations were developed to reflect the PHP contract requirements as defined by DHHS.

The non-benefit expense components (with the exception of profit/underwriting gain and premium taxes) were developed by building up the costs necessary to administer the PHP requirements as defined by DHHS. While these expenses may be expressed as a percent of premium in some exhibits, they were developed as a PMPM. The general administration and utilization management PMPM was developed on a statewide basis and does not currently vary by region. These administrative costs will be reevaluated after PHP contracts are finalized and regional information on the number of PHPs is known. The overall care management PMPM, which is largely comprised of care management staff (non-personnel related expenses for care management is captured under the general administration assumption), was also developed in aggregate on a statewide basis, and thus care management staffing assumptions did not vary by region. In addition to the care management considerations in the non-benefit load, the rates do consider required payments to LHDs and AMHs as base costs in the rate development. These considerations are discussed at the end of Section 13.3.

The tables below show the various non-benefit components summarized as a PMPM and percent of premium by COA.

Table 22: Overall Non-Benefit Expenses PMPM/Payment by COA

COA	General Administration and Utilization Management	Care Management	Profit/ Underwriting Gain	Premium Taxes	Total
ABD PMPM	$48.82	$43.79	$23.24	$27.24	$143.11
TANF, Newborn (<1) PMPM	$28.11	$22.34	$11.92	$13.97	$76.35
TANF, Child (1-20) PMPM	$10.89	$4.50	$2.49	$2.92	$20.80
TANF, Adult (21+) PMPM	$18.97	$12.87	$6.93	$8.12	$46.88
Maternity Event Payment	$70.97	$313.95	$161.92	$189.79	$736.64
Total Standard Plan	$16.37	$10.86	$5.84	$6.85	$39.92

Table 23: Overall Non-Benefit Expenses as a Percent of Premium by COA

COA	General Administration and Utilization Management	Care Management	Profit/ Underwriting Gain	Premium Taxes	Total
ABD	3.7%	3.3%	1.75%	2.01%	10.6%
TANF, Newborn (<1)	4.1%	3.3%	1.75%	2.01%	11.0%
TANF, Child (1-20)	7.6%	3.2%	1.75%	2.01%	14.3%
TANF, Adult (21+)	4.8%	3.3%	1.75%	2.01%	11.6%
Maternity Event	0.8%	3.4%	1.75%	2.01%	7.8%
Total Standard Plan	4.9%	3.3%	1.75%	2.01%	11.7%

Note: The PMPM figures in the table above were translated to a percent of total premium. In comparing these percentages to other states or industry benchmarks, please note that the total premium includes consideration for historical supplemental payments as outlined in Section 11.1.

13.1 Methodology and Data Sources

Mercer developed an administrative model that calculates the expected cost to operate a Medicaid managed care program for each rate cell. 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 DHHS' proposed care management requirements. The results of this modeling and its impact to the capitation rates are discussed in the subsequent sections.

The primary data source for estimating administrative staffing salaries was supplied by the Bureau of Labor Statistics (BLS) website. The Occupational Employment Statistics (OES) program estimates the number of jobs, salary and wage data by surveying employers throughout the country for more than 800 occupations. This data is available on a nationwide basis, by state and between urban and rural areas within each state. The OES survey data includes several statistical measures of salaries and wages, including the hourly and annual mean, median and various percentiles. The most recent information available is as of May 2016. The dataset was restricted to experience for the State of North Carolina. [15]

Colliers International publishes quarterly reports summarizing commercial real estate market statistics, including the average rent cost per square foot by geography. Quarterly reports are prepared for Charlotte, Raleigh-Durham and surrounding cities. The latest reports available for Raleigh-Durham, Charlotte and surrounding areas were as of the third quarter of 2017. This information supported regional cost expectations for commercial real estate needed to administer a Medicaid managed care program. [16,17]

The model output is dependent upon the assumed allocation of PHPs administering the program and their allocation across the six proposed PHP regions. Per legislation, DHHS will contract with four statewide PHPs and up to twelve regional contracts with provider-led entities (PLEs)[18]. Mercer's model currently assumes four statewide PHPs and four regional PLEs. The model allocates applicable staffing positions across regions to account for the anticipated split of responsibilities across regions for PHPs that participate in more than one

[15] https://www.bls.gov/oes/special.requests/oesm16st.zip
[16] http://www.colliers.com/-/media/files/united states/markets/north carolina/charlotte/office market reports/q3 2017 market report - office.pdf
[17] http://www.colliers.com/-/media/files/marketresearch/unitedstates/markets/raleigh/2017 reports/2017-q3-office-raleighdurham-report-colliers.pdf
[18] https://webservices.ncleg.net/ViewBillDocument/2017/7169/0/H403-PCCS10514-TR-21

region. Upon contract award, this assumption will be updated to reflect the actual number of PHPs and PLEs operating within/across regions.

13.2 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 PHP will have program management staff that is further delineated by executive management, financial, clinical operations, legal (general counsel), human resources and information technology. Executive management includes the Chief Executive and Chief Operating Officers. Financial staff includes the Chief Financial Officer, accountants, financial analysts and actuarial staff. Clinical operations include a Chief Medical Officer, Pharmacy Director and BH Coordinator. Information technology staff includes the Chief Information Officer, 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, claims processing and utilization management. Operations staff reflects customer service representatives, Compliance Officer, program integrity team, provider specialists and claims processing.

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

13.3 Care Management Personnel

Care management is foundational to the success of North Carolina's health care system for Medicaid and NC Health Choice beneficiaries, supporting high-quality delivery of the right care at the right place and at the right time in the right setting. DHHS' care management strategy will focus on improving the health of beneficiaries through an innovative, person-centered and well-coordinated system of care that addresses medical and nonmedical drivers of health. Beneficiaries will have access to appropriate care management and coordination support across multiple settings of care, including a strong basis in primary care and connections to specialty care and contributions to health-related resources. Access to local care management will draw from the Advanced Medical Home (AMH) model and participation from the LHDs; additionally DHHS is committed to providing care management for beneficiaries to address the four priority domains of opportunities for health: housing, food, transportation, and interpersonal safety. Mercer has aligned the care management modeling, as outlined below, with the DHHS care management strategy. Please see the North Carolina's Care Management Strategy under Managed Care policy paper, released on March 9, 2018, for more insight into DHHS' care management strategy[19].

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 100.0% 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 22.0% of the Standard Plan population, which represents an increased investment in care management

[19] North Carolina's Care Management Strategy under Managed Care. March 9, 2018. https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf

from the current system. Additionally, the base care management modeling includes consideration for care management FTEs based on a beneficiary to staff ratio. As mentioned, care coordinators are expected to perform tasks such as conducting care needs screening and providing linkage to community resources, which are more administratively focused. Given this, a higher member to staff ratio assumption is used for the care coordinator position. Whereas care managers are anticipated to perform more intensive beneficiary care management activities, and thus Mercer assumed a lower caseload compared to care coordinators. Mercer also assumed varied care manager caseloads depending on a range of low to high-needs priority population beneficiaries. BLS data was then leveraged to estimate the cost per FTE based on anticipated position job requirements. FTE assumptions were calculated based on the Standard Plan population average monthly membership (1.6 million).

Given DHHS' care management strategy and specific requirements outlined in the RFP, Mercer also included consideration in the care management assumption for LHD payment requirements, AMH contracting and payment requirements and additional costs for requirements related to opportunities for health initiatives.

Under managed care, DHHS is initially requiring PHPs to continue the historical payments to LHDs in the capitation rates to ensure payment levels not be disrupted under the transition to managed care. Historical payments made to LHDs for the OBCM and CC4C program are included as a service line item in the base data development. In addition to the base service costs, Mercer included consideration in the care management assumption for a small offset to PHP care management costs given LHD responsibilities along with additional PHP costs for oversight responsibilities.

DHHS has also made program design decisions to incorporate an AMH model under managed care to ease some of the transition from the historical Medical Home model. AMH practices will be designated into Tier 1, 2 or 3 practice categories. DHHS is mandating that PHPs contract with a certain number of AMH practices and also reimburse AMHs similar to the historical payments made to practices in the CA program which are included as a service line item in the base data development (Medical Home Payments). AMH Tier 3 practices will also perform beneficiary care management activities, and thus be reimbursed at an enhanced rate to account for these additional activities. Mercer worked with DHHS to estimate the anticipated number of AMH Tier 3 practices, assuming that approximately 65.0% of beneficiaries are tied to an AMH Tier 3 practice. Based on this assumption, Mercer assumed some level of additional costs to the PHPs to ensure backstop accountability for PHP members tied to an AMH Tier 3 practice and PHP oversight responsibilities and coordination with AMH Tier 3 practices. Note that the assumption around the percent of beneficiaries tied to an AMH Tier 3 practice will be revisited for final rates.

There are also a number of contract and staffing requirements related to the DHHS opportunities for health initiative considered in development of assumed care management costs, such as:

- Basic opportunities for health PHP screening requirements for all members
- Beneficiaries with high unmet social needs, regardless of medical conditions, flagged as priority population for comprehensive evaluation and potentially care management
- Specific PHP staffing requirements, such as a housing specialist

As discussed, the base data already accounts for some level of requirements associated with care management activities (OBCM LHD, CC4C LHD, Medical Home Payments). In addition to the costs captured in the base experience ($1.89 PMPM for LHD payments and $2.35 PMPM for AMH base payments), Mercer included an additional $10.86 PMPM based on the considerations and methodology outlined in Section 13.3 above, totaling $15.10 PMPM associated with medical home and care management requirements/activities.

13.4 Non-Personnel Costs

The capitation rates include consideration for the non-personnel costs associated with program management, administrative operations and care management. Non-personnel costs primarily consist of annual rent and utilities as well as the necessary equipment and supplies required to operate a business, including computers and cell phones. North Carolina commercial real estate market data from various regions throughout the state were utilized to develop cost expectations for the average annual rent cost per square foot per region. The capitation rates also capture costs for staff travel time, IT software, systems and licensing.

Finally, the capitation rates reflect the administrative costs for third-party Pharmacy Benefit Managers (PBMs) to contract with pharmacies, process/pay prescription drug claims and collect rebates for the PHPs. To calculate the impact, Mercer relied upon experience with other states due to the limited availability of data specific to North Carolina. The PBM administrative cost for other states equates to 2.0% of the projected prescription drug claim costs. For the Standard Plan, 2.0% of the base prescription drug experience levels equate to $28 million in administrative PBM costs or roughly $1.50 PMPM.

13.5 Non-Benefit Expense Load Application to Capitation Rates

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 25.0% fixed and 75.0% variable costs for each region.

The fixed PMPM is applied uniformly to all rate cells within each region (other than the Maternity Event payment), such that each rate cell receives the same fixed PMPM. The Maternity Event payment does not include the fixed portion of the administrative expense PMPM as each pregnant woman's rate cell capitation payment (concurrent with the Maternity Event payment) for non-delivery related services will include fixed administrative costs. The remaining portion of the administrative PMPM pertains to variable costs. The total regional PMPM was converted to a rate cell specific PMPM based on distribution of claim costs; the resulting variable PMPM varies by rate cell. The statewide Standard Plan non-benefit expense PMPM prior to the application of profit/underwriting gain and premium taxes is $27.23.

13.6 Profit/Underwriting Gain and Premium Taxes

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.

Mercer has included a 2.01% consideration for PHP premium taxes in the capitation rate development, per DHHS and House Bill 156[20], which indicates legislative intent to apply the commercial insurance premium tax and regulatory surcharge applied to PHPs.

13.7 Health Insurer Provider Fee (HIPF)

The HIPF is a federal fee that applies to certain health insurers. In the context of rate-setting, the HIPF is considered a cost of doing business that is appropriate to recognize in the payments to PHPs. Currently, there is a moratorium on the HIPF for premiums earned in 2018 and uncertainty with respect to the applicability of the

[20] https://webservices.ncleg.net/ViewBillDocument/2017/7124/0/H156-PCCS40774-TR-22

HIPF in the future. As such, no adjustment has been included in the draft capitation rates for the HIPF. DHHS will reimburse PHPs for these fees and will determine the appropriate approach as more information becomes available on the applicability of the fee.

14 CAPITATION RATE DEVELOPMENT EXHIBITS

The first exhibit in this section provides an overview of the MMs and draft capitation rates by COA and region. This exhibit is followed by detailed summaries illustrating the full rate development process for each regional rate cell, from the adjusted base data (including all adjustments outlined in Section 6) to the prospective adjustments outlined in Sections 8 through 12. Additionally, the non-medical expense considerations are outlined in each summary in accordance with the methodology in Section 13 of this Rate Book.

Exhibit 73

Member Months/Deliveries by Region and Category of Aid

Rating Group	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide
Aged, Blind, Disabled	146,847	263,136	328,525	278,511	309,639	267,136	1,593,794
TANF and Other Related Children (<1)	78,257	144,528	211,433	171,144	135,338	108,992	849,691
TANF and Other Related Children (1-20)	1,220,080	2,297,179	3,243,949	2,661,605	2,183,299	1,733,723	13,339,835
TANF and Other Related Adults (21+)	270,425	468,569	711,903	509,487	540,587	407,775	2,908,746
Maternity Event	5,230	9,264	13,078	9,785	8,871	7,245	53,473
Total	**1,715,609**	**3,173,411**	**4,495,811**	**3,620,746**	**3,168,863**	**2,517,626**	**18,692,065**

Capitation Rates by Region and Category of Aid

Rating Group	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide
Aged, Blind, Disabled	$ 1,373.30	$ 1,356.05	$ 1,529.02	$ 1,415.53	$ 1,278.26	$ 1,158.50	$ 1,355.46
TANF and Other Related Children (<1)	$ 749.33	$ 707.22	$ 736.81	$ 660.06	$ 736.49	$ 563.56	$ 695.20
TANF and Other Related Children (1-20)	$ 166.46	$ 148.78	$ 141.55	$ 141.70	$ 147.03	$ 136.70	$ 145.37
TANF and Other Related Adults (21+)	$ 413.55	$ 437.60	$ 394.18	$ 385.86	$ 422.14	$ 373.97	$ 403.88
Maternity Event	$ 9,555.60	$ 9,760.42	$ 9,431.17	$ 8,857.91	$ 10,192.86	$ 8,844.00	$ 9,442.29
Total	**$ 364.43**	**$ 345.46**	**$ 338.37**	**$ 322.48**	**$ 358.20**	**$ 327.48**	**$ 340.78**

14.1 Region 1 Capitation Rate Development Exhibits

Exhibit 74

Region:	**Region 1**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**146,847**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 129.73	$ 1,027.07	1,516	0.5%	0.5%	0.0%	168.6%	168.6%	0.0%	-15.8%	0.0%	-15.8%	$ 297.69	$ 2,799.99	1,276
Inpatient — BH	$ 8.94	$ 728.85	147	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.00	$ 739.83	146
Outpatient Hospital	$ 123.35	$ 444.79	3,328	3.0%	0.5%	2.5%	32.7%	32.7%	0.0%	-30.8%	0.0%	-30.8%	$ 123.72	$ 599.09	2,478
Emergency Room	$ 63.25	$ 515.04	1,474	1.5%	0.5%	1.0%	22.9%	22.9%	0.0%	-19.6%	0.0%	-19.6%	$ 65.37	$ 642.43	1,221
Physician	$ 106.11	$ 134.43	9,472	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-13.0%	0.0%	-13.0%	$ 99.42	$ 136.45	8,743
FQHC/RHC	$ 14.51	$ 128.78	1,352	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 14.33	$ 130.72	1,315
Other Clinic	$ 7.76	$ 307.37	303	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 7.67	$ 312.00	295
Other Practitioner	$ 1.22	$ 78.12	187	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 1.20	$ 79.29	182
Therapies	$ 3.11	$ 110.14	339	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 3.07	$ 111.80	330
Prescribed Drugs	$ 418.40	$ 125.12	40,129	5.8%	5.3%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 482.92	$ 145.87	39,727
Other BH Services	$ 14.31	$ 56.86	3,021	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 15.06	$ 58.58	3,086
LTSS Services	$ 46.57	$ 8.33	67,117	3.8%	0.5%	3.2%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 55.80	$ 9.50	70,463
Durable Medical Equipment	$ 38.17	$ 2.80	163,357	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 33.60	$ 2.85	141,651
Limited Dental Services	$ 0.02	$ 24.51	10	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.02	$ 24.88	11
Optical	$ 0.90	$ 70.12	154	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.93	$ 71.18	157
Lab and X-Ray	$ 7.87	$ 25.67	3,680	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 8.16	$ 26.05	3,760
Transportation	$ 11.32	$ 59.96	2,265	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 11.36	$ 60.87	2,239
Subtotal (Medical)	*$ 995.55*	*N/A*	*297,851*	*3.6%*	*2.5%*	*1.1%*	*26.0%*	*26.0%*	*0.0%*	*-11.9%*	*0.0%*	*-11.9%*	*$ 1,229.33*	*N/A*	*277,080*
CC4C LHD Payments	$ 0.00	$ 4.53	8	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	8
OBCM LHD Payments	$ 0.71	$ 4.93	1,721	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.71	$ 4.93	1,721
Medical Home Payments	$ 4.14	$ 4.66	10,668	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.14	$ 4.66	10,668
Subtotal (LHD/Medical Home Payments)	*$ 4.85*	*N/A*	*12,397*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 4.85*	*N/A*	*12,397*
Total (Medical + LHD/Medical Home)	**$ 1,000.40**	**N/A**	**310,249**	**3.6%**	**2.5%**	**1.1%**	**25.9%**	**25.9%**	**0.0%**	**-11.8%**	**0.0%**	**-11.8%**	**$ 1,234.18**	**N/A**	**289,477**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,234.18**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.46%)	$ 46.55
Care Management (3.08%)	$ 41.42
Profit/Underwriting Gain (1.75%)	$ 23.55
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,345.70**
Premium Taxes (2.01%)	$ 27.60
Total Capitation Rate:	**$ 1,373.30**

Exhibit 75

Region:	**Region 1**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**78,257**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 197.39	$ 642.74	3,685	1.5%	0.5%	1.0%	165.8%	165.8%	0.0%	-15.0%	0.0%	-15.0%	$ 466.31	$ 1,734.07	3,227
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 21.43	$ 152.81	1,683	3.0%	0.5%	2.5%	19.4%	19.4%	0.0%	-15.0%	0.0%	-15.0%	$ 23.77	$ 185.19	1,540
Emergency Room	$ 16.86	$ 238.04	850	1.5%	0.5%	1.0%	19.1%	19.1%	0.0%	-7.5%	0.0%	-7.5%	$ 19.43	$ 287.82	810
Physician	$ 83.51	$ 90.76	11,041	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.6%	0.0%	-7.6%	$ 83.06	$ 92.13	10,819
FQHC/RHC	$ 9.89	$ 130.32	910	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 9.85	$ 132.28	893
Other Clinic	$ 32.26	$ 90.19	4,293	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 32.14	$ 91.55	4,212
Other Practitioner	$ 0.04	$ 36.40	12	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.04	$ 36.95	12
Therapies	$ 1.04	$ 92.32	136	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 1.04	$ 93.72	133
Prescribed Drugs	$ 14.08	$ 46.72	3,617	-2.8%	-2.8%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 12.73	$ 42.97	3,554
Other BH Services	$ 0.06	$ 19.52	38	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.07	$ 20.12	40
LTSS Services	$ 2.10	$ 66.94	376	3.8%	0.5%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.34	$ 67.95	414
Durable Medical Equipment	$ 10.32	$ 4.47	27,705	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 9.98	$ 4.54	26,400
Limited Dental Services	$ 1.60	$ 24.85	771	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.67	$ 25.22	794
Optical	$ 0.02	$ 77.55	4	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 78.72	4
Lab and X-Ray	$ 0.55	$ 20.85	318	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.58	$ 21.17	328
Transportation	$ 1.37	$ 84.50	194	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.38	$ 85.77	194
Subtotal (Medical)	*$ 392.52*	*N/A*	*55,633*	*1.8%*	*0.4%*	*1.4%*	*84.6%*	*84.6%*	*0.0%*	*-13.0%*	*0.0%*	*-13.0%*	*$ 664.39*	*N/A*	*53,373*
CC4C LHD Payments	$ 4.20	$ 4.55	11,071	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.20	$ 4.55	11,071
OBCM LHD Payments	$ 0.00	$ 4.96	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.96	-
Medical Home Payments	$ 2.04	$ 2.46	9,964	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.04	$ 2.46	9,964
Subtotal (LHD/Medical Home Payments)	*$ 6.24*	*N/A*	*21,035*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.24*	*N/A*	*21,035*
Total (Medical + LHD/Medical Home)	**$ 398.76**	**N/A**	**76,668**	**1.7%**	**0.4%**	**1.4%**	**83.4%**	**83.4%**	**0.0%**	**-12.9%**	**0.0%**	**-12.9%**	**$ 670.63**	**N/A**	**74,408**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 670.63**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.85%)	$ 28.28
Care Management (3.06%)	$ 22.50
Profit/Underwriting Gain (1.75%)	$ 12.85
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 734.27**
Premium Taxes (2.01%)	$ 15.06
Total Capitation Rate:	**$ 749.33**

Exhibit 76

Region:	**Region 1**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**1,220,080**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 4.24	$ 1,176.35	43	1.5%	0.5%	1.0%	143.8%	143.8%	0.0%	-15.3%	0.0%	-15.3%	$ 9.16	$ 2,911.63	38
Inpatient — BH	$ 1.12	$ 906.90	15	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.17	$ 920.57	15
Outpatient Hospital	$ 17.75	$ 236.09	902	3.0%	0.5%	2.5%	24.2%	24.2%	0.0%	-15.3%	0.0%	-15.3%	$ 20.40	$ 297.57	823
Emergency Room	$ 12.34	$ 301.77	491	1.5%	0.5%	1.0%	20.0%	20.0%	0.0%	-7.8%	0.0%	-7.8%	$ 14.27	$ 367.44	466
Physician	$ 22.58	$ 72.24	3,751	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.5%	0.0%	-8.5%	$ 22.25	$ 73.33	3,641
FQHC/RHC	$ 4.51	$ 138.57	391	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 4.48	$ 140.66	382
Other Clinic	$ 5.41	$ 101.64	639	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.37	$ 103.17	625
Other Practitioner	$ 0.18	$ 52.86	41	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.18	$ 53.66	40
Therapies	$ 3.74	$ 100.47	447	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 3.72	$ 101.98	437
Prescribed Drugs	$ 40.94	$ 99.52	4,937	5.0%	4.5%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 46.23	$ 113.57	4,884
Other BH Services	$ 7.38	$ 75.98	1,166	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 7.81	$ 78.28	1,197
LTSS Services	$ 0.29	$ 11.13	312	3.8%	0.5%	3.2%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.33	$ 11.59	342
Durable Medical Equipment	$ 2.65	$ 3.38	9,420	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.56	$ 3.43	8,947
Limited Dental Services	$ 0.31	$ 24.74	151	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.32	$ 25.11	155
Optical	$ 0.96	$ 82.55	140	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.00	$ 83.79	143
Lab and X-Ray	$ 0.61	$ 19.28	380	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.64	$ 19.57	390
Transportation	$ 0.52	$ 69.87	89	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.52	$ 70.92	88
Subtotal (Medical)	*$ 125.55*	*N/A*	*23,313*	*3.2%*	*1.8%*	*1.3%*	*9.9%*	*9.9%*	*0.0%*	*-7.4%*	*0.0%*	*-7.4%*	*$ 140.40*	*N/A*	*22,615*
CC4C LHD Payments	$ 0.98	$ 4.52	2,612	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.98	$ 4.52	2,612
OBCM LHD Payments	$ 0.55	$ 4.92	1,343	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.55	$ 4.92	1,343
Medical Home Payments	$ 2.26	$ 2.44	11,108	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.26	$ 2.44	11,108
Subtotal (LHD/Medical Home Payments)	*$ 3.80*	*N/A*	*15,063*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.80*	*N/A*	*15,063*
Total (Medical + LHD/Medical Home)	**$ 129.34**	**N/A**	**38,377**	**3.1%**	**1.8%**	**1.3%**	**9.6%**	**9.6%**	**0.0%**	**-7.2%**	**0.0%**	**-7.2%**	**$ 144.20**	**N/A**	**37,678**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 144.20**
Non-Benefit Expense PMPM/Payment:	
General Administration (6.88%)	$ 11.22
Care Management (2.97%)	$ 4.84
Profit/Underwriting Gain (1.75%)	$ 2.85
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 163.11**
Premium Taxes (2.01%)	$ 3.35
Total Capitation Rate:	**$ 166.46**

Exhibit 77

Region:	**Region 1**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**270,425**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 28.85	$ 1,218.41	284	3.5%	0.5%	3.0%	152.3%	152.3%	0.0%	-12.2%	0.0%	-12.2%	$ 70.89	$ 3,119.96	273
Inpatient — BH	$ 3.04	$ 791.01	46	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 3.34	$ 802.93	50
Outpatient Hospital	$ 52.51	$ 315.66	1,996	3.0%	0.5%	2.5%	29.2%	29.2%	0.0%	-23.4%	0.0%	-23.4%	$ 56.78	$ 413.99	1,646
Emergency Room	$ 44.26	$ 442.95	1,199	1.5%	0.5%	1.0%	22.8%	22.8%	0.0%	-12.2%	0.0%	-12.2%	$ 49.93	$ 552.16	1,085
Physician	$ 42.41	$ 103.83	4,901	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-12.3%	0.0%	-12.3%	$ 40.04	$ 105.40	4,559
FQHC/RHC	$ 7.40	$ 129.51	686	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 7.30	$ 131.46	667
Other Clinic	$ 8.49	$ 270.90	376	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 8.38	$ 274.98	366
Other Practitioner	$ 0.48	$ 55.98	104	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.48	$ 56.82	101
Therapies	$ 0.02	$ 60.18	3	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.02	$ 61.08	3
Prescribed Drugs	$ 87.61	$ 74.47	14,117	5.3%	5.0%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 99.31	$ 86.21	13,823
Other BH Services	$ 7.37	$ 72.98	1,212	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 7.75	$ 75.19	1,237
LTSS Services	$ 1.20	$ 16.16	893	3.8%	0.5%	3.2%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.34	$ 16.56	974
Durable Medical Equipment	$ 5.78	$ 2.31	30,015	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 5.54	$ 2.35	28,323
Limited Dental Services	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ -	-
Optical	$ 0.35	$ 69.10	60	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.36	$ 70.14	62
Lab and X-Ray	$ 8.80	$ 30.33	3,480	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 9.12	$ 30.79	3,553
Transportation	$ 1.90	$ 69.90	327	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.91	$ 70.95	323
Subtotal (Medical)	*$ 300.47*	*N/A*	*59,700*	*3.3%*	*1.8%*	*1.5%*	*23.0%*	*23.0%*	*0.0%*	*-11.0%*	*0.0%*	*-11.0%*	*$ 362.49*	*N/A*	*57,043*
CC4C LHD Payments	$ 0.00	$ 4.40	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.40	-
OBCM LHD Payments	$ 3.21	$ 4.91	7,845	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.21	$ 4.91	7,845
Medical Home Payments	$ 1.67	$ 2.37	8,429	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.67	$ 2.37	8,429
Subtotal (LHD/Medical Home Payments)	*$ 4.87*	*N/A*	*16,274*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 4.87*	*N/A*	*16,274*
Total (Medical + LHD/Medical Home)	**$ 305.35**	**N/A**	**75,974**	**3.2%**	**1.8%**	**1.4%**	**22.6%**	**22.6%**	**0.0%**	**-10.9%**	**0.0%**	**-10.9%**	**$ 367.37**	**N/A**	**73,317**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 367.37**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.55%)	$ 18.45
Care Management (3.04%)	$ 12.33
Profit/Underwriting Gain (1.75%)	$ 7.09
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 405.24**
Premium Taxes (2.01%)	$ 8.31
Total Capitation Rate:	**$ 413.55**

Exhibit 78

Region:	**Region 1**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**5,230**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,122.90	$ 782.43	32,558	0.5%	0.5%	0.0%	176.1%	176.1%	0.0%	-1.1%	0.0%	-1.1%	$ 5,882.81	$ 2,192.88	32,192
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 393.50	$ 129.75	36,392	3.0%	0.5%	2.5%	26.3%	26.3%	0.0%	-22.5%	0.0%	-22.5%	$ 420.96	$ 166.38	30,361
Emergency Room	$ 314.33	$ 337.39	11,180	1.5%	0.5%	1.0%	23.3%	23.3%	0.0%	-11.3%	0.0%	-11.3%	$ 359.66	$ 422.25	10,221
Physician	$ 1,545.86	$ 184.45	100,570	2.5%	0.5%	2.0%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,678.24	$ 188.75	106,694
FQHC/RHC	$ 200.94	$ 151.46	15,921	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 216.39	$ 153.74	16,890
Other Clinic	$ 201.31	$ 129.75	18,619	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 216.79	$ 131.70	19,753
Other Practitioner	$ 0.11	$ 75.77	17	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.11	$ 76.92	18
Therapies	$ -	$ -	-	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.01	$ 87.29	2	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 89.93	2
LTSS Services	$ 1.53	$ 6.69	2,735	3.8%	0.5%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.70	$ 6.80	3,009
Durable Medical Equipment	$ 8.02	$ 77.96	1,234	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 8.38	$ 79.14	1,271
Limited Dental Services	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Optical	$ 0.03	$ 115.45	3	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 117.19	3
Lab and X-Ray	$ 36.57	$ 25.11	17,477	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 38.24	$ 25.49	18,004
Transportation	$ 12.63	$ 104.01	1,458	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 12.79	$ 105.58	1,453
Subtotal (Medical)	*$ 4,837.74*	*N/A*	*238,166*	*1.6%*	*0.5%*	*1.1%*	*78.8%*	*78.8%*	*0.0%*	*-2.6%*	*0.0%*	*-2.6%*	*$ 8,836.13*	*N/A*	*239,873*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 4,837.74**	**N/A**	**238,166**	**1.6%**	**0.5%**	**1.1%**	**78.8%**	**78.8%**	**0.0%**	**-2.6%**	**0.0%**	**-2.6%**	**$ 8,836.13**	**N/A**	**239,873**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 8,836.13**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.72%)	$ 67.03
Care Management (3.17%)	$ 296.52
Profit/Underwriting Gain (1.75%)	$ 163.86
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 9,363.54**
Premium Taxes (2.01%)	$ 192.07
Total Capitation Rate:	**$ 9,555.60**

14.2 Region 2 Capitation Rate Development Exhibits

Exhibit 79

Region:	**Region 2**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**263,136**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 127.01	$ 989.44	1,540	0.5%	0.5%	0.0%	167.2%	167.2%	0.0%	-15.8%	0.0%	-15.8%	$ 289.97	$ 2,683.58	1,297
Inpatient — BH	$ 6.03	$ 693.41	104	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 6.07	$ 703.87	103
Outpatient Hospital	$ 118.21	$ 502.17	2,825	3.0%	0.5%	2.5%	36.7%	36.7%	0.0%	-27.1%	0.0%	-27.1%	$ 128.74	$ 696.66	2,218
Emergency Room	$ 64.34	$ 521.01	1,482	1.5%	0.5%	1.0%	29.6%	29.6%	0.0%	-19.6%	0.0%	-19.6%	$ 70.13	$ 685.43	1,228
Physician	$ 101.06	$ 130.66	9,282	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-11.8%	0.0%	-11.8%	$ 94.62	$ 132.63	8,561
FQHC/RHC	$ 2.00	$ 123.26	195	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 1.95	$ 125.12	187
Other Clinic	$ 8.65	$ 328.01	316	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 8.41	$ 332.95	303
Other Practitioner	$ 0.79	$ 75.00	126	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.77	$ 76.13	121
Therapies	$ 3.04	$ 108.18	337	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 2.96	$ 109.81	323
Prescribed Drugs	$ 392.84	$ 135.10	34,894	6.0%	5.5%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 456.65	$ 158.64	34,543
Other BH Services	$ 15.45	$ 64.37	2,880	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 16.26	$ 66.33	2,942
LTSS Services	$ 65.78	$ 5.71	138,253	1.0%	0.5%	0.5%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 72.71	$ 6.52	133,906
Durable Medical Equipment	$ 40.27	$ 2.96	163,123	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 35.45	$ 3.01	141,448
Limited Dental Services	$ 0.04	$ 25.18	19	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.04	$ 25.56	20
Optical	$ 0.93	$ 71.12	157	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.97	$ 72.20	161
Lab and X-Ray	$ 10.84	$ 23.14	5,623	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 11.24	$ 23.49	5,744
Transportation	$ 12.46	$ 89.20	1,676	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 12.06	$ 90.54	1,598
Subtotal (Medical)	*$ 969.74*	*N/A*	*362,832*	*3.4%*	*2.6%*	*0.8%*	*27.2%*	*27.2%*	*0.0%*	*-11.4%*	*0.0%*	*-11.4%*	*$ 1,209.00*	*N/A*	*334,703*
CC4C LHD Payments	$ 0.00	$ 4.53	13	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	13
OBCM LHD Payments	$ 0.76	$ 4.93	1,844	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.76	$ 4.93	1,844
Medical Home Payments	$ 4.26	$ 4.67	10,942	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.26	$ 4.67	10,942
Subtotal (LHD/Medical Home Payments)	*$ 5.02*	*N/A*	*12,800*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.02*	*N/A*	*12,800*
Total (Medical + LHD/Medical Home)	**$ 974.76**	**N/A**	**375,632**	**3.4%**	**2.6%**	**0.8%**	**27.0%**	**27.0%**	**0.0%**	**-11.3%**	**0.0%**	**-11.3%**	**$ 1,214.02**	**N/A**	**347,504**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,214.02**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.64%)	$ 48.35
Care Management (3.25%)	$ 43.18
Profit/Underwriting Gain (1.75%)	$ 23.25
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,328.79**
Premium Taxes (2.01%)	$ 27.26
Total Capitation Rate:	**$ 1,356.05**

Exhibit 80

Region:	**Region 2**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**144,528**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 178.20	$ 561.51	3,808	1.5%	0.5%	1.0%	172.5%	172.5%	0.0%	-15.0%	0.0%	-15.0%	$ 431.67	$ 1,553.43	3,335
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 14.26	$ 155.20	1,103	3.0%	0.5%	2.5%	36.6%	36.6%	0.0%	-7.5%	0.0%	-7.5%	$ 19.69	$ 215.21	1,098
Emergency Room	$ 22.03	$ 264.40	1,000	1.5%	0.5%	1.0%	26.9%	26.9%	0.0%	-7.5%	0.0%	-7.5%	$ 27.04	$ 340.55	953
Physician	$ 81.34	$ 90.04	10,841	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.8%	0.0%	-6.8%	$ 80.44	$ 91.39	10,561
FQHC/RHC	$ 4.34	$ 114.62	455	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 4.26	$ 116.35	440
Other Clinic	$ 36.19	$ 98.28	4,419	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 35.53	$ 99.76	4,274
Other Practitioner	$ 0.01	$ 34.22	3	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.01	$ 34.74	3
Therapies	$ 0.75	$ 99.92	90	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.73	$ 101.42	87
Prescribed Drugs	$ 13.47	$ 46.55	3,472	-1.5%	-1.5%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 12.65	$ 44.48	3,412
Other BH Services	$ 0.06	$ 23.20	29	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.06	$ 23.91	30
LTSS Services	$ 0.43	$ 19.60	266	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.45	$ 19.89	270
Durable Medical Equipment	$ 7.58	$ 26.72	3,406	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 7.34	$ 27.12	3,246
Limited Dental Services	$ 2.22	$ 24.95	1,070	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.33	$ 25.32	1,102
Optical	$ 0.03	$ 96.58	3	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 98.03	3
Lab and X-Ray	$ 0.81	$ 16.24	598	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.85	$ 16.49	616
Transportation	$ 0.95	$ 91.49	124	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.92	$ 92.87	119
Subtotal (Medical)	*$ 362.67*	*N/A*	*30,686*	*1.6%*	*0.4%*	*1.2%*	*87.6%*	*87.6%*	*0.0%*	*-12.6%*	*0.0%*	*-12.6%*	*$ 623.99*	*N/A*	*29,547*
CC4C LHD Payments	$ 4.18	$ 4.55	11,040	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.18	$ 4.55	11,040
OBCM LHD Payments	$ 0.00	$ 4.94	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.94	-
Medical Home Payments	$ 2.05	$ 2.47	9,956	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.05	$ 2.47	9,956
Subtotal (LHD/Medical Home Payments)	*$ 6.24*	*N/A*	*20,997*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.24*	*N/A*	*20,997*
Total (Medical + LHD/Medical Home)	**$ 368.91**	**N/A**	**51,683**	**1.6%**	**0.4%**	**1.2%**	**86.2%**	**86.2%**	**0.0%**	**-12.5%**	**0.0%**	**-12.5%**	**$ 630.22**	**N/A**	**50,544**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 630.22**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.08%)	$ 28.25
Care Management (3.23%)	$ 22.41
Profit/Underwriting Gain (1.75%)	$ 12.13
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 693.01**
Premium Taxes (2.01%)	$ 14.22
Total Capitation Rate:	**$ 707.22**

Exhibit 81

Region:	**Region 2**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**2,297,179**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 4.66	$ 1,303.09	43	1.5%	0.5%	1.0%	142.3%	142.3%	0.0%	-15.3%	0.0%	-15.3%	$ 10.00	$ 3,204.87	37
Inpatient — BH	$ 0.93	$ 658.91	17	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.96	$ 668.84	17
Outpatient Hospital	$ 10.63	$ 232.55	548	3.0%	0.5%	2.5%	35.7%	35.7%	0.0%	-7.8%	0.0%	-7.8%	$ 14.53	$ 320.41	544
Emergency Room	$ 13.73	$ 322.66	511	1.5%	0.5%	1.0%	28.4%	28.4%	0.0%	-7.8%	0.0%	-7.8%	$ 17.00	$ 420.59	485
Physician	$ 19.58	$ 69.01	3,405	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.2%	0.0%	-7.2%	$ 19.29	$ 70.05	3,305
FQHC/RHC	$ 1.27	$ 112.69	136	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.25	$ 114.39	131
Other Clinic	$ 5.90	$ 103.64	683	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.78	$ 105.21	659
Other Practitioner	$ 0.10	$ 78.83	16	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.10	$ 80.02	15
Therapies	$ 2.96	$ 116.23	305	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.89	$ 117.98	294
Prescribed Drugs	$ 36.87	$ 96.69	4,576	4.8%	4.3%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 41.33	$ 109.55	4,527
Other BH Services	$ 4.72	$ 77.02	736	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 5.00	$ 79.35	756
LTSS Services	$ 0.09	$ 7.29	148	1.0%	0.5%	0.5%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.09	$ 7.59	150
Durable Medical Equipment	$ 2.19	$ 2.64	9,940	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.11	$ 2.68	9,441
Limited Dental Services	$ 0.44	$ 24.80	211	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.45	$ 25.17	217
Optical	$ 1.04	$ 83.53	149	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.08	$ 84.79	153
Lab and X-Ray	$ 1.56	$ 18.66	1,001	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.62	$ 18.94	1,028
Transportation	$ 0.42	$ 90.47	55	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.41	$ 91.83	53
Subtotal (Medical)	*$ 107.08*	*N/A*	*22,480*	*2.9%*	*1.8%*	*1.1%*	*13.0%*	*13.0%*	*0.0%*	*-6.1%*	*0.0%*	*-6.1%*	*$ 123.90*	*N/A*	*21,812*
CC4C LHD Payments	$ 0.99	$ 4.52	2,627	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.99	$ 4.52	2,627
OBCM LHD Payments	$ 0.56	$ 4.92	1,362	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.56	$ 4.92	1,362
Medical Home Payments	$ 2.30	$ 2.45	11,277	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.30	$ 2.45	11,277
Subtotal (LHD/Medical Home Payments)	*$ 3.85*	*N/A*	*15,265*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.85*	*N/A*	*15,265*
Total (Medical + LHD/Medical Home)	**$ 110.93**	**N/A**	**37,745**	**2.8%**	**1.8%**	**1.1%**	**12.6%**	**12.6%**	**0.0%**	**-5.9%**	**0.0%**	**-5.9%**	**$ 127.75**	**N/A**	**37,078**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 127.75**
Non-Benefit Expense PMPM/Payment:	
General Administration (7.51%)	$ 10.95
Care Management (3.12%)	$ 4.54
Profit/Underwriting Gain (1.75%)	$ 2.55
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 145.79**
Premium Taxes (2.01%)	$ 2.99
Total Capitation Rate:	**$ 148.78**

Exhibit 82

Region:	**Region 2**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**468,569**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 25.50	$ 1,075.55	285	3.5%	0.5%	3.0%	164.6%	164.6%	0.0%	-12.2%	0.0%	-12.2%	$ 65.71	$ 2,888.39	273
Inpatient — BH	$ 2.18	$ 684.80	38	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.39	$ 695.12	41
Outpatient Hospital	$ 37.85	$ 345.57	1,314	3.0%	0.5%	2.5%	37.1%	37.1%	0.0%	-15.9%	0.0%	-15.9%	$ 47.69	$ 480.99	1,190
Emergency Room	$ 44.76	$ 459.65	1,168	1.5%	0.5%	1.0%	29.3%	29.3%	0.0%	-12.2%	0.0%	-12.2%	$ 53.18	$ 603.48	1,057
Physician	$ 48.34	$ 108.58	5,342	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.9%	0.0%	-8.9%	$ 46.74	$ 110.22	5,089
FQHC/RHC	$ 0.70	$ 117.82	71	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.68	$ 119.60	68
Other Clinic	$ 7.89	$ 247.13	383	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 7.67	$ 250.86	367
Other Practitioner	$ 0.38	$ 67.54	68	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.37	$ 68.56	65
Therapies	$ 0.01	$ 55.14	3	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.01	$ 55.97	2
Prescribed Drugs	$ 109.27	$ 94.39	13,891	5.5%	5.3%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 124.75	$ 110.06	13,602
Other BH Services	$ 7.49	$ 78.18	1,149	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 7.87	$ 80.54	1,173
LTSS Services	$ 2.29	$ 6.56	4,195	1.0%	0.5%	0.5%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.37	$ 6.73	4,219
Durable Medical Equipment	$ 5.68	$ 2.17	31,485	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 5.44	$ 2.20	29,709
Limited Dental Services	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ -	-
Optical	$ 0.52	$ 66.38	93	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.53	$ 67.38	95
Lab and X-Ray	$ 14.24	$ 26.01	6,571	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 14.76	$ 26.40	6,708
Transportation	$ 2.43	$ 92.79	315	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.36	$ 94.19	300
Subtotal (Medical)	*$ 309.54*	*N/A*	*66,372*	*3.4%*	*2.2%*	*1.2%*	*22.1%*	*22.1%*	*0.0%*	*-8.4%*	*0.0%*	*-8.4%*	*$ 382.53*	*N/A*	*63,960*
CC4C LHD Payments	$ 0.00	$ 4.49	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.49	-
OBCM LHD Payments	$ 3.41	$ 4.91	8,345	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.41	$ 4.91	8,345
Medical Home Payments	$ 1.68	$ 2.36	8,542	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.68	$ 2.36	8,542
Subtotal (LHD/Medical Home Payments)	*$ 5.09*	*N/A*	*16,887*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.09*	*N/A*	*16,887*
Total (Medical + LHD/Medical Home)	**$ 314.63**	**N/A**	**83,258**	**3.3%**	**2.2%**	**1.1%**	**21.8%**	**21.8%**	**0.0%**	**-8.3%**	**0.0%**	**-8.3%**	**$ 387.62**	**N/A**	**80,847**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 387.62**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.64%)	$ 19.89
Care Management (3.21%)	$ 13.79
Profit/Underwriting Gain (1.75%)	$ 7.50
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 428.81**
Premium Taxes (2.01%)	$ 8.80
Total Capitation Rate:	**$ 437.60**

Exhibit 83

Region:	**Region 2**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**9,264**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 1,974.45	$ 695.42	34,071	0.5%	0.5%	0.0%	192.2%	192.2%	0.0%	-1.1%	0.0%	-1.1%	$ 5,791.09	$ 2,062.87	33,687
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 422.88	$ 127.27	39,872	3.0%	0.5%	2.5%	39.4%	39.4%	0.0%	-15.0%	0.0%	-15.0%	$ 547.56	$ 180.10	36,484
Emergency Room	$ 482.68	$ 336.14	17,232	1.5%	0.5%	1.0%	30.9%	30.9%	0.0%	-11.3%	0.0%	-11.3%	$ 586.57	$ 446.80	15,754
Physician	$ 1,783.48	$ 223.60	95,712	2.0%	0.5%	1.5%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,908.00	$ 228.82	100,062
FQHC/RHC	$ 7.03	$ 128.05	658	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 7.46	$ 129.98	688
Other Clinic	$ 103.39	$ 146.12	8,491	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 109.72	$ 148.33	8,876
Other Practitioner	$ 0.01	$ 26.65	3	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 27.05	3
Therapies	$ -	$ -	-	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.02	$ 44.57	6	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.02	$ 45.92	6
LTSS Services	$ 2.30	$ 5.43	5,089	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.37	$ 5.51	5,165
Durable Medical Equipment	$ 1.92	$ 28.57	808	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.01	$ 29.00	833
Limited Dental Services	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Optical	$ 0.02	$ 80.24	3	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.02	$ 81.45	4
Lab and X-Ray	$ 37.25	$ 18.96	23,580	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 38.95	$ 19.24	24,291
Transportation	$ 10.71	$ 98.89	1,300	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 10.46	$ 100.38	1,250
Subtotal (Medical)	*$ 4,826.14*	*N/A*	*226,824*	*1.4%*	*0.5%*	*0.9%*	*83.5%*	*83.5%*	*0.0%*	*-2.6%*	*0.0%*	*-2.6%*	*$ 9,004.24*	*N/A*	*227,103*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 4,826.14**	**N/A**	**226,824**	**1.4%**	**0.5%**	**0.9%**	**83.5%**	**83.5%**	**0.0%**	**-2.6%**	**0.0%**	**-2.6%**	**$ 9,004.24**	**N/A**	**227,103**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 9,004.24**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.76%)	$ 72.39
Care Management (3.35%)	$ 320.23
Profit/Underwriting Gain (1.75%)	$ 167.37
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 9,564.24**
Premium Taxes (2.01%)	$ 196.18
Total Capitation Rate:	**$ 9,760.42**

14.3 Region 3 Capitation Rate Development Exhibits

Exhibit 84

Region:	**Region 3**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**328,525**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 129.48	$ 973.44	1,596	0.5%	0.5%	0.0%	160.5%	160.5%	0.0%	-15.8%	0.0%	-15.8%	$ 288.21	$ 2,574.08	1,344
Inpatient — BH	$ 6.97	$ 564.40	148	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 7.02	$ 572.90	147
Outpatient Hospital	$ 107.23	$ 473.60	2,717	0.5%	0.5%	0.0%	40.6%	40.6%	0.0%	-27.1%	0.0%	-27.1%	$ 111.56	$ 675.70	1,981
Emergency Room	$ 70.12	$ 506.46	1,661	0.5%	0.5%	0.0%	35.6%	35.6%	0.0%	-19.6%	0.0%	-19.6%	$ 77.62	$ 697.07	1,336
Physician	$ 115.69	$ 135.02	10,282	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-10.8%	0.0%	-10.8%	$ 111.09	$ 137.05	9,727
FQHC/RHC	$ 3.26	$ 111.07	352	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 3.21	$ 112.75	342
Other Clinic	$ 11.05	$ 452.97	293	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 10.91	$ 459.80	285
Other Practitioner	$ 0.88	$ 75.64	140	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.87	$ 76.78	136
Therapies	$ 5.12	$ 110.04	559	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 5.06	$ 111.70	543
Prescribed Drugs	$ 466.24	$ 162.55	34,419	7.3%	6.8%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 561.37	$ 197.74	34,067
Other BH Services	$ 15.73	$ 48.73	3,875	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 16.56	$ 50.20	3,958
LTSS Services	$ 95.93	$ 5.15	223,581	1.0%	0.5%	0.5%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 106.05	$ 5.88	216,553
Durable Medical Equipment	$ 46.52	$ 3.22	173,462	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 41.55	$ 3.27	152,647
Limited Dental Services	$ 0.03	$ 25.39	14	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.03	$ 25.77	14
Optical	$ 0.68	$ 71.34	114	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.71	$ 72.42	118
Lab and X-Ray	$ 9.90	$ 23.45	5,066	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 10.42	$ 23.81	5,252
Transportation	$ 10.77	$ 58.66	2,204	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 10.33	$ 59.54	2,083
Subtotal (Medical)	*$ 1,095.59*	*N/A*	*460,482*	*3.8%*	*3.3%*	*0.6%*	*23.9%*	*23.9%*	*0.0%*	*-10.3%*	*0.0%*	*-10.3%*	*$ 1,362.59*	*N/A*	*430,534*
CC4C LHD Payments	$ 0.00	$ 4.53	12	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	12
OBCM LHD Payments	$ 0.74	$ 4.93	1,806	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.74	$ 4.93	1,806
Medical Home Payments	$ 4.33	$ 4.80	10,825	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.33	$ 4.80	10,825
Subtotal (LHD/Medical Home Payments)	*$ 5.07*	*N/A*	*12,643*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.07*	*N/A*	*12,643*
Total (Medical + LHD/Medical Home)	**$ 1,100.67**	**N/A**	**473,125**	**3.8%**	**3.2%**	**0.6%**	**23.8%**	**23.8%**	**0.0%**	**-10.3%**	**0.0%**	**-10.3%**	**$ 1,367.66**	**N/A**	**443,178**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,367.66**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.65%)	$ 54.66
Care Management (3.32%)	$ 49.75
Profit/Underwriting Gain (1.75%)	$ 26.22
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,498.29**
Premium Taxes (2.01%)	$ 30.73
Total Capitation Rate:	**$ 1,529.02**

Exhibit 85

Region:	**Region 3**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**211,433**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 180.57	$ 576.42	3,759	1.5%	0.5%	1.0%	185.2%	185.2%	0.0%	-15.0%	0.0%	-15.0%	$ 457.70	$ 1,668.59	3,292
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 10.78	$ 168.14	769	0.5%	0.5%	0.0%	44.3%	44.3%	0.0%	-7.5%	0.0%	-7.5%	$ 14.61	$ 246.35	712
Emergency Room	$ 21.61	$ 251.16	1,033	0.5%	0.5%	0.0%	32.3%	32.3%	0.0%	-7.5%	0.0%	-7.5%	$ 26.84	$ 337.20	955
Physician	$ 84.14	$ 93.02	10,855	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-6.8%	0.0%	-6.8%	$ 84.45	$ 94.42	10,733
FQHC/RHC	$ 1.55	$ 111.80	166	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 1.54	$ 113.48	163
Other Clinic	$ 34.02	$ 95.22	4,287	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 33.89	$ 96.65	4,207
Other Practitioner	$ 0.07	$ 37.45	24	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.07	$ 38.01	23
Therapies	$ 1.04	$ 91.12	137	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 1.04	$ 92.49	135
Prescribed Drugs	$ 15.35	$ 51.56	3,572	-0.5%	-0.5%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 14.86	$ 50.79	3,511
Other BH Services	$ 0.08	$ 16.68	57	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.08	$ 17.19	59
LTSS Services	$ 1.77	$ 14.85	1,433	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.83	$ 15.07	1,454
Durable Medical Equipment	$ 8.57	$ 26.22	3,920	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 8.41	$ 26.62	3,791
Limited Dental Services	$ 1.72	$ 24.96	829	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.83	$ 25.34	867
Optical	$ 0.01	$ 95.98	1	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 97.42	1
Lab and X-Ray	$ 1.68	$ 34.10	590	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.78	$ 34.61	617
Transportation	$ 0.89	$ 95.72	111	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.86	$ 97.16	106
Subtotal (Medical)	*$ 363.84*	*N/A*	*31,543*	*1.7%*	*0.5%*	*1.2%*	*94.6%*	*94.6%*	*0.0%*	*-12.7%*	*0.0%*	*-12.7%*	*$ 649.78*	*N/A*	*30,623*
CC4C LHD Payments	$ 4.17	$ 4.55	10,997	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.17	$ 4.55	10,997
OBCM LHD Payments	$ 0.00	$ 4.91	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.91	-
Medical Home Payments	$ 1.93	$ 2.47	9,370	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.93	$ 2.47	9,370
Subtotal (LHD/Medical Home Payments)	*$ 6.10*	*N/A*	*20,367*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.10*	*N/A*	*20,367*
Total (Medical + LHD/Medical Home)	**$ 369.94**	**N/A**	**51,910**	**1.6%**	**0.5%**	**1.2%**	**93.1%**	**93.1%**	**0.0%**	**-12.6%**	**0.0%**	**-12.6%**	**$ 655.88**	**N/A**	**50,991**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 655.88**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.10%)	$ 29.62
Care Management (3.30%)	$ 23.86
Profit/Underwriting Gain (1.75%)	$ 12.63
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 722.00**
Premium Taxes (2.01%)	$ 14.81
Total Capitation Rate:	**$ 736.81**

Exhibit 86

Region:	**Region 3**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**3,243,949**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 3.82	$ 1,102.70	42	1.5%	0.5%	1.0%	158.2%	158.2%	0.0%	-15.3%	0.0%	-15.3%	$ 8.75	$ 2,890.55	36
Inpatient — BH	$ 0.65	$ 543.61	14	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.68	$ 551.80	15
Outpatient Hospital	$ 7.92	$ 265.07	359	0.5%	0.5%	0.0%	41.2%	41.2%	0.0%	-7.8%	0.0%	-7.8%	$ 10.47	$ 379.92	331
Emergency Room	$ 12.75	$ 297.52	514	0.5%	0.5%	0.0%	33.1%	33.1%	0.0%	-7.8%	0.0%	-7.8%	$ 15.89	$ 401.98	474
Physician	$ 21.62	$ 75.97	3,415	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.1%	0.0%	-7.1%	$ 21.63	$ 77.12	3,365
FQHC/RHC	$ 0.55	$ 116.79	57	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.55	$ 118.55	56
Other Clinic	$ 5.83	$ 99.31	705	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.79	$ 100.81	690
Other Practitioner	$ 0.20	$ 81.18	29	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.20	$ 82.40	29
Therapies	$ 3.05	$ 100.48	364	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 3.02	$ 101.99	356
Prescribed Drugs	$ 35.23	$ 97.06	4,356	4.5%	4.0%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 39.21	$ 109.18	4,309
Other BH Services	$ 5.36	$ 75.76	849	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 5.67	$ 78.06	872
LTSS Services	$ 0.29	$ 7.85	436	1.0%	0.5%	0.5%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.30	$ 8.17	441
Durable Medical Equipment	$ 2.10	$ 3.33	7,548	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.05	$ 3.38	7,276
Limited Dental Services	$ 0.31	$ 24.82	151	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.33	$ 25.19	157
Optical	$ 0.63	$ 84.22	90	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.67	$ 85.49	94
Lab and X-Ray	$ 1.61	$ 20.89	927	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.71	$ 21.21	967
Transportation	$ 0.38	$ 71.14	65	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.37	$ 72.21	62
Subtotal (Medical)	*$ 102.32*	*N/A*	*19,921*	*2.7%*	*1.7%*	*0.9%*	*12.6%*	*12.6%*	*0.0%*	*-6.0%*	*0.0%*	*-6.0%*	*$ 117.28*	*N/A*	*19,528*
CC4C LHD Payments	$ 1.00	$ 4.52	2,649	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.00	$ 4.52	2,649
OBCM LHD Payments	$ 0.54	$ 4.92	1,329	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.54	$ 4.92	1,329
Medical Home Payments	$ 2.24	$ 2.46	10,933	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.24	$ 2.46	10,933
Subtotal (LHD/Medical Home Payments)	*$ 3.79*	*N/A*	*14,911*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.79*	*N/A*	*14,911*
Total (Medical + LHD/Medical Home)	**$ 106.10**	**N/A**	**34,832**	**2.6%**	**1.7%**	**0.9%**	**12.2%**	**12.2%**	**0.0%**	**-5.8%**	**0.0%**	**-5.8%**	**$ 121.06**	**N/A**	**34,439**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 121.06**
Non-Benefit Expense PMPM/Payment:	
General Administration (7.79%)	$ 10.81
Care Management (3.18%)	$ 4.40
Profit/Underwriting Gain (1.75%)	$ 2.43
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 138.70**
Premium Taxes (2.01%)	$ 2.85
Total Capitation Rate:	**$ 141.55**

Exhibit 87

Region:	**Region 3**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**711,903**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 21.38	$ 1,109.26	231	3.5%	0.5%	3.0%	177.7%	177.7%	0.0%	-12.2%	0.0%	-12.2%	$ 57.83	$ 3,126.78	222
Inpatient — BH	$ 1.79	$ 570.73	38	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.96	$ 579.33	41
Outpatient Hospital	$ 31.42	$ 314.76	1,198	0.5%	0.5%	0.0%	41.1%	41.1%	0.0%	-15.9%	0.0%	-15.9%	$ 37.85	$ 450.89	1,007
Emergency Room	$ 46.59	$ 442.95	1,262	0.5%	0.5%	0.0%	35.2%	35.2%	0.0%	-12.2%	0.0%	-12.2%	$ 56.19	$ 608.01	1,109
Physician	$ 45.96	$ 110.31	5,000	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.7%	0.0%	-8.7%	$ 45.17	$ 111.97	4,840
FQHC/RHC	$ 1.37	$ 107.36	153	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 1.35	$ 108.98	148
Other Clinic	$ 6.90	$ 219.96	377	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 6.81	$ 223.28	366
Other Practitioner	$ 0.38	$ 61.29	74	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.37	$ 62.21	72
Therapies	$ 0.03	$ 56.50	6	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.03	$ 57.35	6
Prescribed Drugs	$ 90.81	$ 88.16	12,361	6.0%	5.8%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 105.15	$ 104.25	12,103
Other BH Services	$ 6.97	$ 63.22	1,323	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 7.33	$ 65.14	1,351
LTSS Services	$ 2.71	$ 5.73	5,673	1.0%	0.5%	0.5%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.79	$ 5.87	5,706
Durable Medical Equipment	$ 5.84	$ 2.42	28,964	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 5.68	$ 2.46	27,737
Limited Dental Services	$ 0.00	$ 15.06	0	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ 15.28	-
Optical	$ 0.21	$ 69.10	36	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.22	$ 70.14	37
Lab and X-Ray	$ 11.88	$ 27.77	5,132	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 12.49	$ 28.19	5,317
Transportation	$ 1.79	$ 73.43	293	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.72	$ 74.54	277
Subtotal (Medical)	*$ 276.02*	*N/A*	*62,119*	*3.1%*	*2.3%*	*0.8%*	*23.8%*	*23.8%*	*0.0%*	*-8.5%*	*0.0%*	*-8.5%*	*$ 342.93*	*N/A*	*60,339*
CC4C LHD Payments	$ 0.00	$ 4.35	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.35	-
OBCM LHD Payments	$ 3.39	$ 4.91	8,284	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.39	$ 4.91	8,284
Medical Home Payments	$ 1.73	$ 2.43	8,529	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.73	$ 2.43	8,529
Subtotal (LHD/Medical Home Payments)	*$ 5.11*	*N/A*	*16,813*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.11*	*N/A*	*16,813*
Total (Medical + LHD/Medical Home)	**$ 281.13**	**N/A**	**78,932**	**3.1%**	**2.2%**	**0.8%**	**23.4%**	**23.4%**	**0.0%**	**-8.4%**	**0.0%**	**-8.4%**	**$ 348.04**	**N/A**	**77,151**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 348.04**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.86%)	$ 18.79
Care Management (3.28%)	$ 12.66
Profit/Underwriting Gain (1.75%)	$ 6.76
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 386.26**
Premium Taxes (2.01%)	$ 7.92
Total Capitation Rate:	**$ 394.18**

Exhibit 88

Region:	**Region 3**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**13,078**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,014.40	$ 731.64	33,039	0.5%	0.5%	0.0%	183.1%	183.1%	0.0%	-1.1%	0.0%	-1.1%	$ 5,723.26	$ 2,102.36	32,668
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 260.14	$ 134.71	23,174	0.5%	0.5%	0.0%	41.5%	41.5%	0.0%	-15.0%	0.0%	-15.0%	$ 317.55	$ 193.45	19,697
Emergency Room	$ 454.86	$ 371.06	14,710	0.5%	0.5%	0.0%	35.8%	35.8%	0.0%	-11.3%	0.0%	-11.3%	$ 556.54	$ 511.55	13,055
Physician	$ 1,637.47	$ 233.26	84,239	2.5%	0.5%	2.0%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,777.69	$ 238.70	89,369
FQHC/RHC	$ 6.89	$ 129.90	636	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 7.42	$ 131.86	675
Other Clinic	$ 229.74	$ 193.00	14,284	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 247.40	$ 195.90	15,154
Other Practitioner	$ 0.25	$ 40.26	75	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.27	$ 40.87	79
Therapies	$ 0.02	$ 89.84	3	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 91.20	3
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ -	$ -	-	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
LTSS Services	$ 3.95	$ 1.10	43,314	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.07	$ 1.11	43,964
Durable Medical Equipment	$ 1.83	$ 25.70	852	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.94	$ 26.09	891
Limited Dental Services	$ 0.00	$ 24.71	2	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 25.08	2
Optical	$ 0.01	$ 69.74	2	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 70.79	2
Lab and X-Ray	$ 43.38	$ 27.82	18,714	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 46.04	$ 28.24	19,565
Transportation	$ 10.32	$ 91.31	1,356	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 9.98	$ 92.68	1,293
Subtotal (Medical)	*$ 4,663.26*	*N/A*	*234,400*	*1.3%*	*0.5%*	*0.8%*	*83.1%*	*83.1%*	*0.0%*	*-2.2%*	*0.0%*	*-2.2%*	*$ 8,692.19*	*N/A*	*236,416*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 4,663.26**	**N/A**	**234,400**	**1.3%**	**0.5%**	**0.8%**	**83.1%**	**83.1%**	**0.0%**	**-2.2%**	**0.0%**	**-2.2%**	**$ 8,692.19**	**N/A**	**236,416**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 8,692.19**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.77%)	$ 71.48
Care Management (3.42%)	$ 316.20
Profit/Underwriting Gain (1.75%)	$ 161.73
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 9,241.60**
Premium Taxes (2.01%)	$ 189.57
Total Capitation Rate:	**$ 9,431.17**

14.4 Region 4 Capitation Rate Development Exhibits

Exhibit 89

Region:	**Region 4**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**278,511**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 139.30	$ 981.10	1,704	0.5%	0.5%	0.0%	140.5%	140.5%	0.0%	-15.8%	0.0%	-15.8%	$ 286.30	$ 2,395.56	1,434
Inpatient — BH	$ 7.28	$ 779.26	112	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 7.33	$ 791.01	111
Outpatient Hospital	$ 99.43	$ 511.26	2,334	2.0%	0.5%	1.5%	27.8%	27.8%	0.0%	-27.1%	0.0%	-27.1%	$ 98.34	$ 663.24	1,779
Emergency Room	$ 60.29	$ 513.40	1,409	3.0%	0.5%	2.5%	29.1%	29.1%	0.0%	-19.6%	0.0%	-19.6%	$ 68.42	$ 672.90	1,220
Physician	$ 102.74	$ 140.47	8,777	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-10.5%	0.0%	-10.5%	$ 97.53	$ 142.59	8,208
FQHC/RHC	$ 7.18	$ 116.80	738	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 6.99	$ 118.56	707
Other Clinic	$ 14.07	$ 482.53	350	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 13.69	$ 489.81	335
Other Practitioner	$ 0.63	$ 79.24	95	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.61	$ 80.44	91
Therapies	$ 6.25	$ 114.97	653	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 6.08	$ 116.70	625
Prescribed Drugs	$ 436.64	$ 172.91	30,303	7.3%	6.8%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 525.73	$ 210.34	29,993
Other BH Services	$ 20.97	$ 57.09	4,407	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 23.06	$ 58.82	4,704
LTSS Services	$ 63.82	$ 4.97	153,947	1.0%	0.5%	0.5%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 70.56	$ 5.68	149,108
Durable Medical Equipment	$ 35.22	$ 2.63	160,886	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 31.46	$ 2.67	141,580
Limited Dental Services	$ 0.04	$ 24.79	17	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.04	$ 25.17	18
Optical	$ 1.02	$ 70.57	174	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 1.07	$ 71.63	180
Lab and X-Ray	$ 8.98	$ 21.73	4,959	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.45	$ 22.06	5,142
Transportation	$ 9.66	$ 58.76	1,973	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.70	$ 59.64	1,951
Subtotal (Medical)	*$ 1,013.52*	*N/A*	*372,838*	*4.1%*	*3.3%*	*0.8%*	*22.3%*	*22.3%*	*0.0%*	*-10.3%*	*0.0%*	*-10.3%*	*$ 1,256.35*	*N/A*	*347,188*
CC4C LHD Payments	$ 0.00	$ 4.53	12	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	12
OBCM LHD Payments	$ 0.71	$ 4.93	1,734	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.71	$ 4.93	1,734
Medical Home Payments	$ 4.33	$ 4.81	10,806	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.33	$ 4.81	10,806
Subtotal (LHD/Medical Home Payments)	*$ 5.05*	*N/A*	*12,552*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.05*	*N/A*	*12,552*
Total (Medical + LHD/Medical Home)	**$ 1,018.58**	**N/A**	**385,390**	**4.1%**	**3.3%**	**0.8%**	**22.2%**	**22.2%**	**0.0%**	**-10.2%**	**0.0%**	**-10.2%**	**$ 1,261.40**	**N/A**	**359,740**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,261.40**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.82%)	$ 53.04
Care Management (3.49%)	$ 48.36
Profit/Underwriting Gain (1.75%)	$ 24.27
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,387.08**
Premium Taxes (2.01%)	$ 28.45
Total Capitation Rate:	**$ 1,415.53**

Exhibit 90

Region:	**Region 4**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**171,144**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 190.31	$ 557.05	4,100	1.5%	0.5%	1.0%	127.1%	127.1%	0.0%	-15.0%	0.0%	-15.0%	$ 384.15	$ 1,284.17	3,590
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 8.96	$ 155.04	694	2.0%	0.5%	1.5%	26.1%	26.1%	0.0%	-7.5%	0.0%	-7.5%	$ 11.10	$ 198.45	671
Emergency Room	$ 23.20	$ 264.53	1,052	3.0%	0.5%	2.5%	26.7%	26.7%	0.0%	-7.5%	0.0%	-7.5%	$ 29.71	$ 340.27	1,048
Physician	$ 91.70	$ 100.13	10,989	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.8%	0.0%	-6.8%	$ 90.70	$ 101.64	10,708
FQHC/RHC	$ 7.72	$ 106.01	874	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 7.58	$ 107.61	845
Other Clinic	$ 33.86	$ 94.92	4,280	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 33.23	$ 96.36	4,139
Other Practitioner	$ 0.02	$ 46.61	6	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.02	$ 47.31	5
Therapies	$ 0.83	$ 100.79	99	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.82	$ 102.31	96
Prescribed Drugs	$ 13.60	$ 55.01	2,966	-0.5%	-0.8%	0.3%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 13.16	$ 53.79	2,937
Other BH Services	$ 0.09	$ 43.76	24	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.10	$ 45.08	26
LTSS Services	$ 0.76	$ 14.77	620	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.79	$ 15.00	629
Durable Medical Equipment	$ 3.36	$ 5.60	7,205	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 3.30	$ 5.69	6,967
Limited Dental Services	$ 1.96	$ 25.00	942	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.08	$ 25.37	985
Optical	$ 0.02	$ 86.73	3	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.02	$ 88.04	3
Lab and X-Ray	$ 0.82	$ 20.53	482	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.88	$ 20.84	504
Transportation	$ 1.17	$ 95.08	148	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.18	$ 96.51	147
Subtotal (Medical)	*$ 378.39*	*N/A*	*34,482*	*1.7%*	*0.5%*	*1.3%*	*65.8%*	*65.8%*	*0.0%*	*-12.4%*	*0.0%*	*-12.4%*	*$ 578.82*	*N/A*	*33,299*
CC4C LHD Payments	$ 4.18	$ 4.55	11,024	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.18	$ 4.55	11,024
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ 1.94	$ 2.45	9,496	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.94	$ 2.45	9,496
Subtotal (LHD/Medical Home Payments)	*$ 6.12*	*N/A*	*20,519*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.12*	*N/A*	*20,519*
Total (Medical + LHD/Medical Home)	**$ 384.51**	**N/A**	**55,001**	**1.7%**	**0.5%**	**1.2%**	**64.8%**	**64.8%**	**0.0%**	**-12.2%**	**0.0%**	**-12.2%**	**$ 584.94**	**N/A**	**53,818**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 584.94**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.35%)	$ 28.11
Care Management (3.47%)	$ 22.43
Profit/Underwriting Gain (1.75%)	$ 11.32
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 646.80**
Premium Taxes (2.01%)	$ 13.27
Total Capitation Rate:	**$ 660.06**

Exhibit 91

Region:	**Region 4**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**2,661,605**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 4.03	$ 1,142.94	42	1.5%	0.5%	1.0%	139.7%	139.7%	0.0%	-15.3%	0.0%	-15.3%	$ 8.55	$ 2,780.86	37
Inpatient — BH	$ 1.19	$ 677.93	21	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.25	$ 688.15	22
Outpatient Hospital	$ 8.12	$ 315.72	309	2.0%	0.5%	1.5%	28.2%	28.2%	0.0%	-7.8%	0.0%	-7.8%	$ 10.19	$ 410.93	298
Emergency Room	$ 13.17	$ 317.30	498	3.0%	0.5%	2.5%	27.9%	27.9%	0.0%	-7.8%	0.0%	-7.8%	$ 16.97	$ 411.86	494
Physician	$ 19.49	$ 80.97	2,889	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.1%	0.0%	-7.1%	$ 19.21	$ 82.19	2,805
FQHC/RHC	$ 2.21	$ 104.48	254	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.17	$ 106.06	245
Other Clinic	$ 5.57	$ 101.19	660	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.45	$ 102.72	637
Other Practitioner	$ 0.10	$ 81.57	14	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.09	$ 82.80	14
Therapies	$ 5.80	$ 112.43	619	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.68	$ 114.13	597
Prescribed Drugs	$ 31.22	$ 104.68	3,579	5.0%	4.5%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 35.25	$ 119.45	3,541
Other BH Services	$ 6.18	$ 82.67	896	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 6.83	$ 85.18	962
LTSS Services	$ 0.17	$ 9.05	230	1.0%	0.5%	0.5%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.18	$ 9.43	233
Durable Medical Equipment	$ 1.97	$ 2.89	8,178	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.93	$ 2.94	7,882
Limited Dental Services	$ 0.37	$ 24.79	180	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.39	$ 25.17	188
Optical	$ 1.08	$ 81.90	158	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.14	$ 83.14	165
Lab and X-Ray	$ 1.32	$ 15.75	1,002	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.39	$ 15.99	1,044
Transportation	$ 0.34	$ 76.95	53	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.35	$ 78.11	53
Subtotal (Medical)	*$ 102.34*	*N/A*	*19,584*	*3.1%*	*1.8%*	*1.3%*	*11.0%*	*11.0%*	*0.0%*	*-6.1%*	*0.0%*	*-6.1%*	*$ 117.01*	*N/A*	*19,216*
CC4C LHD Payments	$ 1.00	$ 4.52	2,643	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.00	$ 4.52	2,643
OBCM LHD Payments	$ 0.52	$ 4.92	1,277	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.52	$ 4.92	1,277
Medical Home Payments	$ 2.26	$ 2.46	11,025	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.26	$ 2.46	11,025
Subtotal (LHD/Medical Home Payments)	*$ 3.78*	*N/A*	*14,945*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.78*	*N/A*	*14,945*
Total (Medical + LHD/Medical Home)	**$ 106.11**	**N/A**	**34,529**	**3.0%**	**1.7%**	**1.3%**	**10.6%**	**10.6%**	**0.0%**	**-5.9%**	**0.0%**	**-5.9%**	**$ 120.79**	**N/A**	**34,161**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 120.79**
Non-Benefit Expense PMPM/Payment:	
General Administration (7.92%)	$ 11.00
Care Management (3.34%)	$ 4.63
Profit/Underwriting Gain (1.75%)	$ 2.43
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 138.85**
Premium Taxes (2.01%)	$ 2.85
Total Capitation Rate:	**$ 141.70**

Exhibit 92

Region:	**Region 4**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**509,487**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 22.93	$ 1,072.48	257	3.5%	0.5%	3.0%	147.3%	147.3%	0.0%	-12.2%	0.0%	-12.2%	$ 55.23	$ 2,692.51	246
Inpatient — BH	$ 1.52	$ 781.59	23	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.67	$ 793.37	25
Outpatient Hospital	$ 32.56	$ 365.16	1,070	2.0%	0.5%	1.5%	28.0%	28.0%	0.0%	-15.9%	0.0%	-15.9%	$ 37.19	$ 474.34	941
Emergency Room	$ 46.91	$ 477.43	1,179	3.0%	0.5%	2.5%	29.7%	29.7%	0.0%	-12.2%	0.0%	-12.2%	$ 58.43	$ 628.77	1,115
Physician	$ 43.34	$ 114.28	4,551	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.6%	0.0%	-8.6%	$ 42.05	$ 116.00	4,349
FQHC/RHC	$ 3.63	$ 109.90	396	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 3.53	$ 111.56	379
Other Clinic	$ 8.19	$ 173.46	567	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 7.96	$ 176.08	543
Other Practitioner	$ 0.31	$ 76.28	48	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.30	$ 77.43	46
Therapies	$ 0.02	$ 55.71	5	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.02	$ 56.55	5
Prescribed Drugs	$ 85.46	$ 90.48	11,334	5.8%	5.5%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 98.26	$ 106.25	11,098
Other BH Services	$ 8.42	$ 80.12	1,262	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 9.26	$ 82.55	1,346
LTSS Services	$ 1.87	$ 5.78	3,881	1.0%	0.5%	0.5%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.93	$ 5.92	3,903
Durable Medical Equipment	$ 4.52	$ 2.00	27,061	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 4.39	$ 2.03	25,914
Limited Dental Services	$ 0.00	$ 17.31	0	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ 17.57	-
Optical	$ 0.35	$ 68.98	62	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.37	$ 70.02	64
Lab and X-Ray	$ 11.52	$ 23.80	5,810	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 12.12	$ 24.16	6,019
Transportation	$ 1.63	$ 73.25	267	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.64	$ 74.35	264
Subtotal (Medical)	*$ 273.19*	*N/A*	*57,772*	*3.5%*	*2.1%*	*1.4%*	*20.6%*	*20.6%*	*0.0%*	*-8.5%*	*0.0%*	*-8.5%*	*$ 334.33*	*N/A*	*56,258*
CC4C LHD Payments	$ 0.00	$ 4.50	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.50	-
OBCM LHD Payments	$ 3.44	$ 4.91	8,407	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.44	$ 4.91	8,407
Medical Home Payments	$ 1.64	$ 2.43	8,122	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.64	$ 2.43	8,122
Subtotal (LHD/Medical Home Payments)	*$ 5.08*	*N/A*	*16,530*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.08*	*N/A*	*16,530*
Total (Medical + LHD/Medical Home)	**$ 278.28**	**N/A**	**74,302**	**3.5%**	**2.0%**	**1.4%**	**20.2%**	**20.2%**	**0.0%**	**-8.4%**	**0.0%**	**-8.4%**	**$ 339.42**	**N/A**	**72,788**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 339.42**
Non-Benefit Expense PMPM/Payment:	
General Administration (5.04%)	$ 19.06
Care Management (3.44%)	$ 13.01
Profit/Underwriting Gain (1.75%)	$ 6.62
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 378.11**
Premium Taxes (2.01%)	$ 7.76
Total Capitation Rate:	**$ 385.86**

Exhibit 93

Region:	**Region 4**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**9,785**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,093.45	$ 740.20	33,939	0.5%	0.5%	0.0%	128.4%	128.4%	0.0%	-1.1%	0.0%	-1.1%	$ 4,798.41	$ 1,715.92	33,557
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 423.85	$ 158.18	32,156	2.0%	0.5%	1.5%	22.9%	22.9%	0.0%	-15.0%	0.0%	-15.0%	$ 469.91	$ 197.34	28,575
Emergency Room	$ 560.31	$ 405.58	16,578	3.0%	0.5%	2.5%	30.8%	30.8%	0.0%	-11.3%	0.0%	-11.3%	$ 710.66	$ 538.42	15,839
Physician	$ 1,617.62	$ 217.64	89,190	2.0%	0.5%	1.5%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,730.56	$ 222.72	93,243
FQHC/RHC	$ 55.59	$ 127.28	5,241	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 59.00	$ 129.20	5,480
Other Clinic	$ 268.71	$ 163.49	19,724	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 285.16	$ 165.95	20,620
Other Practitioner	$ 0.00	$ 40.83	1	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 41.45	1
Therapies	$ -	$ -	-	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.10	$ 59.99	20	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.11	$ 61.81	22
LTSS Services	$ 1.87	$ 4.43	5,065	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.93	$ 4.50	5,141
Durable Medical Equipment	$ 1.43	$ 48.06	356	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.51	$ 48.78	372
Limited Dental Services	$ 0.01	$ 25.18	4	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 25.56	4
Optical	$ 0.00	$ 58.20	0	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 59.08	1
Lab and X-Ray	$ 69.50	$ 26.95	30,945	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 73.76	$ 27.36	32,352
Transportation	$ 13.88	$ 90.71	1,836	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 14.05	$ 92.08	1,831
Subtotal (Medical)	*$ 5,106.33*	*N/A*	*235,056*	*1.5%*	*0.5%*	*1.0%*	*56.8%*	*56.8%*	*0.0%*	*-2.7%*	*0.0%*	*-2.7%*	*$ 8,145.07*	*N/A*	*237,036*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 5,106.33**	**N/A**	**235,056**	**1.5%**	**0.5%**	**1.0%**	**56.8%**	**56.8%**	**0.0%**	**-2.7%**	**0.0%**	**-2.7%**	**$ 8,145.07**	**N/A**	**237,036**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 8,145.07**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.81%)	$ 70.60
Care Management (3.60%)	$ 312.30
Profit/Underwriting Gain (1.75%)	$ 151.90
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 8,679.86**
Premium Taxes (2.01%)	$ 178.04
Total Capitation Rate:	**$ 8,857.91**

14.5 Region 5 Capitation Rate Development Exhibits

Exhibit 94

Region:	**Region 5**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**309,639**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 133.02	$ 956.37	1,669	0.5%	0.5%	0.0%	137.8%	137.8%	0.0%	-15.8%	0.0%	-15.8%	$ 270.34	$ 2,308.99	1,405
Inpatient — BH	$ 5.72	$ 688.22	100	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 5.76	$ 698.60	99
Outpatient Hospital	$ 88.31	$ 518.64	2,043	1.0%	0.5%	0.5%	32.5%	32.5%	0.0%	-27.1%	0.0%	-27.1%	$ 87.91	$ 697.46	1,512
Emergency Room	$ 60.17	$ 476.23	1,516	3.0%	0.5%	2.5%	29.6%	29.6%	0.0%	-19.6%	0.0%	-19.6%	$ 68.54	$ 626.61	1,313
Physician	$ 110.96	$ 138.09	9,642	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-9.6%	0.0%	-9.6%	$ 106.40	$ 140.17	9,109
FQHC/RHC	$ 6.15	$ 100.86	731	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 5.98	$ 102.38	701
Other Clinic	$ 10.65	$ 437.72	292	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 10.37	$ 444.32	280
Other Practitioner	$ 0.89	$ 76.24	141	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.87	$ 77.39	135
Therapies	$ 7.67	$ 107.82	853	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 7.46	$ 109.45	818
Prescribed Drugs	$ 381.68	$ 135.75	33,740	6.0%	5.5%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 443.68	$ 159.40	33,400
Other BH Services	$ 16.93	$ 72.15	2,816	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 18.62	$ 74.34	3,005
LTSS Services	$ 62.61	$ 4.75	158,180	-0.7%	0.5%	-1.2%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 65.67	$ 5.42	145,381
Durable Medical Equipment	$ 33.46	$ 2.76	145,544	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 29.45	$ 2.80	126,206
Limited Dental Services	$ 0.03	$ 24.85	17	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.04	$ 25.22	17
Optical	$ 1.60	$ 65.55	294	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 1.66	$ 66.54	300
Lab and X-Ray	$ 11.56	$ 24.58	5,643	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 11.99	$ 24.95	5,765
Transportation	$ 6.92	$ 72.58	1,143	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 7.19	$ 73.67	1,172
Subtotal (Medical)	*$ 938.33*	*N/A*	*364,365*	*3.3%*	*2.6%*	*0.6%*	*23.5%*	*23.5%*	*0.0%*	*-10.5%*	*0.0%*	*-10.5%*	*$ 1,141.92*	*N/A*	*330,617*
CC4C LHD Payments	$ 0.01	$ 4.53	13	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 4.53	13
OBCM LHD Payments	$ 0.74	$ 4.93	1,811	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.74	$ 4.93	1,811
Medical Home Payments	$ 4.35	$ 4.76	10,946	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.35	$ 4.76	10,946
Subtotal (LHD/Medical Home Payments)	*$ 5.10*	*N/A*	*12,771*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.10*	*N/A*	*12,771*
Total (Medical + LHD/Medical Home)	**$ 943.43**	**N/A**	**377,135**	**3.2%**	**2.6%**	**0.6%**	**23.4%**	**23.4%**	**0.0%**	**-10.4%**	**0.0%**	**-10.4%**	**$ 1,147.01**	**N/A**	**343,388**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,147.01**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.55%)	$ 44.42
Care Management (3.13%)	$ 39.22
Profit/Underwriting Gain (1.75%)	$ 21.92
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,252.56**
Premium Taxes (2.01%)	$ 25.69
Total Capitation Rate:	**$ 1,278.26**

Exhibit 95

Region:	**Region 5**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**135,338**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 198.39	$ 541.57	4,396	1.5%	0.5%	1.0%	158.4%	158.4%	0.0%	-15.0%	0.0%	-15.0%	$ 455.55	$ 1,420.24	3,849
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 7.84	$ 128.58	732	1.0%	0.5%	0.5%	29.1%	29.1%	0.0%	-7.5%	0.0%	-7.5%	$ 9.65	$ 168.50	687
Emergency Room	$ 21.24	$ 213.83	1,192	3.0%	0.5%	2.5%	26.2%	26.2%	0.0%	-7.5%	0.0%	-7.5%	$ 27.09	$ 273.96	1,187
Physician	$ 97.61	$ 103.51	11,316	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.8%	0.0%	-6.8%	$ 96.54	$ 105.07	11,026
FQHC/RHC	$ 3.18	$ 100.01	381	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 3.12	$ 101.52	368
Other Clinic	$ 34.93	$ 93.67	4,476	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 34.29	$ 95.08	4,328
Other Practitioner	$ 0.02	$ 71.76	4	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.02	$ 72.84	4
Therapies	$ 0.89	$ 81.02	132	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.88	$ 82.24	128
Prescribed Drugs	$ 16.28	$ 46.43	4,208	-1.0%	-1.0%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 15.53	$ 45.05	4,136
Other BH Services	$ 0.14	$ 24.17	72	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.16	$ 24.90	77
LTSS Services	$ 0.36	$ 18.84	229	-0.7%	0.5%	-1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.35	$ 19.12	220
Durable Medical Equipment	$ 3.88	$ 3.62	12,863	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 3.75	$ 3.67	12,257
Limited Dental Services	$ 2.30	$ 24.96	1,104	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.40	$ 25.33	1,137
Optical	$ 0.08	$ 78.39	13	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.09	$ 79.57	13
Lab and X-Ray	$ 0.88	$ 25.81	410	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.92	$ 26.20	422
Transportation	$ 1.68	$ 159.80	126	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.76	$ 162.21	130
Subtotal (Medical)	*$ 389.71*	*N/A*	*41,653*	*1.6%*	*0.4%*	*1.2%*	*82.3%*	*82.3%*	*0.0%*	*-12.6%*	*0.0%*	*-12.6%*	*$ 652.11*	*N/A*	*39,971*
CC4C LHD Payments	$ 4.19	$ 4.55	11,043	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.19	$ 4.55	11,043
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ 1.98	$ 2.46	9,682	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.98	$ 2.46	9,682
Subtotal (LHD/Medical Home Payments)	*$ 6.17*	*N/A*	*20,725*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.17*	*N/A*	*20,725*
Total (Medical + LHD/Medical Home)	**$ 395.87**	**N/A**	**62,378**	**1.6%**	**0.4%**	**1.2%**	**81.1%**	**81.1%**	**0.0%**	**-12.5%**	**0.0%**	**-12.5%**	**$ 658.27**	**N/A**	**60,695**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 658.27**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.92%)	$ 28.28
Care Management (3.12%)	$ 22.51
Profit/Underwriting Gain (1.75%)	$ 12.63
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 721.69**
Premium Taxes (2.01%)	$ 14.80
Total Capitation Rate:	**$ 736.49**

Exhibit 96

Region:	**Region 5**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**2,183,299**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 5.20	$ 1,165.36	54	1.5%	0.5%	1.0%	130.3%	130.3%	0.0%	-15.3%	0.0%	-15.3%	$ 10.60	$ 2,723.82	47
Inpatient — BH	$ 0.82	$ 660.11	15	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.86	$ 670.06	15
Outpatient Hospital	$ 7.63	$ 281.40	325	1.0%	0.5%	0.5%	26.9%	26.9%	0.0%	-7.8%	0.0%	-7.8%	$ 9.20	$ 362.62	304
Emergency Room	$ 13.39	$ 266.59	603	3.0%	0.5%	2.5%	27.3%	27.3%	0.0%	-7.8%	0.0%	-7.8%	$ 17.18	$ 344.59	598
Physician	$ 20.89	$ 75.62	3,315	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.1%	0.0%	-7.1%	$ 20.59	$ 76.76	3,219
FQHC/RHC	$ 1.36	$ 93.95	174	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.33	$ 95.37	168
Other Clinic	$ 5.67	$ 101.76	668	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.55	$ 103.29	644
Other Practitioner	$ 0.10	$ 83.85	14	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.10	$ 85.11	13
Therapies	$ 6.24	$ 104.99	714	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 6.11	$ 106.58	688
Prescribed Drugs	$ 36.30	$ 92.19	4,725	3.5%	3.0%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 39.25	$ 100.74	4,676
Other BH Services	$ 5.84	$ 77.45	905	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 6.46	$ 79.80	971
LTSS Services	$ 0.12	$ 7.41	199	-0.7%	0.5%	-1.2%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.12	$ 7.72	191
Durable Medical Equipment	$ 1.67	$ 2.52	7,917	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.61	$ 2.56	7,519
Limited Dental Services	$ 0.46	$ 24.79	222	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.48	$ 25.17	228
Optical	$ 1.35	$ 81.66	199	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.41	$ 82.89	204
Lab and X-Ray	$ 1.28	$ 20.86	737	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.34	$ 21.17	757
Transportation	$ 0.46	$ 96.87	57	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.48	$ 98.33	59
Subtotal (Medical)	*$ 108.79*	*N/A*	*20,843*	*2.6%*	*1.4%*	*1.2%*	*11.2%*	*11.2%*	*0.0%*	*-6.1%*	*0.0%*	*-6.1%*	*$ 122.66*	*N/A*	*20,303*
CC4C LHD Payments	$ 0.98	$ 4.52	2,597	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.98	$ 4.52	2,597
OBCM LHD Payments	$ 0.58	$ 4.92	1,421	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.58	$ 4.92	1,421
Medical Home Payments	$ 2.28	$ 2.45	11,177	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.28	$ 2.45	11,177
Subtotal (LHD/Medical Home Payments)	*$ 3.84*	*N/A*	*15,195*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.84*	*N/A*	*15,195*
Total (Medical + LHD/Medical Home)	**$ 112.63**	**N/A**	**36,038**	**2.5%**	**1.3%**	**1.2%**	**10.9%**	**10.9%**	**0.0%**	**-5.9%**	**0.0%**	**-5.9%**	**$ 126.50**	**N/A**	**35,498**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 126.50**
Non-Benefit Expense PMPM/Payment:	
General Administration (7.44%)	$ 10.72
Care Management (3.00%)	$ 4.33
Profit/Underwriting Gain (1.75%)	$ 2.52
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 144.07**
Premium Taxes (2.01%)	$ 2.96
Total Capitation Rate:	**$ 147.03**

Exhibit 97

Region:	**Region 5**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**540,587**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 25.56	$ 1,056.63	290	3.5%	0.5%	3.0%	151.0%	151.0%	0.0%	-12.2%	0.0%	-12.2%	$ 62.50	$ 2,692.07	279
Inpatient — BH	$ 2.18	$ 720.15	36	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.39	$ 731.00	39
Outpatient Hospital	$ 30.10	$ 344.33	1,049	1.0%	0.5%	0.5%	34.8%	34.8%	0.0%	-15.9%	0.0%	-15.9%	$ 35.15	$ 471.05	895
Emergency Room	$ 45.78	$ 428.39	1,282	3.0%	0.5%	2.5%	30.2%	30.2%	0.0%	-12.2%	0.0%	-12.2%	$ 57.24	$ 566.38	1,213
Physician	$ 53.98	$ 116.47	5,562	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 52.51	$ 118.22	5,330
FQHC/RHC	$ 3.56	$ 98.24	434	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 3.46	$ 99.72	416
Other Clinic	$ 6.99	$ 229.11	366	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 6.80	$ 232.56	351
Other Practitioner	$ 0.34	$ 74.06	55	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.33	$ 75.17	53
Therapies	$ 0.03	$ 56.72	6	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.03	$ 57.58	6
Prescribed Drugs	$ 100.69	$ 84.52	14,295	5.8%	5.5%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 115.77	$ 99.25	13,997
Other BH Services	$ 8.03	$ 74.65	1,291	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 8.82	$ 76.91	1,377
LTSS Services	$ 2.09	$ 5.06	4,942	-0.7%	0.5%	-1.2%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.04	$ 5.19	4,717
Durable Medical Equipment	$ 5.23	$ 2.45	25,588	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 5.01	$ 2.49	24,146
Limited Dental Services	$ 0.00	$ 15.40	0	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ 15.63	-
Optical	$ 0.55	$ 64.90	101	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.57	$ 65.88	103
Lab and X-Ray	$ 14.42	$ 27.68	6,252	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 14.95	$ 28.10	6,383
Transportation	$ 1.79	$ 90.32	238	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.86	$ 91.68	243
Subtotal (Medical)	*$ 301.32*	*N/A*	*61,789*	*3.5%*	*2.2%*	*1.2%*	*20.6%*	*20.6%*	*0.0%*	*-8.2%*	*0.0%*	*-8.2%*	*$ 369.42*	*N/A*	*59,547*
CC4C LHD Payments	$ 0.00	$ 4.29	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.29	-
OBCM LHD Payments	$ 3.44	$ 4.91	8,406	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.44	$ 4.91	8,406
Medical Home Payments	$ 1.82	$ 2.41	9,096	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.82	$ 2.41	9,096
Subtotal (LHD/Medical Home Payments)	*$ 5.26*	*N/A*	*17,502*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.26*	*N/A*	*17,502*
Total (Medical + LHD/Medical Home)	**$ 306.58**	**N/A**	**79,290**	**3.4%**	**2.2%**	**1.2%**	**20.3%**	**20.3%**	**0.0%**	**-8.1%**	**0.0%**	**-8.1%**	**$ 374.69**	**N/A**	**77,049**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 374.69**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.57%)	$ 18.92
Care Management (3.10%)	$ 12.81
Profit/Underwriting Gain (1.75%)	$ 7.24
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 413.65**
Premium Taxes (2.01%)	$ 8.48
Total Capitation Rate:	**$ 422.14**

Exhibit 98

Region:	**Region 5**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**8,871**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,193.63	$ 728.98	36,110	0.5%	0.5%	0.0%	177.4%	177.4%	0.0%	-1.1%	0.0%	-1.1%	$ 6,108.10	$ 2,052.92	35,704
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 364.84	$ 123.36	35,489	1.0%	0.5%	0.5%	38.4%	38.4%	0.0%	-15.0%	0.0%	-15.0%	$ 442.21	$ 173.31	30,618
Emergency Room	$ 494.61	$ 359.72	16,500	3.0%	0.5%	2.5%	32.0%	32.0%	0.0%	-11.3%	0.0%	-11.3%	$ 633.12	$ 481.96	15,764
Physician	$ 1,842.99	$ 244.06	90,616	2.0%	0.5%	1.5%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,971.67	$ 249.75	94,734
FQHC/RHC	$ 48.15	$ 147.88	3,908	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 51.10	$ 150.11	4,085
Other Clinic	$ 121.52	$ 130.54	11,170	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 128.95	$ 132.51	11,678
Other Practitioner	$ 0.00	$ 39.70	0	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 40.29	-
Therapies	$ 0.03	$ 50.54	8	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.04	$ 51.30	8
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.01	$ 53.51	3	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.02	$ 55.14	4
LTSS Services	$ 2.79	$ 4.71	7,100	-0.7%	0.5%	-1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.73	$ 4.78	6,838
Durable Medical Equipment	$ 4.24	$ 48.05	1,060	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.44	$ 48.77	1,092
Limited Dental Services	$ 0.00	$ 24.88	2	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 25.26	2
Optical	$ 0.01	$ 74.25	2	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 75.37	2
Lab and X-Ray	$ 53.28	$ 27.25	23,468	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 55.72	$ 27.66	24,175
Transportation	$ 19.34	$ 110.73	2,095	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 20.28	$ 112.40	2,165
Subtotal (Medical)	*$ 5,145.45*	*N/A*	*227,532*	*1.4%*	*0.5%*	*0.9%*	*79.9%*	*79.9%*	*0.0%*	*-2.4%*	*0.0%*	*-2.4%*	*$ 9,418.38*	*N/A*	*226,870*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 5,145.45**	**N/A**	**227,532**	**1.4%**	**0.5%**	**0.9%**	**79.9%**	**79.9%**	**0.0%**	**-2.4%**	**0.0%**	**-2.4%**	**$ 9,418.38**	**N/A**	**226,870**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 9,418.38**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.73%)	$ 72.80
Care Management (3.22%)	$ 322.02
Profit/Underwriting Gain (1.75%)	$ 174.79
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 9,987.98**
Premium Taxes (2.01%)	$ 204.88
Total Capitation Rate:	**$ 10,192.86**

14.6 Region 6 Capitation Rate Development Exhibits

Exhibit 99

Region:	**Region 6**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**267,136**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 126.88	$ 984.78	1,546	0.5%	0.5%	0.0%	80.4%	80.4%	0.0%	-15.8%	0.0%	-15.8%	$ 195.55	$ 1,803.15	1,301
Inpatient — BH	$ 8.06	$ 739.88	131	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 8.12	$ 751.03	130
Outpatient Hospital	$ 73.69	$ 555.98	1,590	2.5%	0.5%	2.0%	20.9%	20.9%	0.0%	-23.3%	0.0%	-23.3%	$ 73.59	$ 682.56	1,294
Emergency Room	$ 60.23	$ 502.10	1,439	3.0%	0.5%	2.5%	22.8%	22.8%	0.0%	-19.6%	0.0%	-19.6%	$ 64.98	$ 625.74	1,246
Physician	$ 102.52	$ 144.05	8,540	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.6%	0.0%	-8.6%	$ 99.44	$ 146.22	8,161
FQHC/RHC	$ 7.59	$ 105.38	864	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 7.38	$ 106.97	828
Other Clinic	$ 13.59	$ 479.94	340	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 13.22	$ 487.18	326
Other Practitioner	$ 0.92	$ 73.79	150	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.90	$ 74.90	144
Therapies	$ 4.90	$ 114.78	512	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 4.76	$ 116.51	491
Prescribed Drugs	$ 361.87	$ 137.61	31,556	6.5%	6.0%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 426.63	$ 163.89	31,237
Other BH Services	$ 11.97	$ 58.63	2,450	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 12.78	$ 60.41	2,539
LTSS Services	$ 63.78	$ 5.18	147,724	0.0%	0.5%	-0.5%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 68.43	$ 5.91	138,872
Durable Medical Equipment	$ 35.69	$ 2.88	148,872	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 30.95	$ 2.92	127,193
Limited Dental Services	$ 0.03	$ 24.79	17	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.04	$ 25.17	17
Optical	$ 1.34	$ 70.15	229	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 1.37	$ 71.21	231
Lab and X-Ray	$ 9.43	$ 21.46	5,270	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.63	$ 21.79	5,305
Transportation	$ 9.36	$ 60.14	1,867	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.39	$ 61.04	1,846
Subtotal (Medical)	*$ 891.83*	*N/A*	*353,097*	*3.6%*	*2.8%*	*0.8%*	*14.4%*	*14.4%*	*0.0%*	*-9.4%*	*0.0%*	*-9.4%*	*$ 1,027.17*	*N/A*	*321,160*
CC4C LHD Payments	$ 0.00	$ 4.53	12	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	12
OBCM LHD Payments	$ 0.74	$ 4.93	1,797	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.74	$ 4.93	1,797
Medical Home Payments	$ 4.43	$ 4.79	11,106	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.43	$ 4.79	11,106
Subtotal (LHD/Medical Home Payments)	*$ 5.17*	*N/A*	*12,914*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.17*	*N/A*	*12,914*
Total (Medical + LHD/Medical Home)	**$ 897.01**	**N/A**	**366,012**	**3.5%**	**2.8%**	**0.8%**	**14.4%**	**14.4%**	**0.0%**	**-9.4%**	**0.0%**	**-9.4%**	**$ 1,032.35**	**N/A**	**334,074**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,032.35**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.88%)	$ 44.08
Care Management (3.43%)	$ 38.92
Profit/Underwriting Gain (1.75%)	$ 19.87
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,135.21**
Premium Taxes (2.01%)	$ 23.29
Total Capitation Rate:	**$ 1,158.50**

Exhibit 100

Region:	**Region 6**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**108,992**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 186.59	$ 563.87	3,971	1.5%	0.5%	1.0%	80.6%	80.6%	0.0%	-15.0%	0.0%	-15.0%	$ 299.59	$ 1,033.95	3,477
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 9.46	$ 177.29	640	2.5%	0.5%	2.0%	14.7%	14.7%	0.0%	-3.8%	0.0%	-3.8%	$ 11.25	$ 206.49	654
Emergency Room	$ 23.56	$ 250.58	1,128	3.0%	0.5%	2.5%	19.7%	19.7%	0.0%	-7.5%	0.0%	-7.5%	$ 28.51	$ 304.52	1,123
Physician	$ 85.63	$ 99.31	10,346	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.6%	0.0%	-6.6%	$ 84.83	$ 100.81	10,098
FQHC/RHC	$ 5.93	$ 104.62	680	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 5.82	$ 106.20	658
Other Clinic	$ 39.15	$ 107.87	4,355	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 38.43	$ 109.49	4,211
Other Practitioner	$ 0.02	$ 45.25	5	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.02	$ 45.93	5
Therapies	$ 0.93	$ 106.30	105	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.91	$ 107.90	101
Prescribed Drugs	$ 14.97	$ 51.97	3,457	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 14.72	$ 51.97	3,398
Other BH Services	$ 0.09	$ 18.16	62	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.10	$ 18.71	65
LTSS Services	$ 0.53	$ 61.61	104	0.0%	0.5%	-0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.53	$ 62.54	102
Durable Medical Equipment	$ 2.56	$ 5.93	5,185	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 2.44	$ 6.02	4,868
Limited Dental Services	$ 2.54	$ 25.00	1,220	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.62	$ 25.38	1,238
Optical	$ 0.06	$ 82.70	9	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.07	$ 83.95	9
Lab and X-Ray	$ 0.57	$ 19.91	344	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.59	$ 20.21	349
Transportation	$ 2.45	$ 121.09	243	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.48	$ 122.91	242
Subtotal (Medical)	*$ 375.04*	*N/A*	*31,854*	*1.7%*	*0.5%*	*1.2%*	*41.5%*	*41.5%*	*0.0%*	*-11.8%*	*0.0%*	*-11.8%*	*$ 492.90*	*N/A*	*30,599*
CC4C LHD Payments	$ 4.18	$ 4.55	11,034	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.18	$ 4.55	11,034
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ 1.98	$ 2.45	9,713	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.98	$ 2.45	9,713
Subtotal (LHD/Medical Home Payments)	*$ 6.17*	*N/A*	*20,746*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.17*	*N/A*	*20,746*
Total (Medical + LHD/Medical Home)	**$ 381.21**	**N/A**	**52,601**	**1.7%**	**0.5%**	**1.2%**	**40.9%**	**40.9%**	**0.0%**	**-11.6%**	**0.0%**	**-11.6%**	**$ 499.06**	**N/A**	**51,345**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 499.06**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.47%)	$ 24.69
Care Management (3.41%)	$ 18.82
Profit/Underwriting Gain (1.75%)	$ 9.66
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 552.23**
Premium Taxes (2.01%)	$ 11.33
Total Capitation Rate:	**$ 563.56**

Exhibit 101

Region:	**Region 6**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**1,733,723**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 4.06	$ 1,250.47	39	1.5%	0.5%	1.0%	62.1%	62.1%	0.0%	-15.3%	0.0%	-15.3%	$ 5.83	$ 2,056.96	34
Inpatient — BH	$ 0.79	$ 588.74	16	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.83	$ 597.62	17
Outpatient Hospital	$ 7.42	$ 344.68	258	2.5%	0.5%	2.0%	20.8%	20.8%	0.0%	-4.1%	0.0%	-4.1%	$ 9.27	$ 422.64	263
Emergency Room	$ 13.78	$ 283.12	584	3.0%	0.5%	2.5%	21.9%	21.9%	0.0%	-7.8%	0.0%	-7.8%	$ 16.92	$ 350.20	580
Physician	$ 17.85	$ 71.05	3,015	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.9%	0.0%	-6.9%	$ 17.64	$ 72.12	2,935
FQHC/RHC	$ 1.93	$ 101.69	228	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.89	$ 103.22	220
Other Clinic	$ 6.11	$ 106.65	688	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.98	$ 108.26	663
Other Practitioner	$ 0.10	$ 73.50	17	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.10	$ 74.61	16
Therapies	$ 3.39	$ 115.26	353	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 3.31	$ 117.00	340
Prescribed Drugs	$ 36.95	$ 99.29	4,465	4.0%	3.5%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 40.53	$ 110.09	4,418
Other BH Services	$ 4.52	$ 74.47	728	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 4.85	$ 76.73	759
LTSS Services	$ 0.17	$ 10.81	193	0.0%	0.5%	-0.5%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.18	$ 11.26	190
Durable Medical Equipment	$ 1.66	$ 2.70	7,383	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.58	$ 2.74	6,909
Limited Dental Services	$ 0.52	$ 24.80	252	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.53	$ 25.18	255
Optical	$ 1.35	$ 83.40	194	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.39	$ 84.66	196
Lab and X-Ray	$ 1.20	$ 18.64	775	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.24	$ 18.92	784
Transportation	$ 0.51	$ 78.21	78	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.51	$ 79.38	77
Subtotal (Medical)	*$ 102.33*	*N/A*	*19,266*	*2.8%*	*1.6%*	*1.2%*	*6.8%*	*6.8%*	*0.0%*	*-5.3%*	*0.0%*	*-5.3%*	*$ 112.58*	*N/A*	*18,656*
CC4C LHD Payments	$ 0.99	$ 4.52	2,636	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.99	$ 4.52	2,636
OBCM LHD Payments	$ 0.57	$ 4.92	1,392	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.57	$ 4.92	1,392
Medical Home Payments	$ 2.29	$ 2.45	11,236	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.29	$ 2.45	11,236
Subtotal (LHD/Medical Home Payments)	*$ 3.86*	*N/A*	*15,264*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.86*	*N/A*	*15,264*
Total (Medical + LHD/Medical Home)	**$ 106.19**	**N/A**	**34,530**	**2.7%**	**1.5%**	**1.2%**	**6.6%**	**6.6%**	**0.0%**	**-5.2%**	**0.0%**	**-5.2%**	**$ 116.44**	**N/A**	**33,920**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 116.44**
Non-Benefit Expense PMPM/Payment:	
General Administration (8.05%)	$ 10.78
Care Management (3.28%)	$ 4.39
Profit/Underwriting Gain (1.75%)	$ 2.34
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 133.95**
Premium Taxes (2.01%)	$ 2.75
Total Capitation Rate:	**$ 136.70**

Exhibit 102

Region:	**Region 6**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**407,775**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 23.19	$ 1,176.40	237	3.5%	0.5%	3.0%	81.4%	81.4%	0.0%	-12.2%	0.0%	-12.2%	$ 40.98	$ 2,166.63	227
Inpatient — BH	$ 2.38	$ 809.18	35	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.62	$ 821.37	38
Outpatient Hospital	$ 27.05	$ 393.56	825	2.5%	0.5%	2.0%	29.3%	29.3%	0.0%	-12.2%	0.0%	-12.2%	$ 33.09	$ 516.49	769
Emergency Room	$ 47.01	$ 414.42	1,361	3.0%	0.5%	2.5%	24.3%	24.3%	0.0%	-12.2%	0.0%	-12.2%	$ 56.09	$ 522.91	1,287
Physician	$ 42.29	$ 113.15	4,485	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.6%	0.0%	-7.6%	$ 41.45	$ 114.85	4,331
FQHC/RHC	$ 4.29	$ 101.10	509	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 4.17	$ 102.63	487
Other Clinic	$ 8.30	$ 190.48	523	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 8.07	$ 193.35	501
Other Practitioner	$ 0.40	$ 70.27	69	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.39	$ 71.33	66
Therapies	$ 0.01	$ 49.06	2	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.01	$ 49.80	2
Prescribed Drugs	$ 93.13	$ 89.35	12,508	6.3%	6.0%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 108.61	$ 106.41	12,248
Other BH Services	$ 6.92	$ 67.76	1,225	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 7.38	$ 69.81	1,268
LTSS Services	$ 1.44	$ 5.45	3,177	0.0%	0.5%	-0.5%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.44	$ 5.58	3,102
Durable Medical Equipment	$ 5.03	$ 2.27	26,589	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 4.75	$ 2.30	24,721
Limited Dental Services	$ 0.00	$ 15.11	0	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ 15.34	-
Optical	$ 0.37	$ 70.19	63	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.38	$ 71.25	64
Lab and X-Ray	$ 12.33	$ 25.34	5,840	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 12.59	$ 25.72	5,874
Transportation	$ 1.76	$ 75.48	280	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.77	$ 76.61	277
Subtotal (Medical)	*$ 275.91*	*N/A*	*57,728*	*3.8%*	*2.4%*	*1.4%*	*13.6%*	*13.6%*	*0.0%*	*-7.5%*	*0.0%*	*-7.5%*	*$ 323.78*	*N/A*	*55,261*
CC4C LHD Payments	$ 0.00	$ 4.30	1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.30	1
OBCM LHD Payments	$ 3.51	$ 4.91	8,579	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.51	$ 4.91	8,579
Medical Home Payments	$ 1.83	$ 2.39	9,189	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.83	$ 2.39	9,189
Subtotal (LHD/Medical Home Payments)	*$ 5.34*	*N/A*	*17,769*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.34*	*N/A*	*17,769*
Total (Medical + LHD/Medical Home)	**$ 281.25**	**N/A**	**75,496**	**3.7%**	**2.3%**	**1.3%**	**13.4%**	**13.4%**	**0.0%**	**-7.4%**	**0.0%**	**-7.4%**	**$ 329.12**	**N/A**	**73,030**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 329.12**
Non-Benefit Expense PMPM/Payment:	
General Administration (5.05%)	$ 18.51
Care Management (3.39%)	$ 12.41
Profit/Underwriting Gain (1.75%)	$ 6.41
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 366.46**
Premium Taxes (2.01%)	$ 7.52
Total Capitation Rate:	**$ 373.97**

Exhibit 103

Region:	**Region 6**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**7,245**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,253.84	$ 796.85	33,941	0.5%	0.5%	0.0%	119.1%	119.1%	0.0%	-1.1%	0.0%	-1.1%	$ 4,955.47	$ 1,771.95	33,559
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 251.05	$ 142.22	21,183	2.5%	0.5%	2.0%	34.5%	34.5%	0.0%	-11.3%	0.0%	-11.3%	$ 322.65	$ 194.13	19,944
Emergency Room	$ 434.28	$ 300.99	17,314	3.0%	0.5%	2.5%	24.7%	24.7%	0.0%	-11.3%	0.0%	-11.3%	$ 525.27	$ 381.05	16,542
Physician	$ 1,702.46	$ 242.44	84,265	2.0%	0.5%	1.5%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,821.33	$ 248.10	88,095
FQHC/RHC	$ 135.92	$ 157.13	10,380	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 144.24	$ 159.49	10,852
Other Clinic	$ 271.40	$ 130.77	24,904	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 288.01	$ 132.74	26,036
Other Practitioner	$ 0.01	$ 69.47	1	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 70.51	1
Therapies	$ -	$ -	-	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.00	$ 93.72	0	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 96.56	-
LTSS Services	$ 4.00	$ 13.23	3,623	0.0%	0.5%	-0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.00	$ 13.43	3,570
Durable Medical Equipment	$ 1.48	$ 66.69	267	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.53	$ 67.69	271
Limited Dental Services	$ 0.01	$ 24.79	3	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 25.16	3
Optical	$ 0.02	$ 90.87	3	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 92.24	3
Lab and X-Ray	$ 52.78	$ 25.94	24,413	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 54.38	$ 26.33	24,779
Transportation	$ 21.22	$ 112.14	2,270	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 21.47	$ 113.83	2,263
Subtotal (Medical)	*$ 5,128.46*	*N/A*	*222,569*	*1.4%*	*0.5%*	*0.9%*	*55.1%*	*55.1%*	*0.0%*	*-2.0%*	*0.0%*	*-2.0%*	*$ 8,138.38*	*N/A*	*225,919*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 5,128.46**	**N/A**	**222,569**	**1.4%**	**0.5%**	**0.9%**	**55.1%**	**55.1%**	**0.0%**	**-2.0%**	**0.0%**	**-2.0%**	**$ 8,138.38**	**N/A**	**225,919**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 8,138.38**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.80%)	$ 69.36
Care Management (3.54%)	$ 306.83
Profit/Underwriting Gain (1.75%)	$ 151.66
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 8,666.24**
Premium Taxes (2.01%)	$ 177.76
Total Capitation Rate:	**$ 8,844.00**

15 OTHER CONSIDERATIONS

The following section represents other rating considerations not reflected in the Section 14 capitation rate summaries.

15.1 Member Choice

15.1.1 Tribal Members

DHHS, in consultation with North Carolina's only federally recognized tribe, determined that members of federally-recognized tribes should be exempt from mandatory enrollment in managed care and have the choice between Medicaid FFS and enrolling in a PHP or tribal option, if one is available. Members of federally recognized tribes will default to Medicaid FFS unless a tribal option is available.

Mercer has identified the portion of the Standard Plan population that has accessed services at one of the tribal healthcare facilities. Using this data as a potential proxy for the size and PMPM of the tribal population, Mercer found that approximately 2.3% of the Standard Plan population eligible in Region 1 utilized services at a tribal provider, with limited tribal provider utilization for beneficiaries eligible in other regions. Mercer also noted that the population that accessed services at a tribal provider exhibited a higher than average PMPM cost. If all claims and MMs associated with tribal providers were excluded from the base experience, the average base PMPM in Region 1 would decline by approximately 1.6%. Mercer is working with DHHS to develop a more refined impact analysis to inform an adjustment for final rates. Note that any adjustment included in the final rates will need to also account for the number of beneficiaries anticipated to opt in to managed care.

15.1.2 BH I/DD Tailored Plan

Per S.L. 2018-48[21], the BH I/DD Tailored Plan for individuals with high BH needs will launch one year after the implementation of managed care. The majority of Medicaid and NC Health Choice enrollees, including adults and children with lower BH needs, will receive services through the Standard Plan upon launch of managed care. Individuals with higher BH needs that meet certain eligibility criteria may participate in the BH I/DD Tailored Plans. Beneficiaries passively enrolled in the future BH I/DD Tailored Plan may choose to opt out of the BH I/DD Tailored Plan, and instead receive services under the Standard Plan. Additionally, Standard Plan beneficiaries who exhibit a need for unique BH I/DD Tailored Plan services may also opt out of the Standard Plan and enroll in FFS and LME/MCOs (before BH I/DD Tailored Plans go live). Mercer will work with DHHS to further refine adjustments related to the delineation of Standard Plan and BH I/DD Tailored Plan populations as part of the final rates. Further information about this population and potential member choice can be found in Appendix F.

15.2 Performance Withholds

DHHS has proposed a performance-based incentive system financed through a withhold as part of the program design. Per S.L. 2018-49, performance withholds will not apply to the first 18 months of managed care implementation. The long-term goal of the incentives would be to ensure that PHPs deliver value around the various DHHS priorities and ultimately improve quality of care provided to the Medicaid population in North Carolina.

When the withhold program is enacted, DHHS and its actuaries will ensure the payment implications of withholds are designed to comply with federal regulations. Any withhold must be reviewed by the Actuary to determine that the withhold should be "reasonably achievable" and the capitation rate including the withhold must be certified as actuarially sound. The methodology to perform the actuarial soundness assessment will be further refined as the actual withhold percentages are defined and the metrics finalized.

[21] SL 2018-48/House Bill 403 Medicaid and Behavioral Health Modifications. https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H403v6.pdf

15.3 Risk Adjustment

DHHS will implement a prospective risk adjustment process as required by the managed care legislation (Section 5.5(a) of Session Law 2015-245). Health-based risk adjustment has been documented in multiple Society of Actuaries (SOA) studies and other publications as a significantly better predictor of healthcare costs than traditional age/gender rating. A risk adjusted payment process differentiates capitation payments to PHPs based on measured risk differences in their enrolled populations. Appropriately paying PHPs for their enrolled population, enables the overall managed care program to operate effectively and efficiently and discourages PHPs to avoid enrolling higher risk individuals. Since risk adjustment is reliant on detailed claims or encounter information, the PHPs have a strong incentive to submit complete and accurate encounters. Finally, risk adjustment can simplify the rate structure by reducing the number of rate cells needed from a systems and payment perspective.

15.3.1 Risk Adjustment Model

While many models exist, DHHS is proposing to use the Chronic Illness Disability Payment System plus Pharmacy (CDPS+Rx) model to adjust the capitation payments beginning at the start of Contract Year 1 to reflect the underlying health risk of the members enrolled in each PHP. The CDPS+Rx model is a disease classification system developed by researchers from the University of California, San Diego (UCSD). The model uses medical and pharmacy data to assign risk markers that correlate to predictive, high cost disease conditions. Along with being built on a Medicaid-specific framework, the CDPS+Rx model is the most prevalent model used within Medicaid, approved by CMS, has limited licensing fees and maintains a high level of transparency regarding its model logic and assumptions. Many commercially available models that were developed using commercial healthcare populations and services are not as transparent and are generally more costly to implement. While the CDPS+Rx model inherently addresses some unique aspects of Medicaid members, additional information may be incorporated into the model where appropriate.

Medicaid Rx will also be run in conjunction with CDPS+Rx as a means to evaluate the impact of encounter data submitted by the PHPs. Medicaid Rx was also developed by UCSD and is based on a similar framework and common principles as CDPS+Rx. Since pharmacy claims/encounters are typically more straightforward to collect, Medicaid Rx results can be used as a benchmark against the CDPS+Rx results where full medical claims/encounters are being utilized. Medicaid Rx uses only pharmacy information within the risk assessment process and has been used by states where full diagnostic encounters were not reliable. Both model results will be actively evaluated and available in the event the results need to be adjusted based on the adequacy and validity of PHP-reported encounters.

Both models will be calibrated using State-specific FFS data upon implementation. While the model developers often utilize an external (“national”) data set for producing relative cost categories, the use of State-specific data best reflects North Carolina’s populations, provider practice patterns and covered benefits. FFS data is readily available and of sufficient quality to use for the calibration process. Since the risk adjustment will be applied prospectively to capitation payments, the model weights will be calibrated on a prospective basis. The risk adjustment cost weights may be updated periodically if material changes are made to covered benefits, more relevant data becomes available, or at the discretion of DHHS.

Risk adjustment considerations will be specifically evaluated for the BH I/DD Tailored Plans as well as the LTSS populations to assess whether the current models selected for implementation of the standard plans are suitable for risk adjustment of those populations. Alternatively, other models or calibration will be considered for these specialized populations.

15.3.2 Data Collection

The risk adjustment process utilizes beneficiary eligibility, demographic, diagnosis and pharmacy claims data. Risk adjustment will be implemented at the start of the program and will initially utilize DHHS FFS data. PHP-reported encounter data will also be collected and validated as it becomes available. After the data elements have been collected, they must be validated for completeness and accuracy. Risk adjustment data will be evaluated for consistency of reporting in terms of volume and completeness of critical fields (i.e., diagnosis codes). During the initial months after implementation, DHHS will review encounter data as often as monthly to identify and address issues with the completeness of the data. This validation is crucial for general program monitoring as well as rate-setting and risk adjustment.

For risk adjustment analysis, data will be extracted and analyzed on a semi-annual basis for development of beneficiary risk scores. The data extraction dates will be clearly communicated to the PHPs to ensure they have a chance to submit/re-submit any encounters to be considered in the risk adjustment process. While the PHPs are expected to constantly be submitting encounters to DHHS in a timely manner, clearly communicating cut-off dates when the data are utilized for risk adjustment analysis will allow the PHPs to plan resubmissions, adjustments and other transactions to ensure they are included in the risk adjustment process.

The presence of a single diagnosis, regardless of position on the claim, or a single national drug code is sufficient to support a classification into a CDPS+Rx diagnostic category. Consistent with general risk adjustment practices, laboratory and diagnostic radiology claims will be excluded from the disease classification process. These services often do not indicate the presence of a disease condition and may produce "false positives" within the results. While only managed care covered benefits will be included in the cost weight development, FFS claims will be used for disease condition flagging where available and appropriate.

15.3.3 Calculation of Risk Scores

Beneficiary Risk Score Development

Using the models and data described above, a risk assessment will be performed for each scored beneficiary. Scored beneficiaries are defined as any individual with at least six months of eligibility (non-continuous) during the 12-month study period. The six month scoring criteria provides sufficient time to accumulate beneficiary's applicable health diagnosis and pharmacy usage.

The risk assessment is performed by assigning any applicable disease condition categories to each scored beneficiary. Once the disease condition flagging is complete, each beneficiary's acuity level (i.e., beneficiary risk score) will be determined by adding the relative cost of all their flagged conditions and demographic category. This process of calculating individual beneficiary risk scores is anticipated to occur every six months.

PHP Enrollment

Once the scored and unscored beneficiaries are given a risk score, actual PHP enrollment is collected to evaluate the average risk scores for each PHP. Since the goal of risk adjustment is to project payments during the contract period, an enrollment snapshot that represents PHP membership will be applied as close to the contract period start date as possible. For example, for July risk adjustment, an enrollment snapshot as of June based on beneficiary selection and assignment is expected to be utilized.

The enrollment snapshot is cross-referenced to the individual beneficiary risk score file to develop a raw average risk score for each PHP. DHHS is considering updating the enrollment snapshot each month for the first six months of program implementation in each region to account for the higher member movement that may occur. At that point it will be evaluated if moving to quarterly updates is appropriate and eventually moving to semi-annual updates when deemed appropriate. Similarly, as populations are phased into managed care, the PHP enrollment snapshots may be updated monthly for the first six months of managed care.

Budget Neutral Risk Scores

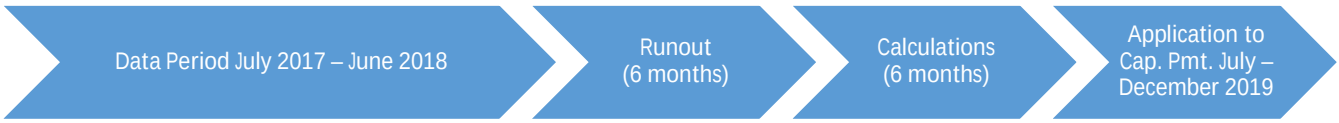
The average risk scores will be calculated for each rate cell for all beneficiaries who are enrolled in each PHP. Since the data used to produce the risk adjustment cost weights and the 12 month application are from different time periods, distortions in the model results occur due to changes in practice patterns and coding specificity. Therefore, the initial results are considered to be "raw" risk scores. The distortions described previously may cause the raw risk scores to be inappropriately inflated or deflated, depending on the populations and models being applied. To address this issue, a budget neutrality adjustment is required.

CMS requires that risk adjustment be applied in a budget neutral manner. This calculation is done by dividing each PHP's raw risk score by the total PHP raw risk score for each rate cell. This adjustment will result in the weighted average of the budget neutral risk scores equaling 1.0. The final payments made to the PHP are determined by multiplying a base capitation rate by each PHP's budget neutral risk score and by its enrollment for each rate cell.

15.3.4 Frequency of Updates

The risk adjustment study period (used to set risk scores by beneficiary) will be updated every six months corresponding with the first and second half of each contract year. For each six month update cycle, a full year of encounter or claims data will be pulled for a time period beginning two years before the beginning of the cycle. This timing allows for six months of runout and six months of calculation time. This semi-annual process will also allow for 6 months of overlapping data with each update. The illustration below shows a sample timeline.

Figure 3: Risk Adjustment Analysis



15.3.5 Final Capitation Rates

The final budget neutral risk scores for each PHP will be applied to the base capitation rates for the Medicaid and NC Health Choice populations, thus producing the risk adjusted rates for each rate cell. The resulting capitation rates will reflect the relative risk between PHPs and rate cells. Risk adjustment is anticipated to be applied to all managed care populations, but will not be applied to the Maternity Event payments and newborn rate cells. Maternity Event payments are not typically risk adjusted because the delivery payment is already a form of risk adjustment. Newborns are also typically excluded from risk adjustment because it is challenging due to the lack of historical data at the beneficiary level. DHHS is utilizing a separate rate cell for newborns to account for their higher than average costs.

The resulting risk adjustment scores are projections of relative risk, and actual relative risk will likely differ from that which was projected. The PHPs are encouraged to review the results with their own data. DHHS will use the risk adjustment scores to adjust actuarially sound base capitation rates as a means of matching PHP payments to their relative risks. Use of the risk adjustment results for any purpose beyond that stated may not be appropriate. The risk adjustment model produces precise adjustment factors that are applied to the 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. Although health-based risk adjustment is not a perfect system that predicts all variation in beneficiary and PHP

costs, published results have shown that using health status as a predictor of costs is a significant improvement over age/gender rating.

When developing a risk adjustment payment approach, there are many decision points and assumptions that need to be determined. The methodology described in this section is based on program goals and objectives, multiple discussions between DHHS and its actuaries and best/common practice of risk adjustment use in other state Medicaid programs. Further, DHHS made decisions based on the specific implementation schedule and approach to managed care within North Carolina's Medicaid program. For example, the selection of both a diagnosis and pharmacy-based models provides DHHS with flexibility and options in light of encounter data uncertainty at the onset of the program. As the program matures, certain assumptions may be re-evaluated to enable the risk adjustment methodology to best achieve DHHS' objectives.

15.4 Medical Loss Ratio

The CMS Final Rule outlines requirements for rate-setting and financial reporting related to the 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 PHP 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. Lastly, the Final Rule allows, but does not require, states to implement a remittance process for PHPs which do not meet state-established minimum MLR thresholds.

15.4.1 Implied MLR Calculation based on Capitation Rate Development

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 PHP contract. 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 State. Mercer calculated the implied MLRs for each rate cell on a statewide average basis using the MLR methodology outlined in the Final Rule. A summary of this calculation is offered below and illustrated in the Table 24. While CMS has established a minimum MLR for Medicaid rate-setting of 85%, the higher MLRs are allowable as long as rates "are adequate for reasonable, appropriate, and attainable non benefit costs" as noted in 42 CFR 438.4(b)(9).

As is shown, the numerator includes all of the expected medical claims for the rate cell (i.e., Gross Medical PMPM) as well as 85.0% of the included care management considerations included as part of the non-benefit expenses. These care management costs were included in the numerator as DHHS expects much of the care management costs incurred by the PHPs to meet the definition of Health Care Quality Improvements (HCQI) which is included as part of the numerator within the Final Rule MLR methodology. HCQI are defined within 42 CFR 438.8(e)(3) as:

- Those activities that improve health quality and increase the likelihood of desired health outcomes as defined in 45 CFR 158.150
- Activities related to any External-Quality Review (EQR) activities as defined at 42 CFR 438.358(b) and (c)
- Health Information Technology expenses as defined at 45 CFR 158.151

Additionally, within 42 CFR 438.8(f), CMS outlines that the denominator of the MLR should be premium revenues excluding amounts for PHP taxes/fees/assessments. As a result, Mercer set the denominator in the table below as the total capitation rate less the PHP premium tax considerations included in the rate development process.

For comparison, Mercer also included a traditional pricing MLR calculation in the table below using a methodology that compares the Gross Medical PMPM to the total capitation rate. This pricing MLR is shown in

row H of the table below. This was included to illustrate what portion of the total capitation rate is for medical costs. Also, one minus this ratio illustrates what portion of total capitation is intended for General Administration and Utilization Management, Care Management, Profit/Underwriting Gain and Premium Taxes. These ratios are significantly lower than the Final Rule MLR as they do not include any care management costs in the numerator and premium taxes are included in the denominator.

Table 24: Statewide Implied MLR Calculation by Rate Cell Utilizing Draft Capitation Rates

Capitation Rate Component	ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard Plan
(A) = Gross Medical PMPM or Payment	$1,212.36	$618.85	$124.56	$357.00	$8,705.66	$300.86
(B) = Care Management PMPM or Payment	$43.79	$22.34	$4.50	$12.87	$313.95	$10.86
(C) = (A) + 85% x (B)	$1,249.58	$637.84	$128.39	$367.94	$8,972.52	$310.09
(D) = Total Capitation Rate	$1,355.46	$695.20	$145.37	$403.88	$9,442.29	$340.78
(E) = Premium Taxes PMPM or Payment	$27.24	$13.97	$2.92	$8.12	$189.79	$6.85
(F) = (D) – (E)	$1,328.22	$681.23	$142.44	$395.76	$9,252.50	$333.93
(G) = (C) / (F) = Implied MLR	94.1%	93.6%	90.1%	93.0%	97.0%	92.9%
(H) = (A) / (D) = Pricing MLR	89.4%	89.0%	85.7%	88.4%	92.2%	88.3%

15.4.2 Minimum MLR Threshold

As part of Medicaid Transformation, DHHS will institute a MLR reporting and remittance process for all PHPs to ensure on a retrospective basis that PHPs directed a sufficient portion of the capitation payments received from DHHS to services and activities that improve health in alignment with the program goals and objectives. In accordance with S.L. 2018-49, a statewide minimum MLR threshold will be established at 88% for health care services, with the components of the numerator and denominator to be defined by DHHS (DHHS-defined MLR). To recognize MLR variability across rate cells (as demonstrated in Table 24), the minimum MLR threshold for each PHP shall be calculated based on the actual capitation revenue mix of the PHP, by taking the revenue weighted average of factors to be defined by DHHS for each rating group (ABD; TANF, Newborn; TANF, Child; TANF, Adult; and Maternity Event), based on the total capitation payments for the rating year for each rating group. The factors will be developed from the Implied MLR calculated from the final capitation rates and calibrated to an 88% MLR threshold.

PHPs will be required to calculate and report aggregate MLR on an annual, retrospective basis aligned to the contract year according to two formulas, CMS-defined MLR and DHHS-defined MLR as outlined in the RFP.

If the PHP's DHHS-defined MLR is less than the minimum MLR threshold as defined above, the PHP shall remit to the Department a rebate equal to the denominator of the DHHS-defined MLR, multiplied by the difference between the minimum MLR threshold and the DHHS-defined MLR result. The PHP may make contributions to health-related resources (that meet certain requirements) in lieu of all or a portion of the required rebate.

APPENDIX A — MATERNITY EVENT CRITERIA

Under managed care, DHHS will pay a Maternity Event payment on all live birth events. The Maternity Event payment was constructed to reflect a single payment per delivery, even in the case of multiple births during a delivery event. This payment includes cost of the delivery event, along with pregnancy-related care during the prenatal and postpartum period. The tables below outline the specific logic used to develop the Maternity Event payment structure.

Step 1: Identify Delivery Event

The live birth event is identified using the following logic of CPT codes and DRG codes. The live birth event is flagged if there is either a CPT code or DRG code on the claim.

Live Birth CPT Codes

CPT Code	Type	Description
59400	Vaginal	Delivery, Antepartum Care and Postpartum Care
59409	Vaginal	Delivery
59410	Vaginal	Delivery and Postpartum Care
59510	Cesarean	Delivery, Antepartum Care and Postpartum Care
59514	Cesarean	Delivery
59515	Cesarean	Delivery and Postpartum Care

Live Birth DRG Codes

DRG Code	Description
765	Cesarean section with CC/MCC
766	Cesarean section without CC/MCC
767	Vaginal delivery with sterilization and/or D&C
768	Vaginal delivery with O.R. procedure except sterilization and/or D&C
774	Vaginal delivery with complicating diagnoses
775	Vaginal delivery without complicating diagnoses

Step 2: Identify Prenatal and Postpartum Care

For beneficiaries identified in Step 1 above as having a live birth event, Mercer included all claims with the following International Classification of Diseases (ICD)-10 codes in any diagnosis position for eight full months prior to the delivery event and two full months following the delivery event. This captures the pregnancy-related costs for the prenatal and postpartum periods.

ICD-10 Code Ranges for Prenatal and Postpartum Care

Code Range	Description	Prenatal Care	Postpartum Care
O00-O08	Pregnancy with abortive outcome	Included only codes where pregnancy outcome is unclear	Included only codes relating to puerperium
O09	Supervision of high risk pregnancy	Included all codes	N/A
O10-O16	Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium	Excluded codes relating to childbirth and puerperium	Included only codes relating to puerperium
O20-O29	Other maternal disorders	Excluded codes relating to	N/A

Code Range	Description	Prenatal Care	Postpartum Care
	predominately related to pregnancy	childbirth and puerperium	
O30-O48	Maternal care related to the fetus and amniotic cavity and possible delivery problems	Included all codes	N/A
O60-O77	Complications of labor and delivery	Included all codes dealing with unspecified, second and third trimester	Included only codes relating to puerperium
O80-O82	Encounter for delivery	N/A	N/A
O85-O92	Complications predominately related to the puerperium	Included all codes dealing with unspecified, first, second and third trimester	Included only codes relating to puerperium
O94-O9A	Other obstetric conditions, not elsewhere classified	Excluded codes relating to childbirth and puerperium	Included only codes relating to puerperium

Step 3: Identify Other Pregnancy-Related Services

For beneficiaries identified in Step 1 above as having a live birth event, Mercer also included other pregnancy-related services, consistent with current State clinical coverage policies. Utilization for these services are included for eight full months prior to and two full months following the delivery event.

Childbirth Education Clinical Coverage Policy

CPT Code	Description
S9442	Birthing Class

Obstetrics and PMH Clinical Coverage Policy

CPT Code	Description
59425	Antepartum care only; 4–6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
T1015	FQHC/RHC visit
59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta (separate procedure)
99360	Physician standby service, requiring prolonged physician attendance, each 30 minutes (e.g., operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)
99464	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn
S0280	PMH Incentive
S0281	PMH Incentive

Fetal Surveillance Clinical Coverage Policy

CPT Code	Description
Ultrasound in Maternity Care	
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional

CPT Code	Description
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., reevaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, reevaluation of organ system(s) suspected or confirmed to be abnormal on a 76801
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76820	Doppler velocimetry, fetal; umbilical artery
76821	Doppler velocimetry, fetal; middle cerebral artery
Fetal Oxytocin Stress Testing	
59020	Fetal Contract Stress Test
Fetal Non-Stress Testing	
59025	Fetal Non-Stress Test
Biophysical Profile	
76818	Fetal biophysical profile; with non-stress testing
76819	Fetal biophysical profile; without non-stress testing
Fetal Echocardiography	
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study
93325	Doppler echocardiography color flow velocity mapping
Amniocentesis & Chorionic Villus Sampling	
59000	Amniocentesis, Diagnostic
59001	Amniocentesis, Therapeutic
76946	Echo Guide For Amniocentesis
82143	Amniotic Fluid Scan
82963	Assay Of Glucosidase
83661	L/S Ratio, Fetal Lung

CPT Code	Description
83662	Foam Stability, Fetal Lung
83663	Fluoro Polarize, Fetal Lung
83664	Lamellar Body, Fetal Lung
84081	Amniotic Fluid Enzyme Test
88235	Tissue Culture, Placenta
88267	Chromosome Analysis, Placenta
88269	Chromosome Analysis, Amniotic
59015	Chorion Biopsy
76945	Echo Guide, Villus Sampling
Cordocentesis	
59012	Fetal Cord Puncture, Prenatal
Fetal Fibronectin Testing	
82731	Assay Of Fetal Fibronectin

Budget-Neutral Maternity Adjustment

As previously outlined in Section 4, the Maternity Event payment is constructed to capture costs related to the delivery event along with the cost of providing prenatal services (occurring 8 full months prior to the live birth event) and postpartum services (occurring 2 full months after the live birth event). However, the data extract only reflects claims paid through September 2017. As such, prenatal costs associated with deliveries occurring after September 30, 2017 are not captured using the Maternity Event payment logic outlined in Steps 1-3 above. To account for this delivery event lag, Mercer made a budget-neutral adjustment to the data to capture additional prenatal costs, not necessarily tied to a live birth event, and summarized those under the Maternity Event payment. The table below illustrates the budget neutral shift in costs for prenatal services under the Maternity Event payment.

SFY 2017 Impact of Maternity Event Payment Adjustment

COA	Dollar Amount
ABD	$(898,826)
TANF, Newborn (<1)	$(12,445)
TANF, Children (1-20)	$(3,787,242)
TANF, Adults (21+)	$(13,469,265)
Maternity Event	$18,167,778
Total Standard Plan	$0

APPENDIX B — OTHER POPULATION ELIGIBILITY CRITERIA

Future Managed Care Populations Criteria

The following table represents the mapping logic used to define the future populations that DHHS has proposed to phase in to managed care after initial implementation (pending legislation).

Future Managed Care Populations

Population Group	Program Aid Code/Eligibility Code
BH I/DD Tailored Plan	See Appendix E
Foster Children and Adopted Children	HSFCY, HSFNN, IASCN, IASCY, MFCNN
Non-Dual LTSS — Nursing Facility Level Of Care (NFLOC)	Identify 3 months of consecutive nursing home utilization; mark member as being NF from first month of 3 month consecutive utilization forward
Dual Eligibles, not eligible for BH I/DD Tailored Plan	A beneficiary was identified as dual-eligible if either their eligibility fields "MA_STATUS" or "MB_STATUS" had a value of "MA" or "MB" respectively. Dual eligible beneficiaries not identified as eligible for the BH I/DD Tailored Plan were summarized into the following population groupings: • LTSS Population: NFLOC • Non-LTSS Population: ABD, TANF and Other Related Children/Adults, NC Health Choice, M-CHIP and Foster Children and Adopted Children

Permanently Excluded Population Criteria

The following table represents the mapping logic used to define the proposed permanently excluded populations.

Permanently Excluded Population Criteria

Population Group	Program Aid Code/Eligibility Code
Medically Needy	Fourth digit of program category code of "M"
Family Planning	MAFDN
Partial Duals	MQBBN, MQBEN, MQBQN
Aliens (Emergency Services Only)	Eligibility codes with a fourth character of F, H, O, R or V
Refugees	MRFMN, MRFNN, RRFCN
Health Insurance Premium Program	Beneficiary roster provided by DHHS
Inmates	Living Arrangement Code 16
CAP/C	Setting of Care codes (HC, IC or SC)
CAP/DA	Setting of Care codes (CI, CS, ID or SD)

Note that beneficiaries enrolled in Program of All-Inclusive Care for the Elderly (PACE) are excluded from managed care and population criteria will be refined for final capitation rate development.

APPENDIX C — RATE CELL DETERMINATION

As a part of the capitation rate development to support DHHS, Mercer developed rate cell recommendations for the Standard Plan population. The following section provides background and support for the recommended rate cell structure. Overall, Mercer developed the rate cell recommendations to (1) best match payment to risk and (2) consider the operational challenges to payout on the recommended rate cells.

Rate cells are used to develop variable payment rates accounting for material cost differences amongst regions and populations. Since the managed care population will have choice of PHP, the rate cell structure is intended to differentiate payments to PHPs where disproportionate enrollment of certain populations occurs. For example, if a PHP has a disproportionate share of higher cost newborns, a rate cell structure with a special payment for newborns would allow that PHP to be adequately reimbursed for their higher share of newborn members. However, the number of rate cells necessary to account for these material differences is predicated on DHHS' decision to risk adjust the rates. A risk adjustment model accounts for much of the age/gender risk within a population, and differentiates payments to PHPs based on their enrolled population risk profile. Since DHHS has chosen to use the CDPS+Rx model to risk adjust the capitation rates, the rate cell structure does not necessitate as many age/gender splits.

The following subsections outline key considerations, methodology and recommendations for structuring the Standard Plan rate cells.

Methodology

To evaluate rate cell recommendations, Mercer reviewed summarized historical cost and utilization data for the Medicaid and NC Health Choice programs. This data summarization included FFS claims experience for services covered under DHHS' FFS program, as well as encounter data for BH services covered under the Medicaid BH managed care program currently operated by the LME/MCOs. The data was initially evaluated based on detailed population, age and regional breakouts.

Mercer weighed a number of factors when developing the rate cell recommendations, such as:

- Rate cell groupings should be developed by grouping populations with similar cost profiles together.
- Rate cells must contain a credible number of MMs to be able to mitigate volatility to help control predictability of expenses. More rate cells may better match payment to risk, but may be more difficult administratively and some rate cells may lack credibility.
- Fewer rate cells simplifies the rate-setting and payment processes and increases credibility, but may not do as good of a job matching payment to risk as each rate cells has a broader range of members.
- Risk adjustment helps reduce the number of rate cells needed as the risk adjustment process captures age/gender factors.
- Rate cells may, but are not required to, consider the unique characteristics and services available to certain populations.
- Rate cells are easier to operationalize if they rely on data readily available on administrative or eligibility records. For example, populations requiring a qualifying diagnosis or level of care assessment may be more administratively difficult for DHHS to operationalize on an ongoing basis.

Additionally, Mercer reviewed ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification) to understand acceptable factors used to establish distinct rate cells. Specifically, section 3.2.2 of ASOP 49 provides guidance for the structure of Medicaid managed care capitation rates by rate cell developed to account for material cost differences. Examples of reasonable rate cell characteristics, outlined in ASOP 49, include: age, gender, qualifying event (e.g., maternity delivery), geographic region, Medicaid eligibility group, eligibility for Medicare benefits, diagnosis or risk adjustment factors. In the recommendations outlined below

for the Standard Plan population, Mercer focused on the following: Medicaid eligibility group, age, qualifying event and geographic region.

Population Rate Cell Recommendations

Historical data was summarized by population and age group for beneficiaries covered under the Standard Plan. Mercer first reviewed the cost volatility, cost differential and membership levels on a statewide basis for various population/age splits.

Mercer also reviewed other state rate cell structures to understand industry standards and also considered how risk adjustment would help account for any cost differentials by population. As a reminder, the risk adjustment model assigns cost weights by gender, age and also based on certain disease prevalence. Since the risk adjustment model will be calibrated to North Carolina's specific experience, certain cost differences amongst age bands (e.g., the ABD adult PMPM is more than twice the ABD child PMPM) may be accounted for through the risk adjustment process.

Given that DHHS has chosen to risk adjust the capitation rates, Mercer recommended reducing the number of population/age delineations since there is not a large population difference (other than for ABD) and much of the cost differential associated with age breakouts will be captured under the risk adjustment model. As such, Mercer recommended the following four rate cells plus the Maternity Event payment.

See below for observations used to determine the necessary level of detail to retain in the rate cell structure.

The ABD population is much more costly than TANF, NC Health Choice and M-CHIP (ABD costs are more than five times the total PMPM cost for other Standard Plan populations). Additionally, there is a separate risk adjustment model for the TANF and ABD population. As such, Mercer recommended a separate ABD rate cell.

ABD observations:

- When looking closer at the ABD population, there is a clear cost differential between the newborn, child and adult group. However, recall that the risk adjustment model will calibrate the cost weights for the defined age/gender splits in the model and will thus account for the differential. As a point of reference, Mercer reviewed average risk scores from another state Medicaid program by age/gender band for the ABD non-dual population. Mercer observed that cost weights from other state experience mirror some of the differential observed in the North Carolina experience. Mercer expects the calibration of risk scores to the North Carolina data will result in more alignment of the risk scores to the differential child and adult costs in the North Carolina ABD population.
- Specific to ABD newborn beneficiaries, in some years these beneficiaries have costs more than three times that of the child and adult ABD age groups. However, this group is highly volatile year over year. What's more, ABD newborn beneficiaries make up less than 1.0% of the ABD population and less than 0.1% of the total Standard Plan membership. As such, Mercer recommended blending the ABD newborns with the rest of the ABD population.

TANF and Other Related Children/Adult observations:

- The TANF newborn population has a substantial membership base (approximately 900,000), with steady PMPMs year over year. However, costs are over three times the cost of TANF children (1-20). Thus, given TANF newborns are more costly and have a robust membership base, Mercer recommended a separate TANF newborn rate cell.
- For the remaining child (1-20 population), Mercer recommended combining the TANF, NC Health Choice and M-CHIP population into a single rate cell. In the base experience, NC Health Choice and M-CHIP are within +5.0% of the TANF child PMPM. Using a similar risk adjustment analysis as described above, Mercer observes the risk scores for these populations are also similar.
- The remaining Medicaid population is exclusively TANF adults; as such, Mercer recommended a separate rate cell for the TANF adult (21+ population).

As previously discussed, DHHS will make a Maternity Event payment alongside the monthly capitation payment. Maternity Event payments help to align payment to risk. Deliveries are expensive, and prospective risk adjustment models are generally designed to reflect costs associated with chronic conditions, not pregnancy. As a result, in risk adjusted payment models, event payments are often used to mitigate the risk that any PHP has a disproportionate number of enrollees with maternity expenses.

Regional Rate Cell Recommendations

DHHS has defined six PHP regions (see Section 3, Figure 1). For the Standard Plan population each region has over 1.7 million MMs; review of the six regional/rate cell combinations also shows a credible number of MMs to be able to mitigate volatility to help control predictability of expenses. The capitation rates provided in this Draft Rate Book reflect the six PHP regions. However, as a part of final capitation rate development, Mercer will evaluate further regional breakouts that may be necessary due to meaningful cost and utilization variances within certain regions beyond those addressed through rate cells and risk adjustment.

APPENDIX D — CATEGORY OF SERVICE CRITERIA

The following tables represent the mapping logic used to define the detailed COS. The FFS data detailed COS logic is based on a combination of claim type and State-defined categories based on provider taxonomy. The encounter data detailed COS logic is based on logic defined and used for the development of the LME/MCO capitation rates. The COS groups are assigned in a hierarchy, as outlined in the tables below. Note that this list includes a comprehensive assignment of all COS, and is not limited to those covered under the Standard Plan.

Excluded Services

COS Description	Data Source	Coding Logic
Capitation	FFS	Claim_Type '4' This excludes the following capitation payments: MedSolutions, PACE, BH LME Capitation, Innovations LME Capitation
Dental	FFS	Claim_Type 'D' OR (Procedure codes with first character 'D', but NOT [(D0145 OR D1206) AND not claim type D])
Local Education Agency	FFS	Claim_Type '0'
Children's Developmental Services Agencies	FFS	Claim_Type 'V'
Excluded Optical Services (Eyeglasses and Fittings)	FFS	Billing Provider NPI = 1376576777 (Nash Optical Lab) OR Procedure Codes = 92340, 92341, 92342, 92353, 92370
Excluded PCMH Payments	FFS	Claim_Type 'M' AND not identified as an included PCMH Payment below

Covered Services

COS Description	COS Detailed Description	Data Source	Coding Logic
Included PCMH Payments	Medical Home Payments	FFS	Claim_Type 'M' AND BILL_PRVDR_ATYP_NPI is Null AND paid amount is: $1.00 OR $2.50 OR $5.00
	OBCM Payments	FFS	Claim_Type 'M' AND BILL_PRVDR_ATYP_NPI is NOT Null AND paid amount is: $4.96 or $4.71
	CC4C Payments	FFS	Claim_Type 'M' AND BILL_PRVDR_ATYP_NPI is NOT Null AND -For all months: paid amount is $4.56 -For only September 2015: paid amount $4.56 or $4.33
Therapies	Therapies	FFS	Claim_type '2'
Dental (limited)	Dental (limited)	FFS	Procedure codes D0145 OR D1206, when billed without claim type 'D'
Inpatient — PH	Inpatient — PH	FFS	[State COS = 0015 (HOSP INPT-GENERAL) OR 0019 (HOSP INPT-SPECIALITY) OR 0051 (HOSP INPT-GEN XOVERS) OR 0040 (HOSP INPT-INDIAN)]
Inpatient — BH	Inpatient — BH	LME/MCO Encounters	Revenue code 101–182, 184–219
Emergency Room	Emergency Room	FFS	Revenue code 0450 - 0459 OR CPT codes 99281 - 99285 State COS = 0050 (HOSP OUTPT-EMER. ROOM) Note: If claim has Inpatient bill type, dollars should be assigned to Inpatient regardless of Emergency Room revenue code or Emergency Room State COS.
		LME/MCO Encounters	Revenue code 0450 - 0459 OR CPT codes 99281 - 99285 Note: If claim has Inpatient bill type, dollars should be assigned to Inpatient regardless of Emergency Room revenue code.

COS Description	COS Detailed Description	Data Source	Coding Logic
Outpatient Hospital — PH	Outpatient Hospital — PH	FFS	[State COS = 0016 (HOSP OUTPT-GENERAL) OR 0045 (HOSP OUTPT-SPECIALITY) OR 0048 (AMBULATORY SURG CENTER) OR 0052 (HOSP OUTPT-GEN XOVERS) OR 0042 (HOSP OUTPT-INDIAN)]
Outpatient Hospital — BH	Outpatient Hospital — BH	LME/MCO Encounters	Procedure codes 90785, 90791, 90792, 90801–90899, 96100, 96101, 96110, 96111, 96115–96118, G0431, G0434, H0001, H0002, H0004, H0005, H0010, H0012–H0015, H0020, H0031, H2035, Q3014, S9485, T1023, covered E/M codes (99xxx) or Revenue codes 450–459, 900–910, 912–918
LTSS — ICF/IID and Nursing Home	ICF/IID	FFS	State COS = 0021 (LTC-ICF MRC, SO) OR 0047 (LTC-ICF MRC, NSO)
		LME/MCO Encounters	Revenue code 100 or 183
	Nursing Home	FFS	State COS = 0020 (LTC-ICF SO AND NSO) OR 0022 (NF-ICF SWING BEDS) OR 0035 (LTC-SNF SO AND NSO) OR 0036 (NF-SNF SWING BEDS) OR 0039 (NF-INDIAN HEALTH) OR 0049 (HOSP LONG TERM CARE) OR 0071 (NF-HEAD LEVEL OF CARE) OR 0072 (NF-VENT LEVEL OF CARE)
Other BH Services	Psychiatric Residential Treatment Facility (PRTF)	FFS	State COS = 0017 (HOSP INPT-MTL,SO < 21) OR 0041 (HOSP INPT-MTL,NSO < 21)
		LME/MCO Encounters	Revenue code 911 or 919
	Other BH Services	FFS	State COS = 0070 (PRACTITIONER-NON PHYS) OR 0084 (HIGH RISK INTERVENTION)
	Assertive Community Treatment (ACT)	LME/MCO Encounters	Procedure code H0040
	Community Support	LME/MCO Encounters	Procedure code H0036, [H2015 AND COA other than Innovations]
	Crisis Services	LME/MCO Encounters	Procedure code S9484, [H2011 AND COA other than Innovations]
	Intensive In-Home Services (IIHS)	LME/MCO Encounters	Procedure code H2022
	Multisystemic Therapy (MST)	LME/MCO Encounters	Procedure code H2033
	Outpatient (including psychotherapy and limited alcohol/drug services)	LME/MCO Encounters	Procedure codes 90785, 90791, 90792, 90801–90899, 96100, 96101, 96110, 96111, 96115–96118, G0431, G0434, H0001, H0002, H0004, H0005, H0010, H0012–H0015, H0020, H0031, H2035, Q3014, S9485, T1023, covered E/M codes (99xxx) or Revenue codes 450–459, 900–910, 912–919
	Partial Hosp/Day Tx	LME/MCO Encounters	Procedure code H0035, H2012
	Psych Rehab	LME/MCO Encounters	Procedure code H2017
	BH Long-term Residential	LME/MCO Encounters	Procedure code H0019, H0046, H2020, S5145

COS Description	COS Detailed Description	Data Source	Coding Logic
Physician — Primary Care	Physician — Primary Care	FFS	State COS = 0027 (PHYSICIAN) AND Taxonomy_Codes = 207Q00000X, 207RA0000X, 208000000X, 2080A0000X, 208D00000X, 363A00000X, 363L00000X, 363LF0000X
Physician — Specialty	Physician — Specialty	FFS	State COS = 0027 (PHYSICIAN) without the taxonomy restriction on Physician Primary Care.
FQHC/RHC	FQHC/RHC	FFS	State COS = 0006 (CLINICS-RURAL HEALTH) OR 0061 (HEALTH CHECK-RURAL HLT) OR 0065 (CLINICS-FQHC,CORE&AMB) OR 0067 (HEALTH CHECK-FQHC) OR [SCOS 0073 (OTHER AMB CARE-INDIAN) AND Claim_Type '5' (RURAL HLTH CLINIC / FEDERALLY QUALIFIED HLTH CNTR)]
Other Clinic	Free-standing Clinics/Health Check — Health Department	FFS	State COS = 0002 (CLINICS-FREE STANDING) OR 0003 (CLINICS-HEALTH DEPT) OR 0033 (HEALTH CHECK-HLTH DEPT) OR 0034 (HEALTH CHECK-OTHR PROV) OR [SCOS 0073 (OTHER AMB CARE-INDIAN) AND NOT (Claim_Type '3' (INSTITUTIONAL AMBULANCE) OR Claim_Type 'T' (AMBULANCE (PROFESSIONAL)))]
	Family Planning Services	FFS	State COS = 0010 (FAMILY PLAN-HOSP INPT) OR 0011 (FAMILY PLAN-HOSP OUTPT) OR 0012 (FAMILY PLAN-PHYSICIAN) OR 0024 (FAMILY PLAN-STERILIZATION) OR 0031 (FAMILY PLAN-DRUGS) OR 0037 (FAMILY PLAN-RURAL HLTH) OR 0038 (FAMILY PLAN-HLTH DEPT) OR 0066 (FAMILY PLAN-FQHC)
Other Practitioner	Other Practitioner	FFS	State COS = 0028 (CHIROPRACTIC) OR 0046 (PODIATRY)
Case Management	Case Management	FFS	State COS = 0062 (CASE MANAGEMENT-FSO) OR 0081 (CASE MANAGEMENT-HIV)
LTSS — State Plan Home and Community Based Services (HCBS)	Home Health	FFS	State COS = 0014 (HOME HEALTH) OR 0026 (HOME HEALTH-INDIAN) OR 0059 (HOME INFUSION THERAPY)
	Personal Care	FFS	State COS = 0053 (PERSONAL CARE)
	Hospice	FFS	State COS = 0060 (HOSPICE)
LTSS —HCBS Waiver Services	HCBS Services — FFS	FFS	State COS = 0055 (CAP-DISABLED) OR 0057 (CAP-CHILDREN) OR 0085 (CAP CHOICE)
	Innovations — Day Support	LME/MCO Encounters	Procedure code T2021, T2027
	Innovations — In-Home Services	LME/MCO Encounters	Procedure code H2015, T1015, T2013
	Innovations — Personal Care	LME/MCO Encounters	Procedure code S5125, T1019
	Innovations — Residential Supports	LME/MCO Encounters	Procedure code H2016, T2014, T2016, T2020, T2033
	Innovations — Respite	LME/MCO Encounters	Procedure code H0045, S5150, T1005
	Innovations — Supported Employment	LME/MCO Encounters	Procedure code H2023, H2025, H2026

COS Description	COS Detailed Description	Data Source	Coding Logic
	Innovations — Other	LME/MCO Encounters	Procedure code H2011, S5110, S5111, S5165, T1999, T2025, T2029, T2034, T2038, T2039, T2041 or [B4100–B4162 AND [age_group] = 21+]
	FFS Innovations Services	FFS	State COS = 0056 (CAP-MENTALLY RETARDED)
B3 Services	B3 Services	LME/MCO Encounters	Procedure code 99241 U4, 99242 U4, 99244 U4, H0038, S5151, T1012, H2022 U4, [(H0045, H2016, H2023, H2025-H2026, S5110, S5111, S5125, S5150, S5165, T1005, T1015, T1019, T2013, T2014, T2020, T2021, T2025, T2027, T2029, T2034, T2038, T2039 or T2041) AND COA other than Innovations]
Prescribed Drugs	Prescribed Drugs	FFS	State COS = 0032 (PRESCRIBED DRUGS)
Durable Medical Equipment	Durable Medical Equipment	FFS	State COS = 0013 (HEARING AIDS) OR 0054 (DURABLE MEDICAL EQUIP)
Optical	Optical	FFS	State COS = 0029 (OPTICAL SUPPLIES) OR 0030 (OPTICAL)
Lab and X-ray	Lab and X-ray	FFS	State COS = 0023 (LAB AND X-RAY)
Transportation	Transportation	FFS	State COS = 0001 (AMBULANCE) OR [SCOS 0073 (OTHER AMB CARE-INDIAN) AND (Claim_Type '3' (INSTITUTIONAL AMBULANCE) OR Claim_Type 'T' (AMBULANCE (PROFESSIONAL)))]
Transportation	NEMT	FFS	State COS = 0088 (TRANSPORTATION-COUNTY)

APPENDIX E — BH I/DD TAILORED PLAN CRITERIA

The criteria utilized to summarize beneficiaries eligible for the BH I/DD Tailored Plan is outlined below and is based on DHHS' initially proposed approach from the Fall of 2018. S.L. 2018-48 put forth additional criteria for BH I/DD Tailored Plan eligibility which will be evaluated and considered in final capitation rate development. All diagnosis codes provided in Appendix E will be reviewed for final rate development to ensure consistency with final program requirements.

Mercer identified beneficiaries eligible for a BH I/DD Tailored Plan by reviewing historical data for beneficiaries meeting the clinical criteria at least once during a SFY (July 1 through June 30). The Foster Children and Adopted Children, CAP/C, CAP/DA and NFLOC population groups were not categorized as BH I/DD Tailored Plan unless they were enrolled in the Innovations waiver. The clinical condition criteria are applied as a hierarchy such that beneficiaries only fall within one of the clinical condition categories in a given year. The following populations would be included in the BH I/DD Tailored Plan:

- I/DD
- Serious Emotional Disturbance (SED)/Serious and Persistent Mental Illness (SPMI)
- SUD

Beneficiaries enrolled in the TBI waiver and those with historical utilization of State-funded mental health services will also be eligible for BH I/DD Tailored Plans. However, the TBI waiver was not in effect during the base time period, so claims data for TBI waiver enrollees was not available. Additionally, the identification logic was limited to Medicaid and NC Health Choice claims data, and thus did not capture State-funded mental health service recipients. Children with complex needs, children ages 0 to 3 years old at risk for developmental delay or disability, and children/youth involved with the Division of Juvenile Justice of the Department of Public Safety who meet certain criteria may also be included in the BH I/DD Tailored Plans. However, these groups have not been separately identified for purposes of summarizing the BH I/DD Tailored Plan population at this time.

I/DD Criteria

This group will be eligible for the BH I/DD Tailored Plan, and exempt from Standard Plan enrollment. In order to identify qualifying beneficiaries, Mercer used the available claims and eligibility information to identify the I/DD group; specifically, beneficiaries were assigned if they met at least one of the following criteria:

- Innovations — Special Coverage Code of CM, C2 or IN (Innovations eligibility indicators).
- ICF/IID — FFS data claim type Q (Mental Health) and FFS COS 0021 (LTC-ICF MRC, SO) or 0047 (LTC-ICF MRC, NSO). Encounter data claim experience with revenue codes 100 (room and board, all-inclusive plus ancillary) or 183 (therapeutic leave) used by the LME/MCOs to reimburse for ICF/IID services.
- B3 — One or more claims falling under the B3 COS.
- Innovations Waitlist — Beneficiaries who were included on the waitlist for the Innovations waiver provided by DHHS.
- Transition to Community Living Initiative (TCLI) — Beneficiaries who were included on the TCLI roster provided by DHHS.
- Diagnosis — List of I/DD diagnosis codes (all diagnosis positions) supplied by DHHS.

A list of qualifying I/DD ICD-10 diagnosis codes supplied by DHHS is provided in the table below. These diagnoses will be reviewed for final rate development for consistency with final program requirements.

Code	Description	Code	Description
D82.10	Di George's syndrome	F84.90	Pervasive Developmental Disorder, Unspecified
E70.00	Classical phenylketonuria	F88.00	Other disorders of psychological development
E75.02	Tay-Sachs disease	F89.00	Unspecified disorder of psychological development
E75.19	Other Gangliosidosis	G31.81	Alpers disease

Code	Description	Code	Description
E75.23	Krabbe disease	G31.82	Leigh's Disease
E75.25	Metachromatic Leukodystrophy	G80.20	Spastic Hemiplegic Cerebral Palsy
E75.29	Other Sphingolipidosis	Q00.00	Anencephaly
E75.40	Neuronal ceroid lipofuscinosis	Q02.00	Microcephaly
E76.01	Hurler's syndrome	Q03.00	Malformations of aqueduct of Sylvius
E76.10	Mucopolysaccharidosis, type II	Q03.10	Atresia Of Foramina Of Magendie And Luschka
E76.22	Sanfilippo Mucopolysaccharidoses	Q03.80	Other congenital hydrocephalus
E76.29	Other Mucopolysaccharidoses	Q05.40	Unspecified Spina Bifida With Hydrocephalus
E76.30	Mucopolysaccharidosis, unspecified	Q05.80	Sacral spina bifida without hydrocephalus
E77.10	Defects In Glycoprotein Degradation	Q07.02	Arnold-Chiari Syndrome with Hydrocephalus
E78.71	Barth syndrome	Q07.03	Arnold-Chiari Syndrome With Spina Bifida And Hydrocephalus
E78.72	Smith-Lemli-Opitz Syndrome	Q85.10	Tuberous sclerosis
F70.00	Mild intellectual disabilities	Q86.00	Fetal Alcohol Syndrome
F71.00	Moderate intellectual disabilities	Q87.10	Congenital Malformation Syndromes with short stature
F72.00	Severe intellectual disabilities	Q87.20	Congenital Malformation Syndromes
F73.00	Profound intellectual disabilities	Q87.89	Congenital Malformation Syndromes
F78.00	Other intellectual disabilities	Q90.90	Down Syndrome, Unspecified
F79.00	Unspecified intellectual disabilities	Q91.30	Trisomy 18, unspecified
F84.00	Autistic Disorder	Q91.70	Trisomy 13, unspecified
F84.20	Rett's Syndrome	Q93.40	Deletion of short arm of chromosome 5
F84.30	Other childhood disintegrative disorder	Q98.40	Klinefelter syndrome, unspecified
F84.50	Asperger's Syndrome	Q99.20	Fragile X Chromosome
F84.80	Other Pervasive Developmental Disorders		

SED (Ages 0-17.99) and SPMI (Ages 18+) Criteria

This group will be eligible for the BH I/DD Tailored Plan, and exempt from Standard Plan enrollment; beneficiaries needed to have accessed an enhanced BH service and were identified based on a list of diagnosis codes (primary diagnosis position) supplied by DHHS. SED is defined as being for individuals ages 0 to 17.99 and SPMI is defined as being for individuals ages 18+. A list of qualifying SED and SPMI ICD-10 diagnosis codes supplied by DHHS is provided in the table below. These diagnoses will be reviewed for final rate development for consistency with final program requirements.

SED Diagnosis Code List

Code	Description	Code	Description
F06.30	Mood disorder due to known physiological condition, unsp	F32.20	Major depressv disord, single epsd, sev w/o psych features
F06.31	Mood disorder due to known physiol cond w depressv features	F32.30	Major depressv disord, single epsd, severe w psych features
F06.32	Mood disord d/t physiol cond w major depressive-like epsd	F32.40	Major depressv disorder, single episode, in partial remis
F06.80	Oth mental disorders due to known physiological condition	F32.50	Major depressive disorder, single episode, in full remission
F09.00	Unsp mental disorder due to known physiological condition	F32.80	Other depressive episodes
F20.00	Paranoid schizophrenia	F32.90	Major depressive disorder, single episode, unspecified
F20.10	Disorganized schizophrenia	F33.00	Major depressive disorder, recurrent, mild
F20.20	Catatonic schizophrenia	F33.10	Major depressive disorder, recurrent, moderate
F20.30	Undifferentiated schizophrenia	F33.20	Major depressv disorder, recurrent severe w/o psych features

Code	Description	Code	Description
F20.50	Residual schizophrenia	F33.30	Major depressv disorder, recurrent, severe w psych symptoms
F20.81	Schizophreniform disorder	F33.40	Major depressive disorder, recurrent, in remission, unsp
F20.89	Other schizophrenia	F33.41	Major depressive disorder, recurrent, in partial remission
F20.90	Schizophrenia, unspecified	F33.42	Major depressive disorder, recurrent, in full remission
F22.00	Delusional disorders	F33.80	Other recurrent depressive disorders
F23.00	Brief psychotic disorder	F33.90	Major depressive disorder, recurrent, unspecified
F24.00	Shared psychotic disorder	F34.10	Dysthymic disorder
F25.00	Schizoaffective disorder, bipolar type	F34.80	Other persistent mood [affective] disorders
F25.10	Schizoaffective disorder, depressive type	F34.90	Persistent mood [affective] disorder, unspecified
F25.80	Other schizoaffective disorders	F39.00	Unspecified mood [affective] disorder
F25.90	Schizoaffective disorder, unspecified	F40.00	Agoraphobia, unspecified
F28.00	Oth psych disorder not due to a sub or known physiol cond	F40.01	Agoraphobia with panic disorder
F29.00	Unsp psychosis not due to a substance or known physiol cond	F40.02	Agoraphobia without panic disorder
F30.10	Manic episode without psychotic symptoms, unspecified	F40.10	Social phobia, unspecified
F30.11	Manic episode without psychotic symptoms, mild	F40.11	Social phobia, generalized
F30.12	Manic episode without psychotic symptoms, moderate	F40.80	Other phobic anxiety disorders
F30.13	Manic episode, severe, without psychotic symptoms	F41.00	Panic disorder without agoraphobia
F30.20	Manic episode, severe with psychotic symptoms	F41.10	Generalized anxiety disorder
F30.30	Manic episode in partial remission	F41.30	Other mixed anxiety disorders
F30.40	Manic episode in full remission	F41.80	Other specified anxiety disorders
F30.80	Other manic episodes	F41.90	Anxiety disorder, unspecified
F30.90	Manic episode, unspecified	F42.00	Obsessive-compulsive disorder
F31.00	Bipolar disorder, current episode hypomanic	F43.10	Post-traumatic stress disorder, unspecified
F31.10	Bipolar disord, crnt episode manic w/o psych features, unsp	F43.12	Post-traumatic stress disorder, chronic
F31.11	Bipolar disord, crnt episode manic w/o psych features, mild	F44.89	Other dissociative and conversion disorders
F31.12	Bipolar disord, crnt episode manic w/o psych features, mod	F50.00	Anorexia nervosa, unspecified
F31.13	Bipolar disord, crnt epsd manic w/o psych features, severe	F50.01	Anorexia nervosa, restricting type
F31.20	Bipolar disord, crnt episode manic severe w psych features	F50.02	Anorexia nervosa, binge eating/purging type
F31.30	Bipolar disord, crnt epsd depress, mild or mod severt, unsp	F50.20	Bulimia nervosa
F31.31	Bipolar disorder, current episode depressed, mild	F50.80	Other eating disorders
F31.32	Bipolar disorder, current episode depressed, moderate	F50.90	Eating disorder, unspecified
F31.40	Bipolar disord, crnt epsd depress, sev, w/o psych features	F63.10	Pyromania

Code	Description	Code	Description
F31.50	Bipolar disord, crnt epsd depress, severe, w psych features	F63.30	Trichotillomania
F31.60	Bipolar disorder, current episode mixed, unspecified	F63.81	Intermittent explosive disorder
F31.61	Bipolar disorder, current episode mixed, mild	F63.89	Other impulse disorders
F31.62	Bipolar disorder, current episode mixed, moderate	F84.00	Autistic disorder
F31.63	Bipolar disord, crnt epsd mixed, severe, w/o psych features	F84.50	Asperger's syndrome
F31.64	Bipolar disord, crnt episode mixed, severe, w psych features	F90.00	Attn-defct hyperactivity disorder, predom inattentive type
F31.70	Bipolar disord, currently in remis, most recent episode unsp	F90.10	Attn-defct hyperactivity disorder, predom hyperactive type
F31.71	Bipolar disord, in partial remis, most recent epsd hypomanic	F90.20	Attention-deficit hyperactivity disorder, combined type
F31.72	Bipolar disord, in full remis, most recent episode hypomanic	F90.80	Attention-deficit hyperactivity disorder, other type
F31.73	Bipolar disord, in partial remis, most recent episode manic	F90.90	Attention-deficit hyperactivity disorder, unspecified type
F31.74	Bipolar disorder, in full remis, most recent episode manic	F91.00	Conduct disorder confined to family context
F31.75	Bipolar disord, in partial remis, most recent epsd depress	F91.10	Conduct disorder, childhood-onset type
F31.76	Bipolar disorder, in full remis, most recent episode depress	F91.20	Conduct disorder, adolescent-onset type
F31.77	Bipolar disord, in partial remis, most recent episode mixed	F91.30	Oppositional defiant disorder
F31.78	Bipolar disorder, in full remis, most recent episode mixed	F91.80	Other conduct disorders
F31.81	Bipolar II disorder	F91.90	Conduct disorder, unspecified
F31.89	Other bipolar disorder	F94.10	Reactive attachment disorder of childhood
F31.90	Bipolar disorder, unspecified	F94.20	Disinhibited attachment disorder of childhood
F32.00	Major depressive disorder, single episode, mild	F98.80	Oth behav/emotn disord w onset usly occur in chldhd and adol
F32.10	Major depressive disorder, single episode, moderate	F99.00	Mental disorder, not otherwise specified

SPMI Diagnosis Code List

Code	Description	Code	Description
F20.81	Schizophreniform disorder	F32.10	Major depressive disorder, single episode, moderate
F20.90	Schizophrenia, unspecified	F32.20	Major depressv disord, single epsd, sev w/o psych features
F21.00	Schizotypal disorder	F32.30	Major depressv disord, single epsd, severe w psych features
F25.00	Schizoaffective disorder, bipolar type	F32.40	Major depressv disorder, single episode, in partial remis
F25.10	Schizoaffective disorder, depressive type	F32.90	Major depressive disorder, single episode, unspecified
F29.00	Unsp psychosis not due to a substance or known physiol cond	F33.00	Major depressive disorder, recurrent, mild
F31.00	Bipolar disorder, current episode hypomanic	F33.10	Major depressive disorder, recurrent, moderate

Code	Description	Code	Description
F31.11	Bipolar disord, crnt episode manic w/o psych features, mild	F33.20	Major depressv disorder, recurrent severe w/o psych features
F31.12	Bipolar disord, crnt episode manic w/o psych features, mod	F33.30	Major depressv disorder, recurrent, severe w psych symptoms
F31.13	Bipolar disord, crnt epsd manic w/o psych features, severe	F33.41	Major depressive disorder, recurrent, in partial remission
F31.20	Bipolar disord, crnt episode manic severe w psych features	F33.90	Major depressive disorder, recurrent, unspecified
F31.31	Bipolar disorder, current episode depressed, mild	F40.00	Agoraphobia, unspecified
F31.32	Bipolar disorder, current episode depressed, moderate	F41.00	Panic disorder without agoraphobia
F31.40	Bipolar disord, crnt epsd depress, sev, w/o psych features	F41.10	Generalized anxiety disorder
F31.50	Bipolar disord, crnt epsd depress, severe, w psych features	F42.00	Obsessive-compulsive disorder
F31.73	Bipolar disord, in partial remis, most recent episode manic	F43.10	Post-traumatic stress disorder, unspecified
F31.75	Bipolar disord, in partial remis, most recent epsd depress	F44.00	Dissociative amnesia
F31.81	Bipolar II disorder	F44.10	Dissociative fugue
F31.89	Other bipolar disorder	F44.81	Dissociative identity disorder
F31.90	Bipolar disorder, unspecified	F44.89	Other dissociative and conversion disorders
F32.00	Major depressive disorder, single episode, mild	F44.90	Dissociative and conversion disorder, unspecified

SUD Criteria

This group will be eligible for the BH I/DD Tailored Plan, and exempt from Standard Plan enrollment; beneficiaries needed to have accessed an enhanced BH service and were identified based on a list of diagnosis codes (primary diagnosis position) supplied by DHHS along with beneficiaries with a qualifying SUD drug claim. A list of qualifying SUD ICD-10 diagnosis codes supplied by DHHS for both non-severe and dependence-level conditions is provided in the tables below. These diagnoses will be reviewed for final rate development for consistency with final program requirements.

SUD Non-Severe Diagnosis Code List

Code	Description	Code	Description
F10.10	Alcohol abuse, uncomplicated	F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F10.121	Alcohol abuse with intoxication delirium	F13.231	Sedatv/hyp/anxiolytc dependence w withdrawal delirium
F10.221	Alcohol dependence with intoxication delirium	F13.232	Sedatv/hyp/anxiolytc depend w w/drawal w perceptual disturb
F10.231	Alcohol dependence with withdrawal delirium	F13.239	Sedatv/hyp/anxiolytc dependence w withdrawal, unsp
F10.232	Alcohol dependence w withdrawal with perceptual disturbance	F14.10	Cocaine abuse, uncomplicated
F10.239	Alcohol dependence with withdrawal, unspecified	F14.23	Cocaine dependence with withdrawal
F10.921	Alcohol use, unspecified with intoxication delirium	F15.10	Other stimulant abuse, uncomplicated
F11.10	Opioid abuse, uncomplicated	F15.23	Other stimulant dependence with withdrawal
F11.120	Opioid abuse with intoxication,	F15.929	Other stimulant use, unsp with intoxication,

Code	Description	Code	Description
	uncomplicated		unspecified
F11.129	Opioid abuse with intoxication, unspecified	F15.93	Other stimulant use, unspecified with withdrawal
F11.23	Opioid dependence with withdrawal	F16.10	Hallucinogen abuse, uncomplicated
F11.90	Opioid use, unspecified, uncomplicated	F17.203	Nicotine dependence unspecified, with withdrawal
F11.93	Opioid use, unspecified with withdrawal	F18.10	Inhalant abuse, uncomplicated
F12.10	Cannabis abuse, uncomplicated	F19.10	Other psychoactive substance abuse, uncomplicated
F12.288	Cannabis dependence with other cannabis-induced disorder	F19.231	Oth psychoactive substance dependence w withdrawal delirium
F12.90	Cannabis use, unspecified, uncomplicated	F19.239	Oth psychoactive substance dependence with withdrawal, unsp

SUD Dependence-Level Diagnosis Code List

Code	Description	Code	Description
F10.20	Alcohol dependence, uncomplicated	F19.220	Oth psychoactive substance dependence w intoxication, uncomp
F11.20	Opioid dependence, uncomplicated	F19.24	Oth psychoactive substance dependence w mood disorder
F12.20	Cannabis dependence, uncomplicated	F19.259	Oth psychoactv substance depend w psychotic disorder, unsp
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated	F19.26	Oth psychoactv substance depend w persist amnestic disorder
F14.20	Cocaine dependence, uncomplicated	F19.280	Oth psychoactive substance dependence w anxiety disorder
F15.20	Other stimulant dependence, uncomplicated	F19.281	Oth psychoactive substance dependence w sexual dysfunction
F16.20	Hallucinogen dependence, uncomplicated	F19.282	Oth psychoactive substance dependence w sleep disorder
F18.20	Inhalant dependence, uncomplicated	F19.288	Oth psychoactive substance dependence w oth disorder
F19.20	Other psychoactive substance dependence, uncomplicated	F19.29	Oth psychoactive substance dependence w unsp disorder
F19.21	Other psychoactive substance dependence, in remission		

APPENDIX F — BH I/DD TAILORED PLAN POPULATION

Pursuant to S.L. 2015-245, as amended, DHHS will contract with BH I/DD Tailored Plans for individuals with high BH needs. The BH I/DD Tailored Plans are expected to launch no sooner than one year after the implementation of Standard Plans. The majority of Medicaid and NC Health Choice beneficiaries, including adults and children with lower BH needs, will receive services through the Standard Plan upon launch of managed care. Prior to launch of the BH I/DD Tailored Plans, individuals with higher BH needs that meet certain eligibility criteria will continue to receive coverage through their current delivery system, and have the option to enroll in a Standard Plan. Following launch of the BH I/DD Tailored Plans, eligible beneficiaries will be enrolled into the BH I/DD Tailored Plans with the option to enroll in a Standard Plan. Please see the Behavioral Health and Intellectual/Developmental Disability Tailored Plan Medicaid Managed Care Proposed Concept Paper, released on November 9, 2017 for additional information on the proposed BH I/DD Tailored Plan design.[22] Additional information is included in S.L. 2018-48 legislation. Information outlined below does not reflect legislative changes made during the 2018 session.

Population Eligible for BH I/DD Tailored Plan

Detailed logic used for identifying the population eligible for BH I/DD Tailored Plans that were excluded from the Standard Plan population for purposes of draft rate development is outlined in Appendix E. This logic will be reviewed for final rate development for consistency with final program requirements.

The tables below illustrate the PMPM and average monthly member count for the Standard Plan population, as well as various sub-populations of the BH I/DD Tailored Plan group. The BH I/DD Tailored Plan columns are also summarized by Standard Plan rate cells to illustrate what population group these members would be included in if they opt out of the BH I/DD Tailored Plan (or their current delivery system prior to BH I/DD Tailored Plan launch). Approximately 10.0% of the I/DD population represents Innovations waiver participants and ICF/IID users who are not expected to opt out of the BH I/DD Tailored Plan as these services will only be available through the BH I/DD Tailored Plan. These individuals are included in the I/DD figures below.

Standard Plan and Non-Dual BH I/DD Tailored Plan Population PMPM Summary (based on SFY 2017 experience)

		BH I/DD Tailored Plan Population			
COA	Standard Plan Population	I/DD	SPMI/SED	SUD	Total BH I/DD Tailored Plan Population
ABD	$993.02	$2,707.27	$2,314.62	$1,643.31	$2,594.58
TANF, Newborn (<1)	$388.12	$2,146.91	$2,064.69	$1,786.54	$2,146.65
TANF, Child (1-20)	$110.47	$666.82	$1,666.39	$499.46	$1,013.98
TANF, Adult (21+)	$292.20	$1,211.15	$1,257.40	$893.45	$1,069.22
Maternity Event	$4,991.76	$8,822.83	$8,198.65	$6,356.14	$7,466.61
Total	$240.91	$1,942.30	$1,829.09	$1,070.28	$1,831.13

Standard Plan and Non-Dual BH I/DD Tailored Plan Population Average Monthly Member Count

		BH I/DD Tailored Plan Population			
COA	Standard Plan Population	I/DD	SPMI/SED	SUD	Total BH I/DD Tailored Plan Population
ABD	132,816	33,330	7,062	1,870	42,262
TANF, Newborn (<1)	70,808	1,289	2	1	1,292
TANF, Child (1-20)	1,111,653	19,237	10,962	920	31,118
TANF, Adult (21+)	242,395	2,032	3,435	5,318	10,785
Maternity Event	4,456	30	39	62	130
Total	1,557,672	55,888	21,460	8,108	85,456

[22] Behavioral Health and I/DD Tailored Plan Concept Paper. November 9, 2017. https://files.nc.gov/ncdhhs/documents/files/BH-IDD-TailoredPlan_ConceptPaper_20181109.pdf?CkZhWxchGeNGBa2wXQSrSwWPrqi41aVP

As shown above, the non-dual BH I/DD Tailored Plan population assumed for draft capitation rate development is approximately eight times costlier, on a per member basis, compared to the Standard Plan population. When narrowing this comparison to non-I/DD non-dual BH I/DD Tailored Plan members, this sub-population is approximately seven times costlier, on a per member basis, compared to the Standard Plan population. However, it is important to note that overall the Standard Plan has a significantly larger membership base. The total non-dual BH I/DD Tailored Plan population exempt from Standard Plan enrollment represents approximately 5.5% of the total combined Standard Plan and non-dual BH I/DD Tailored Plan members on a statewide basis.

Standard Plan Beneficiaries Demonstrating Potential Need for BH I/DD Tailored Plans

Beneficiaries who are enrolled in a Standard Plan will have the ability to opt in to the BH I/DD Tailored Plan (or FFS and LME/MCO prior to the launch of the BH I/DD Tailored Plans) if they demonstrate a need for a service offered only through the BH I/DD Tailored Plan (or LME/MCO). Given the potential for individuals to shift between the Standard Plan and BH I/DD Tailored Plan, Mercer will continue to evaluate the cost profiles of these different populations to understand potential impact to capitation rates. No considerations have been made in the draft rates for any shifting expectation. Mercer and DHHS will continue to discuss this issue and may incorporate consideration into risk adjustment or an adjustment into final rate development.

Information related to the BH I/DD Tailored Plan population does not reflect legislative changes made during the 2018 session.

APPENDIX G – APPROACH TO MEDICAID HOSPITAL PAYMENTS AFTER THE TRANSITION TO MANAGED CARE

North Carolina's Department of Health and Human Services (DHHS) and North Carolina hospitals, working through the North Carolina Hospital Association (NCHA), participated in a collaborative process to develop an approach to non-behavioral health-related hospital payments as part of the State's transition to managed care.[23] The table below outlines the approach agreed to by all parties, which will be incorporated in the final PHP rate-setting methodology.[24]

Key Issue	Approach
Hospital payment rate floors under managed care	• Require PHPs to reimburse hospitals no less than the applicable Medicaid fee-for-service (FFS) rate, unless the PHP and hospital have mutually agreed to an alternative reimbursement amount or methodology, for the following durations: o Five contract years to all critical access hospitals and all hospitals located in economically distressed counties as defined by the Department. o Three contract years to all other hospitals.
Inpatient payment methodology	• Each hospital assigned unique DRG base rate that applies in Medicaid FFS and serves as the basis for rate floor under managed care[25]. o Base rate calculated to ensure all hospitals in a class of providers receive the same portion of total inpatient Medicaid and uninsured costs covered; base rate for hospitals owned by UNC Health Care and for Vidant Medical Center set according to same methodology o Inpatient base rates for critical access hospitals (CAHs) calculated to approximate each CAH's current FFS per-discharge reimbursement • The rate floor for PHPs includes Medicaid case weights and outlier methodologies used in calculating inpatient payments to hospitals under FFS. • Each hospital's DRG base rate will be increased annually by the Medicare inpatient hospital PPS market basket update less the productivity adjustment, as published in the Medicare Hospital Inpatient

[23] Hospitals currently negotiate behavioral health reimbursement with LME/MCOs and will continue to negotiate behavioral health reimbursement with PHPs after the managed care transition. Additionally, the FFS reimbursement methodology for behavioral health claims will remain unchanged.
[24] Note that many categories include special treatment for hospitals owned by UNC Health Care and for Vidant Medical Center in order to maintain current net payment levels and reflecting the fact that these hospitals have historically been treated differently under fee-for-service Medicaid.
[25] Hospital rate floor requirements are prescribed in the PHP contract.

Key Issue	Approach
	Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule (called "Medicare market basket update minus productivity adjustment" throughout remainder of document)[26] • PHPs make additional, utilization based, directed payments to hospitals owned by UNC Health Care and Vidant Medical Center to maintain current net payment levels (in combination with other payments).
Outpatient payment methodology	• Each hospital paid defined percentage of charges that approximates 100% of outpatient costs • Applies in Medicaid FFS and serves as the rate floor under managed care[27]. • For purposes of the outpatient payment methodology, charges will not be permitted to increase by more than the Medicare market basket update minus productivity adjustment. • PHPs make additional, utilization based, directed payments to hospitals owned by UNC Health Care and Vidant Medical Center to maintain current net payment levels and in combination with other payments).
Graduate Medical Education	• DHHS will make Medicaid GME payments directly to hospitals; GME payments excluded in developing hospital-specific inpatient DRG base rates (see above) • Direct graduate medical education payments (DGME) calculated using statewide per-resident average of salary/fringe benefit costs, multiplied by each hospital's number of residents (not subject to Medicare resident caps) and adjusted for hospital's share of Medicaid days o For UNC Hospitals and Vidant Medical Center (as the primary affiliated teaching hospitals for each University of North Carolina medical school), DGME payments will be calculated using hospital-specific fully-loaded salary/fringe benefit costs, multiplied by each hospital's number of residents and adjusted for hospital's share of Medicaid days • Indirect medical education (IME) calculated using Medicare formula (excluding Medicare resident caps), multiplied by each hospital's number of Medicaid discharges and CMI o UNC Hospitals and Vidant Medical Center will calculate IME according to the same

[26] "Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule," available at: https://www.federalregister.gov/documents/2017/08/14/2017-16434/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the. CMS also tracks quarterly changes in the market basket update. The Final Rule incorporates this data in setting the annual market basket update. Quarterly market basket data is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html.

[27] Hospital rate floor requirements are prescribed in the PHP contract.

Key Issue	Approach
	methodology • GME payment amounts to be recalculated annually.
Fee-for-Service	• Inpatient and outpatient payment methodologies listed above apply to FFS discharges/encounters. • Approach will lead to increased gross payments only for "crossover claims" (claims where Medicaid is secondary to Medicare or third-party coverage), since supplemental payments are not currently made on those claims. • Increase in provider assessment and/or IGTs will fund the non-federal share of additional payments, so this will not result in increased cost to the State.
MCHIP/NC Health Choice	• Inpatient and outpatient payment methodologies listed above apply to MCHIP and NC Health Choice discharges/encounters. • Approach will lead to increased gross payments, as supplemental payments are not currently paid on NC Health Choice population. • Increase in provider assessment/IGTs will fund non-federal share of additional payments, so this will not result in increased cost to the State.
Additional physician payment methodology for primary affiliated teaching hospitals for each University of North Carolina medical school	• DHHS to leverage current physician UPL payment methodology memorialized in state plan to extent possible; minor adjustments will be made to comply with managed care regulations and transition reimbursement to "directed payment" framework under 42 C.F.R. § 438.6(c).
Financing	<u>Provider Assessment</u>[28] • Establish two separate assessments: o Base assessment. Applies to qualified public hospitals (QPH) and non-qualified public hospitals (NPQH). o Supplemental assessment. Applies to NQPHs only. • Base assessment methodology. o Identify total amount collected under current UPL assessment. o Add non-federal share of crossover claims, incremental GME costs and enhanced NC Health

[28] Revisions to assessment methodology require legislative approval.

Key Issue	Approach
	Choice payments. o Divide amount by total hospital costs for all hospitals subject to the base assessment. • Supplemental assessment methodology. o Identify dollar amount collected under current equity assessment. o Divide amount by total hospital costs for all hospitals subject to the supplemental assessment. • State retains $140 million annually, trended annually based on the Medicare market basket index minus productivity adjustment, from assessment proceeds. Remainder of proceeds used to fund PHP capitation payments, Medicaid and CHIP FFS inpatient and outpatient hospital payments and GME payments. • State to recalculate assessment rates annually to account for changes in Medicaid hospital payments, GME slots, and Medicaid/CHIP federal matching rates, among other factors. • Hospitals currently exempt from the provider assessment under NC 108A-122 will remain exempt from the assessment under the new hospital payment plan. <u>Intergovernmental Transfers (IGTs)</u> • All hospitals that currently make IGTs will continue to make IGTs after the transition to managed care. • Aggregate IGT amounts will be calculated to approximate total IGTs made in the 2018 MRI/GAP plan, adjusted to account for increased crossover claims, incremental GME costs, enhanced NC Health Choice payments, and any other payment increases, and will be adjusted annually to account for changes in Medicaid hospital payments.