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March 9, 2011

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

Re: Capitation Rates for Medicaid Expansion

Dear Jason:

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

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

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

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

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

Data Reliance

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

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

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

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

Variability

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

Background

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

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

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

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

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

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

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

Development of 2011 Average Capitation Rate

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

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

Average 2009 Claim Cost (Row (2))

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

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

Adjustment for Missing Experience (Row (3))

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

Trend (Row (4))

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

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

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

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

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

Benefit Adjustment Factors (Row (5))

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

MNCare

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

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

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

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

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

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

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

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

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

PGAMC

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

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

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

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

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

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

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

Morbidity Adjustments (Row (6))

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

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

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

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

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

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

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

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

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

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

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

Administrative Cost (Row (7))

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

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

Contribution to Surplus (Row (8))

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

Average 2011 Capitation Rate (Row (9))

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

Capitation Rates by Rate Cell

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

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

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

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

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

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

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

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

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

Appendix II-E Tables

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

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Jason, I am available for questions by phone at [redacted] and by e-mail at [redacted].

Sincerely,

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

LMW/mtf

Exhibit A: Development of Average Premium Rate

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

Exhibit B: Summary of Benefits

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

Exhibit C-1: Projected Enrollment

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

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

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

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

Exhibit D - 1: Rates by Rate Cell -- MNCare

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

Exhibit D-2: Rates by Rate Cell -- PGAMC

Development of Metro and Non Metro Area Factors

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

Morbidity Factor

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

Projected 2011 Enrollment

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

Capitation Rate by Rate Cell

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

Exhibit D - 3: Rates by Rate Cell – Additional

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

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

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

Exhibit E: Appendix II-E Tables

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

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

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

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

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

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