

# MERCER

Government Human Services Consulting

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November 2, 2005

Mr. Jon Barley  
Bureau of Managed Health Care  
Ohio Department of Job and Family Services  
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Subject:  
Calendar Year 2006 Rate-Setting Methodology & Capitation Rate  
Certification

Dear Jon:

The Ohio Department of Job and Family Services (State) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rates for Calendar Year (CY) 2006 for the Healthy Families and Healthy Start managed care populations. Mercer has developed CY 2006 capitation rates for 17 specific counties. This methodology letter outlines the rate-setting process, provides information on specific data adjustments, and includes summaries of data from historical fee-for-service (FFS) claims, managed care plan (MCP) reported encounter data, MCP-submitted cost report data, and final rate summaries.

The key components in the CY 2006 rate-setting process are:

- Base data development,
- Managed care rate development, and
- Centers for Medicare and Medicaid Services (CMS) documentation requirements.

Each of these components is described further throughout the document and is depicted in the flowchart included as Appendix A.

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## Base Data Development

The major steps in the development of the base data were similar to previous years. Mercer and the State have discussed the available data sources for rate development and the applicability of these data sources for each county. The data sources used for CY 2006 rate setting were:

- Ohio historical FFS data,
- MCP financial cost report data, and
- MCP encounter data.

## Validation Process

As part of the rate-setting process, Mercer validated each of the data sources that were used to develop rates. The validations included a review of the data to be used in the rate-setting process. During the validation process, Mercer adjusted the data for any data miscodes (e.g., males in the delivery rate cohort) that were found.

## Data Sources

As Ohio's Medicaid program matures, the rate-setting methodology for those counties with stable managed care programs can focus more on plan-reported managed care data, including encounter data and cost reports. For counties without established managed care programs, Mercer continued to use the FFS data as a direct data source. The process to prepare these three data sources for rate setting is detailed below.

Appendix B includes a chart detailing how the counties have been bucketed into mandatory, Preferred Option, voluntary, or new based on the delivery system in place during the base period. This determined which data sources were used in determining county-specific CY 2006 rates. For Stark and Clark counties, all three data sources were considered due to the timing of the counties' change in enrollment type during 2003.

Other sources of information that were used, as necessary, included state enrollment reports, state financial reports, projected managed care penetration rates, information from the MCP surveys, encounter data issues log, and other ad hoc sources.

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## Fee-for-Service Data

FFS experience from the base time period of State Fiscal Year (SFY) 2003–SFY 2004 was used as a direct data source for the counties described below:

- those that had a voluntary managed care program during the base time period, and
- those that did not have a managed care program during the base time period.

In addition to the SFY 2003 and SFY 2004 data, SFY 2002 data supplemented the FFS base data development as a reasonability measure. For the above counties, the FFS data was considered the most credible data source and, in some cases, was the only data available for rate setting.

As in previous years, adjustments were applied to the FFS data to reflect the actuarially equivalent claims experience for the population that will be enrolled in the managed care program. The State Medicaid Management Information System (MMIS) includes data for populations and/or services excluded from managed care and the actual FFS paid claims may be net or gross of certain factors (e.g., gross adjustments or third party liability (TPL)). As a result of these conditions, it was necessary to make adjustments to the FFS base data as documented and quantified in Appendix C and outlined in Appendix A. The FFS data summaries are included in Appendix E.

## Encounter Data

MCP encounter experience from the base time period of SFY 2003–SFY 2004 was used as a direct data source for the counties described below:

- those that had a mandatory managed care program during the base time period, and
- those that had a Preferred Option managed care program during the base time period.

For the above counties, the encounter data was considered a credible data source and was used along with the financial cost report data as a direct data source.

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Although encounter data is generally reflective of the populations and services that are the responsibility of the MCPs, adjustments were applied to the encounter data, as appropriate. Those adjustments, and other considerations, include the following items:

- claims completion factors,
- program changes in the historical base time period (SFY 2003–SFY 2004), and
- other actuarially appropriate adjustments, as needed, and according to the State’s direction to reflect such things as incomplete encounter reporting or other known data issues.

The adjustments to the encounter data are further documented and quantified in Appendix C and outlined in Appendix A. The encounter data summaries are included in Appendix F. These summaries reflect updated completion factors based on our review of the lag triangles included in the CY 2004 cost reports. Appendix D includes an outline of the methodology used to assign unit costs to the encounter records since this is not a required field for reporting encounters.

## Financial Cost Reports

MCP-submitted financial cost reports from the base time period CY 2003–CY 2004 were used as a direct data source for the counties described below:

- those that had a mandatory managed care program during the base time period, and
- those that had a Preferred Option managed care program during the base time period.

For all of the above counties, the cost reports were considered credible data sources. In addition, for counties with voluntary managed care programs during the base time period, the cost reports were taken into consideration when setting rates, although not used as a direct data source.

As with the encounter data, the cost report data typically reflects the populations and services that are the responsibility of the MCPs. However, adjustments were applied to the cost report data, as appropriate. Those adjustments, and other considerations, include the following items:

- program changes in the historical base time period (CY 2003–CY 2004),
- incurred claims estimates based on review of claims lag triangles, and
- other actuarially appropriate adjustments, as needed, to reflect such things as incomplete reporting or other known data issues.

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Mercer considered the CY 2003 and CY 2004 cost reports both in the development of completion factors for the base time period (CY 2003-CY 2004) and in development of the final rate.

The adjustments for the cost report data are further documented and quantified in Appendix C and outlined in Appendix A. The cost reports summaries are included in Appendix G.

## Managed Care Rate Development

This section explains how Mercer developed the final capitation rates paid to contracted MCPs after the base data was developed and multiple years of data were blended for each data source. First, Mercer applied trend and other adjustments to each data source to project the program cost into the contract year. Next, the various data sources were blended into a single managed care rate. Programmatic changes and an administrative component were applied. Finally, relational modeling was used to smooth the results within each county. Appendix A outlines the managed care rate development process. Appendix D provides more detail behind each of the following adjustments.

### Blending Multiple Years of Data

As the programs have matured, we have collected multiple years of FFS and managed care data. In order to utilize all available current information, Mercer combined the yearly data within each data source using a weighted average methodology similar to that used in previous years. Prior to blending these years of data, the base time period experience was trended to a common time period of CY 2004. Mercer applied greater credibility on the most recent year of data to reflect the expectation that the most recent year may be more reflective of future experience and to reflect that fewer adjustments are needed to bring the data to the effective contract period.

### Managed Care Assumptions for the FFS Data Source

In developing managed care savings assumptions, Mercer applied generally accepted actuarial principles that reflect the impact of MCP programs on FFS experience. Mercer reviewed Ohio's historical FFS experience, CY 2003 and CY 2004 cost report data, SFY 2003 and SFY 2004 encounter data, and other state Medicaid managed care experience to develop managed care savings assumptions. These assumptions have been applied to the FFS data to derive managed care cost levels. The assumptions are consistent with an economic and efficiently operated Medicaid managed care plan. The managed care savings assumptions vary by county, rate cohort and category of service (COS).

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Specific adjustments were made in this step to reflect the differences between pharmacy contracting for the State and contracting obtained by the MCPs. Mercer reviewed information related to discount rates, dispensing fees, rebates, encounter data and MCP cost report data to make these adjustments. The rates are reflective of MCP contracting for these services.

## Shadow Pricing

In their encounter submissions, MCPs are not required to report the amount paid for a particular service. Therefore, Mercer developed assumed unit costs that were applied to encounter data. For the inpatient category of service, unit costs were calculated by county based on the average daily cost for each hospital peer group. Unit costs for other COSs were calculated based on Ohio Medicaid FFS reimbursement levels. In addition, a unit cost managed care assumption was applied in the shadow pricing step for the pharmacy COS.

## Prospective Policy Changes

CMS also requires that the rate-setting methodology incorporates the impact of any programmatic changes that have taken place, or are anticipated to take place, between the base period (CY 2004) and the contract period (CY 2006).

The State staff provided Mercer with a detailed list of program changes that may have a material impact on the cost, utilization, or demographic structure of the program prior to, or within, the contract period and whose impact was not included within the base period data. Final programmatic changes approved for SFY 2006 are reflected in the CY 2006 rates, as appropriate. Please refer to Appendix D for the impact of these programmatic changes.

## Clinical Measures/Incentives

Per Appendix M of the Provider Agreement, the State expects the MCPs to reach certain performance levels for selected clinical measures. Mercer reviewed the impact of these standards and incentives on the managed care rates and developed a set of adjustments based upon the State's expected improvement rates. These utilization targets were built into the capitation rates. The individual measures/incentives are quantified in Appendix D.

## Caseload

Historically, the State has experienced significant changes in its Medicaid caseload. These shifts in caseload have affected the demographics of the remaining Medicaid population. Mercer evaluated these caseload variations to determine if an adjustment was necessary to account for

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demographic changes. Based on the data provided by the State, Mercer determined no adjustments were necessary for either the non-delivery or delivery rate cells.

## Selection Issues

There are two selection adjustments that were made in the development of the rates. The first is adverse selection, which accounts for the “missing” managed care data and is applied to historical FFS data. This adjustment is explained in more detail in Appendix C.

The second selection adjustment is voluntary selection, which accounts for the fact that costs associated with individuals who elect to participate in managed care are generally lower than the remaining FFS population. Therefore, the voluntary selection adjustment adjusts for the risk of only those members selecting managed care. The voluntary selection adjustment varies by county, based on the projected managed care penetration level.

Both selection adjustments are reductions to paid claims and utilization for non-delivery data. Appendix D provides more detail around the voluntary selection adjustment, by county.

## Non-State Plan Services

According to the CMS Final Medicaid Managed Care Rule that was implemented August 13, 2003, non-state plan services may not be included in the base data for rate setting. The CY 2004 cost reports contain MCP information that Mercer used to adjust the base data for non-state plan services reported in the cost report and encounter data. Please refer to Appendix D for more information concerning this adjustment.

## Prospective Trend Development

Trend is an estimate of the change in the overall cost of providing a specific benefit service over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in some future year, based on expenses incurred in prior years. Trend was applied by COS to the blended costs for CY 2004 to project the data forward to the CY 2006 contract period.

Cost report data was reviewed for overall per member per month (PMPM) trend levels while the FFS data continued to be a primary source in projecting trend. This year, because of its role in the rate-setting process, the encounter data was available to study utilization trend drivers. Mercer integrated the specific data sources’ trend analysis with a broader analysis of other trend resources. These resources included health care economic factors (e.g., Consumer Price Index

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(CPI) and Data Resource, Inc. (DRI)), trends in neighboring states, the State FFS trend expectations and any Ohio market changes. Moreover, the trend component was comprised of both unit cost and utilization components.

As in the past, Mercer discussed all trend recommendations with State staff. We reviewed the potential impact of initiatives targeted to slow or otherwise affect the trends in the program. Final trend amounts were determined from the many trend resources and this additional program information. Appendix D provides the trend detail by COS.

## Credibility Assignment

Mercer assigned a credibility weight to blend the data sources into a single managed care rate for each county. Each rate was a blending of the data sources as explained above under "Data Sources". Credibility varied by data source and by COS. These credibility weightings were determined based on a review of and comparisons with encounter data, cost report data, FFS data, prior year capitation rates and overall MCP financial results. Appendix D contains the credibility weightings for each data source.

## Caesarean Delivery Rate

Mercer reviewed historical FFS delivery data, recent MCP delivery data, and other program experience to determine an expected caesarean delivery rate under the managed care program. Please refer to Appendix D for the caesarean delivery rate percentages and the adjustment used in rate development.

## Relational Modeling

As is generally the case when setting rates by individual county, variability exists in the relationship between the rate cohorts and the rate increases on a year by year basis. Mercer applied techniques to smooth the volatility including credibility blending of multiple years of data and combining data sources. To further mitigate the volatility in rate levels, Mercer used relational modeling to smooth the residual inconsistencies across rate cells. The relational modeling adjustments shift dollars across rate cells within a county but do not change the composite results by county or in aggregate. Through the use of the adjustments, the range of variances among the counties and rate cohorts was reduced while maintaining budget neutrality.

The relational modeling adjustments were applied to the net medical rates in the capitation rate calculation sheet (CRCS) to develop new adjusted medical rates. An administration load factor was then applied as a percent of premium.

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## Administration/Contingencies

Mercer reviewed the components of the administration/contingencies allowance and evaluated the administration/contingencies rates paid to the MCPs. Factors that were taken into consideration in determining the final administration/contingencies percentages included the State's expectations, Ohio health plan experience, review of other Medicaid program administration/contingencies allowances, and Ohio health plans' lengths of participation in the program. Appendix D provides further detail on the administration/contingencies allowance.

## Certification of Final Rates

The following capitation rates were developed for each participating county for the Calendar Year 2006 contract period:

- Healthy Families/Healthy Start, Less Than 1, Male & Female,
- Healthy Families/Healthy Start, 1 Year Old, Male & Female,
- Healthy Families/Healthy Start, 2-13 Years Old, Male & Female,
- Healthy Families/Healthy Start, 14-18 Years Old, Female,
- Healthy Families/Healthy Start, 14-18 Years Old, Male,
- Healthy Families, 19-44 Years Old, Female,
- Healthy Families, 19-44 Years Old, Male,
- Healthy Families, 45 and Over, Male & Female,
- Healthy Start, 19-64 Years Old, Female, and
- Delivery Payment.

A summary of the rates and the rate increase analysis are included in Appendix H and Appendix I, respectively.

Mercer certifies the above rates were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by Mercer are actuarial projections of future contingent events. Actual MCP costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and to demonstrate that rates are in accordance with applicable law and regulations.

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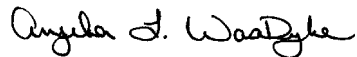
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MCPs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by MCPs for any purpose. Mercer recommends any MCP considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with the State. Use of these rates for purposes beyond that stated may not be appropriate.

Sincerely,



Angela WasDyke, MAAA, ASA

Copy:

Chuck Betley

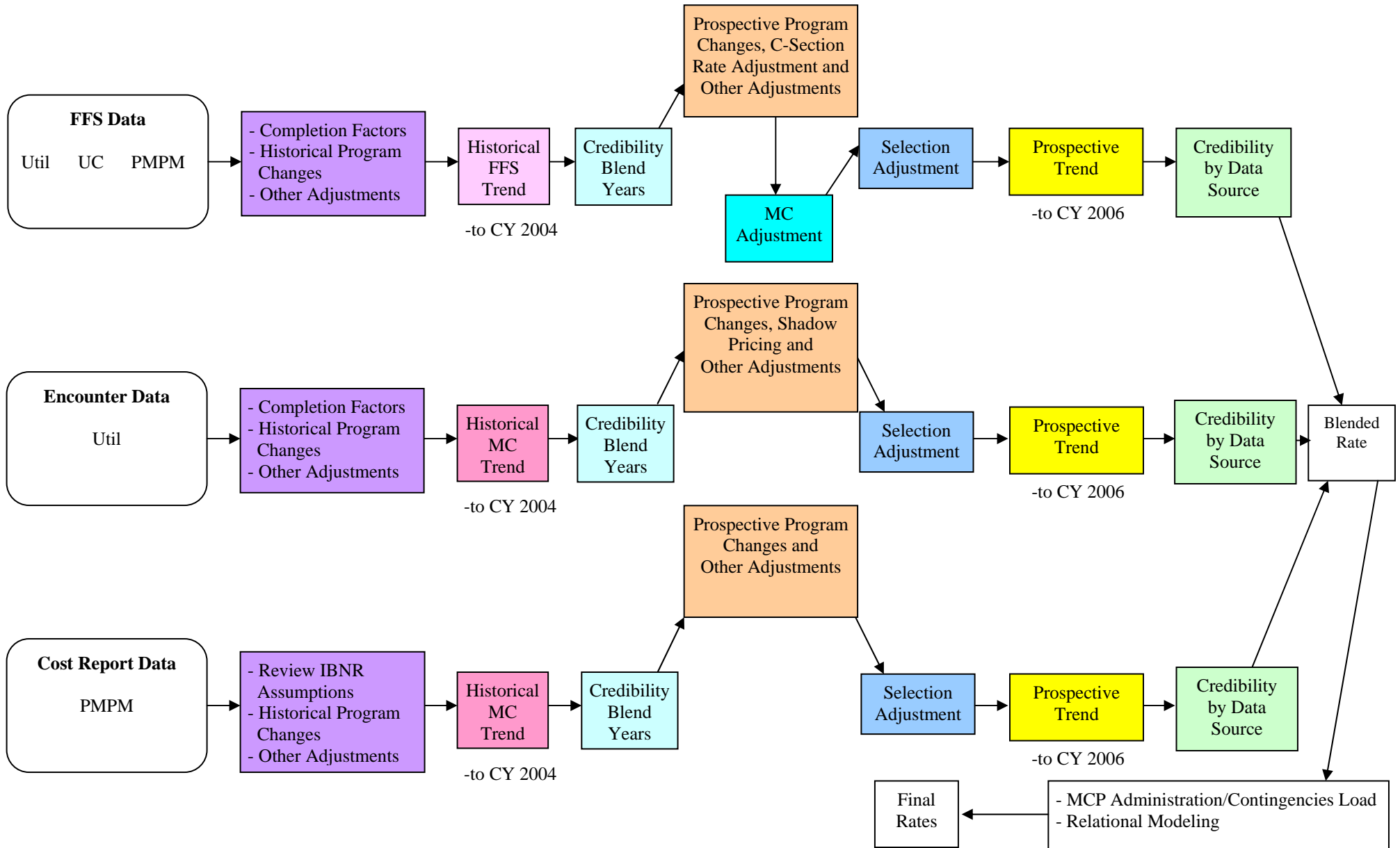
Mitali Ghatak

Shereen Jensen

Wendy Radunz

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## Appendix A – CY 2006 Rate-Setting Methodology



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## Appendix B – County Delivery System Definition

### Mandatory and Preferred Option Counties

Encounter and cost report data were used for counties that were either mandatory or Preferred Option during the base data period. These counties include:

<b>Mandatory:</b>	<b>Preferred Option:</b>
Cuyahoga	Butler
Lucas	Clark (March 2003)
Stark (June 2003)	Franklin
Summit	Hamilton
	Lorain
	Montgomery

### Voluntary and New Counties

FFS data was used for voluntary counties during the base period and new counties entering the managed care program since the time of the base data. These counties include:

<b>Voluntary:</b>	<b>New</b>
Clark (prior to March 2003)	Mahoning
Clermont	Trumbull
Greene	
Pickaway	
Stark (prior to June 2003)	
Warren	
Wood	

County-specific rates were developed for each county listed above.

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## Appendix C – FFS Data Adjustments

This section lists adjustments made to the FFS claims and eligibility information received from the State. Unless stated otherwise, adjustments were applied by multiplying the FFS data by one plus the adjustment factor.

### Completion Factors

The claims data was adjusted to account for the value of claims incurred but unpaid on a COS basis. Mercer used claims for SFY 2003 and SFY 2004 that reflect payments through the dates included in the following table.

<b>State Fiscal Year</b>	<b>Paid Through</b>
<b>2003</b>	03/31/04
<b>2004</b>	12/31/04

The value of the claims incurred during each of these years, but unpaid, was estimated using completion factor analysis.

<b>Category of Service</b>	<b>State Fiscal Year</b>	
	<b>SFY 2003</b>	<b>SFY 2004</b>
Inpatient	99.4%	94.9%
Outpatient	99.5%	99.1%
Physician	99.0%	98.2%
Pharmacy	99.9%	100.7%*
Other	99.2%	98.6%

The incurred dollars and units in our database were completed by dividing by these completion factors.

\* Please note the original completion factor of 99.8% has been updated to 100.7% to reflect the duplicate pharmacy claims from SFY 2004 that have recently been voided from the system.

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## Gross Adjustment File (GAF)

To account for gross debit and credit amounts not reflected in the FFS data, adjustments were applied to the FFS paid claims. The following is a summary of the GAF adjustments applied to the FFS data:

<b>Healthy Start</b>		
<b>Category of Service</b>	<b>SFY 2003</b>	<b>SFY 2004</b>
Inpatient	0.56%	0.30%
Outpatient	-0.03%	-0.12%
Emergency Room	0.00%	0.00%
Primary Care Physician	0.09%	0.08%
OB/GYN	0.00%	0.00%
Specialists	0.00%	0.00%
Ambulatory Surgical Centers	0.00%	0.01%
Pharmacy	0.00%	0.00%
Nursing Facility	0.00%	0.00%
Home Health	0.03%	0.01%
Laboratory	-0.01%	0.03%
Ambulance	0.00%	0.00%
Dental	-0.01%	0.02%
Vision	-0.01%	-0.01%
Non-emergent Transportation	0.00%	0.00%
Supplies & DME	-0.01%	0.02%
Other Practitioners	0.00%	0.00%
Other Services	0.38%	1.99%
Family Planning	0.00%	0.00%

<b>Healthy Families</b>		
<b>Category of Service</b>	<b>SFY 2003</b>	<b>SFY 2004</b>
Inpatient	0.48%	0.09%
Outpatient	-0.02%	-0.06%
Emergency Room	0.00%	0.00%
Primary Care Physician	0.07%	0.09%
OB/GYN	0.00%	0.00%
Specialists	0.00%	0.00%
Ambulatory Surgical Centers	-0.01%	-0.01%
Pharmacy	-0.01%	-0.01%

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<b>Healthy Families (continued)</b>		
<b>Category of Service</b>	<b>SFY 2003</b>	<b>SFY 2004</b>
Nursing Facility	-0.03%	0.00%
Home Health	0.01%	0.01%
Laboratory	0.00%	0.01%
Ambulance	-0.06%	0.00%
Dental	0.00%	0.02%
Vision	-0.01%	0.00%
Non-emergent Transportation	0.00%	0.00%
Supplies & DME	0.00%	0.00%
Other Practitioners	0.00%	0.01%
Other Services	0.00%	0.52%
Family Planning	0.00%	0.00%

## Historical Policy Changes

As part of the rate-setting process, Mercer must account for policy changes that occurred during the base data time period. Changes only reflected in a portion of the data must be applied to the remaining data so that the base data reflects all of the policy changes. All policy changes implemented during SFY 2003 and SFY 2004 were applied in the FFS Data Summaries.

The FFS Data Summary adjustments outlined in the following table show the impact of the specified policy changes applied to the SFY 2003 and SFY 2004 delivery (where applicable) and non-delivery data. These adjustments were calculated based on the “History of Policy Changes” document and other information supplied by the State.

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Policy Changes	Effective Date <sup>1</sup>	Category of Service Affected	Rate Cohorts Affected	Encounter Data Summary Adjustments	
				SFY 2003	SFY 2004
Inpatient Outlier Payment Methodology – Exceptional cost outlier threshold increased from \$250,000 to \$443,463	8/1/2002	Inpatient	All Non-Delivery	-0.1%	0.0%
Anesthesia Services – Conversion factor decreased to \$8.13	9/1/2002	Specialists	All	0.0%	0.0%
Independently-practicing psychologist services eliminated for adults (>21) and pregnant women	1/1/2004	PCP, OB/GYN and Specialists	Ages 19+, including delivery	-0.1%	-0.1%
All podiatry and chiropractic services eliminated for adults (>21) and pregnant women	1/1/2004	Other	HF, Age 19-44, M	-9.0%	-4.5%
			HF, Age 19-44, F	-10.0%	-5.0%
			HF, Age 45+, M & F	-8.0%	-4.0%
			HST, Age 19-64, F	-4.0%	-2.0%

<sup>1</sup> When the effective date is not the beginning of the SFY, a fraction of the adjustment is applied to the SFY the program change was made.

## Third Party Liability Recoveries

TPL can be identified with two components: “cost-avoidance” and “pay and chase” type actions. “Cost-avoidance” occurs when the State initially denies paying a claim because another payer is the primary payer. The State may then pay a residual portion of the charged amount. Only the residual portion of the claim will be included in the FFS data. The portion of the claim paid by another payer has been avoided and not included in reported claim payments. Participating MCPs are expected to pay in a similar fashion and therefore, no adjustment to the FFS data will be required.

In a “pay and chase” scenario, the State pays the claim as though it were the primary payer. Subsequent to payment, the State makes recovery from a third party. The State has indicated the FFS data does not reflect these recoveries. Since MCPs are also expected to take similar recovery actions, the FFS experience was adjusted for “pay and chase” recoveries. The following table summarizes the adjustment factor:

State Fiscal Year	TPL Adjustment Factor
2003	-1.11%
2004	-1.15%

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These factors were applied to both the paid claims and utilization for all non-delivery and delivery COS. Since MCPs do not collect tort recoveries, the data excludes tort collections.

## Hospital Cost Settlements

The State provided Mercer with SFY 2003 and SFY 2004 interim cost settlements for Diagnosis Related Group (DRG) and DRG-exempt hospitals. The DRG-exempt hospital information included inpatient settlements. However, the DRG hospitals only include capital settlements, which were incorporated into the inpatient adjustment. The adjustment has been applied to non-delivery and delivery inpatient, outpatient, and emergency room (ER) claims.

<b>State Fiscal Year</b>	<b>I/P, O/P and ER Adjustment Factor</b>
<b>2003</b>	-0.31%
<b>2004</b>	-0.73%

## Fraud and Abuse

The State does pursue recoveries from fraud and abuse cases. The dollars recovered are accounted for outside of the State's MMIS system and are not included in the FFS data. Therefore, the following adjustments have been applied to the FFS claims and utilization in both the delivery and non-delivery data.

<b>State Fiscal Year</b>	<b>Fraud and Abuse Adjustment Factor</b>
<b>2003</b>	-0.02%
<b>2004</b>	-0.01%

## Excluded Time Periods

The capitation rates paid to the MCPs reflect the risk of serving the eligible enrollees from the date of health plan enrollment forward. Therefore, the non-delivery FFS data has been adjusted to reflect only the time periods for which the MCPs are at risk. Since newborns are automatically eligible for the Medicaid program and are enrolled into their mother's MCP at birth, no adjustment was applied to the "Less Than 1" age group. For other age groups, the adjustment was -7.50% to the paid claims and utilization, and the associated member months have been reduced by -2.50%.

## Adverse Selection

There are two selection adjustments that were made to the data. The first is adverse selection, which has been applied to the historical FFS data and accounts for the "missing" managed care data. The adverse selection adjustment corrects the associated risk of the FFS members to the entire Medicaid population's risk by accounting for the cost of the managed care population.

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This adjustment varies by historical managed care penetration and includes a credibility factor which accounts for differences in State enrollment patterns and data sources. It has been applied to the paid claims and utilization for non-delivery FFS base data.

The second selection adjustment is voluntary selection, which accounts for the fact that costs associated with individuals who elect to participate in managed care are generally lower than the remaining FFS population. This adjustment was not made to the FFS base data, but was made to the capitation rates and is described in the main body of the letter and outlined in Appendix D.

The chart below shows the historical penetration rates and the associated adverse selection adjustment by voluntary county. For new counties, the adverse selection adjustment was zero.

County	SFY 2003		SFY 2004	
	Historical Penetration	Adverse Selection Adjustment	Historical Penetration	Adverse Selection Adjustment
Clark	9%	-0.9%	0%	0.0%
Clermont	1%	-0.2%	1%	-0.2%
Greene	5%	-0.6%	7%	-0.8%
Pickaway	4%	-0.5%	4%	-0.5%
Stark	2%	-0.3%	0%	0.0%
Warren	3%	-0.4%	3%	-0.4%
Wood	15%	-1.6%	14%	-1.5%

## Dual Eligibles

Dual eligible persons are not enrolled in managed care and are therefore not included in the managed care rates. Their experience has been excluded from the base FFS data used to develop the rates.

## Catastrophic Claims

Since the State does not provide reinsurance to the MCPs, the MCPs are expected to purchase reinsurance on their own. To reflect these costs, all claims, including claims above the reinsurance threshold, were included in the base FFS data. The final rates Mercer calculated reflect the total risk associated with the covered population and are expected to be sufficient to cover the cost of the required stop-loss provision.

## DSH Payments

DSH payments are made by the State to providers and are not the responsibility of the MCPs; therefore, the information for these payments was excluded from the FFS data used to develop the rates. No rate adjustment was necessary.

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## Spend Down

The base FFS data is net of recipient spend down. Therefore, no additional adjustment was needed for the rate computations.

## Graduate Medical Education (GME)

The State does not make supplemental GME payments for services delivered to individuals covered under the managed care program. Rather, the MCPs negotiate specific rates with the individual teaching hospitals for the daily cost of care. Therefore, the GME payments are included in the capitation rates paid to the MCPs.

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## Appendix C – Encounter Data Summaries Adjustments

### Claims Completion

Mercer used CY 2004 cost report lag triangles to complete the encounter data. The health plan utilization data was completed by dividing by these completion factors.

	SFY 2003			
MCP	Inpatient/Outpatient	Physician/Clinic	Pharmacy	Other
MCP A	100.0%	100.0%	100.0%	100.0%
MCP B	100.0%	100.0%	100.0%	100.0%
MCP C	100.0%	100.0%	100.0%	100.0%
MCP D	100.0%	100.0%	100.0%	100.0%
MCP E	100.0%	100.0%	100.0%	100.0%
MCP F	100.0%	100.0%	100.0%	100.0%

	SFY 2004			
MCP	Inpatient/Outpatient	Physician/Clinic	Pharmacy	Other
MCP A	99.4%	99.6%	100.0%	99.1%
MCP B	99.7%	99.7%	100.0%	96.5%
MCP C	99.7%	99.4%	100.0%	98.4%
MCP D	99.8%	99.8%	100.0%	99.8%
MCP E	100.0%	100.0%	100.0%	100.0%
MCP F	97.0%	99.2%	100.0%	95.8%

### Historical Policy Changes

As part of the rate-setting process, the data must reflect any policy changes that occurred during the base data time period. Changes only reflected in a portion of the base data must be applied to the remaining base data to keep the data similar. The following policy change adjustments were applied to the encounter data.

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Policy Change	Effective Date <sup>1</sup>	Category of Service Affected	Rate Cohorts Affected	Encounter Data Summary Adjustments	
				SFY 2003	SFY 2004
Independently-practicing psychologist services eliminated for adults (>21) and pregnant women	1/1/2004	PCP, OB/GYN and Specialists	Ages 19+, including delivery	-0.1%	-0.1%
All podiatry and chiropractic services eliminated for adults (>21) and pregnant women	1/1/2004	Other	HF, Age 19-44, M	-9.0%	-4.5%
			HF, Age 19-44, F	-10.0%	-5.0%
			HF, Age 45+, M & F	-8.0%	-4.0%
			HST, Age 19-64, F	-4.0%	-2.0%

<sup>1</sup> When the effective date was not the beginning of the SFY, a fraction of the adjustment was applied to the SFY the program change was made.

## Data Anomaly Corrections

As directed by the State, Mercer made the following adjustments to the encounter data to account for incomplete reporting or other known data issues.

MCP	Category of Service	Dates	Encounter Data Adjustment
MCP F	Vision	4th Quarter, SFY 2004	47.1%

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## Appendix C – Cost Report Data Summaries Adjustments

### IBNR Review/Adjustment

Mercer used CY 2004 cost report claims restatement Report IV and lag triangles to adjust the MCP IBNR estimates in the CY 2003 and CY 2004 financial experience. The table below shows these adjustment factors. The health plan completed dollars were adjusted by multiplying by these factors.

CY 2003					
MCP	Inpatient/ Outpatient	Physician/ Clinic	Pharmacy	Other	Total
MCP A	101%	101%	101%	101%	101%
MCP B	98%	84%	79%	100%	89%
MCP C	97%	99%	100%	100%	98%
MCP D	98%	98%	100%	109%	99%
MCP E	100%	100%	100%	100%	100%
MCP F	100%	100%	100%	100%	100%

CY 2004					
MCP	Inpatient/ Outpatient	Physician/ Clinic	Pharmacy	Other	Total
MCP A	100%	100%	100%	100%	100%
MCP B	99%	103%	100%	92%	99%
MCP C	98%	101%	100%	105%	99%
MCP D	96%	98%	100%	88%	97%
MCP E	100%	100%	100%	100%	100%
MCP F	101%	99%	100%	100%	100%

### Historical Policy Changes

As part of the rate-setting process, the data must reflect any policy changes that occurred during the base data time period. Changes only reflected in a portion of the base data must be applied to the remaining base data to keep the data similar. The following policy change adjustments were applied to the cost report data.

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Policy Change	Effective Date <sup>1</sup>	Category of Service Affected	Rate Cohorts Affected	Cost Report Data Summary Adjustments	
				CY 2003	CY 2004
Independently-practicing psychologist services eliminated for adults (>21) and pregnant women	1/1/2004	PCP, OB/GYN and Specialists	Ages 19+, including delivery	-0.1%	0.0%
All podiatry and chiropractic services eliminated for adults (>21) and pregnant women	1/1/2004	Other	HF, Age 19-44, M	-9.0%	0.0%
			HF, Age 19-44, F	-10.0%	0.0%
			HF, Age 45+, M & F	-8.0%	0.0%
			HST, Age 19-64, F	-4.0%	0.0%

<sup>1</sup> When the effective date was not the beginning of the CY, a fraction of the adjustment was applied to the CY the program change was made.

## Data Anomaly Corrections

Mercer made cost-neutral adjustments to the CY 2003 cost report data to account for recoding of expenses by COS. These adjustments mirror changes that were made in the CY 2004 cost reports.

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## Appendix D – Calendar Year 2006 Rate Development

### Credibility By Year

Mercer placed more credibility on the most recent year of data for each data source. For FFS and encounter data, Mercer used 70% credibility for SFY 2004 data and 30% credibility for SFY 2003 data. For cost report data, Mercer placed 70% credibility on CY 2004 data and 30% credibility on CY 2003 data.

### FFS Historical and Managed Care Historical/Prospective Trend

Historical FFS trend assumptions were used to trend SFY 2003 and SFY 2004 FFS data to the base period (CY 2004) for voluntary and new counties. Credibility was applied to blend together the trended SFY 2003 and the SFY 2004 FFS data. Once the blended FFS data was adjusted to reflect managed care, the prospective managed care trend rates were then applied to develop the CY 2006 rates for voluntary and new counties.

Managed care historical trend was used to trend SFY 2003 and SFY 2004 encounter data and CY 2003 cost report data to the base period (CY 2004) for Preferred Option and mandatory counties. Prospective trend assumptions were then applied to the base period encounter and cost report data for Preferred Option and mandatory counties to develop the CY 2006 rates.

Various policy changes were also considered in the trend development. These changes include Inpatient Recalibration and the Inpatient Rate Freeze. Mercer assumed MCP Inpatient contracting will reflect FFS levels by April 1, 2006. The impact these changes had on trend is shown in Appendix I.

	Non-Delivery Historical FFS		Non-Delivery Historical MC		Non-Delivery Prospective MC	
COS	Unit Cost	Utilization	Unit Cost	Utilization	Unit Cost	Utilization
Inpatient	2.0%	1.0%	6.0%	0.5%	3.5%	0.5%
Outpatient	3.5%	6.5%	3.0%	3.5%	2.5%	3.0%
Physician	4.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Pharmacy	11.0%	8.7%	8.3%	6.0%	5.9%	8.0%
Other	3.5%	5.5%	2.0%	1.5%	2.0%	1.5%

	Delivery Historical FFS		Delivery Historical MC		Delivery Prospective MC	
COS	Unit Cost	Utilization	Unit Cost	Utilization	Unit Cost	Utilization
Inpatient	2.0%	0.0%	4.5%	0.0%	2.5%	0.0%
Physician	4.0%	0.0%	1.0%	0.0%	1.0%	0.0%

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## Prospective Policy Changes

The following adjustments are considered prospective policy changes. These adjustments were not reflected in the base data, but will be implemented prior to or within the contract period.

### Adjustments Affecting Unit Cost

Policy Change	Effective Date	Category of Service Affected	Rate Cohorts Affected	Reductions to Unit Cost
Implementation of \$2 copay for trade-name preferred drugs	1/1/2006	Pharmacy	HF, Age 19-44, F	\$0.85
			HF, Age 19-44, M	\$0.85
			HF, Age 45+, M & F	\$0.92
Implementation of \$3 copay for each dental date of service	1/1/2006	Dental	HF, Age 19-44, F	\$0.83
			HF, Age 19-44, M	\$0.83
			HF, Age 45+, M & F	\$0.90
Implementation of \$2 copay for vision exams and \$1 copay for dispensing services	1/1/2006	Other	HF, Age 19-44, F	\$0.28
			HF, Age 19-44, M	\$0.28
			HF, Age 45+, M & F	\$0.30
			HST, Age 19-64, F	\$0.29

### Adjustments Affecting Utilization

Policy Change	Effective Date	Category of Service Affected	Rate Cohorts Affected	Percent Adjustment to Utilization
Reduction in coverage of dental services	1/1/2006	Dental	HF, Age 19-44, F	-30.8%
			HF, Age 19-44, M	-30.8%
			HF, Age 45+, M & F	-33.3%
			HST, Age 19-64, F	-31.9%

The policy change in the Federal Poverty Level (FPL) from 100% to 90% did not have an impact on the rates.

## Clinical Measures/Incentives

Since the State requires the plans to reach, at minimum, the performance standard for each of the indicators from Appendix M of the SFY 2006 Provider Agreement, Mercer will build this expectation into the capitation rates. To calculate the adjustments, Mercer reviewed MCP clinical measures percentages for the CY 2004 base year and projected these rates forward by building in the State's expected improvement rate. Mercer then calculated the percent change from base year to the rating period, and applied the adjustment as a portion of COS. The following chart provides additional detail on each adjustment.

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Clinical Measure	Rate Cohort	Category of Service Affected	Adjustment
<b>Prenatal Care – Frequency of Ongoing Prenatal Care</b> Target: 80% of eligible population must receive 81% or more of expected number of prenatal visits.	HF/HST, 14-18 F HST, 19-64 F HF, 19-44 F	OB/GYN Physician	OB/GYN: 1.7% Physician: 0.2%
<b>Prenatal Care – Post Partum Visits</b> Target: 80% of the eligible population must receive a post partum visit.	HF/HST, 14-18 F HST, 19-64 F HF, 19-44 F	OB/GYN	0.1%
<b>Preventive Care for Children – Well-Child Visits</b> Target: 80% of children receive expected number of visits: Children who turn 15 mos. old; 6+ visits. Children who were 3-6 years old; 1+ visit. Children who were 12-21 years old; 1+ visit.	HF/HST, <1 M&F HF/HST, 1 M&F HF/HST, 2-13 M&F HF/HST, 14-18 M HF/HST, 14-18 F	Physician	<1 M&F: 2.4% 1 M&F: 1.2% 2-13 M&F: 0.5% 14-18 M: 1.5% 14-18 F: 1.5%
<b>Use of Appropriate Medications for People with Asthma</b> Target: 80% of eligible Asthma members receive prescribed medications acceptable as primary therapy for long-term control of asthma.	HF/HST, 2-13 M&F HF/HST, 14-18 M HF/HST, 14-18 F HF, 19-44 M HF, 19-44 F HF, 45+ M&F HST, 19-64 F	Pharmacy	0.2%
<b>Annual Dental Visits</b> Target: 60% of enrolled children age 4-21 receive 1 dental visit.	HF/HST, 2-13 M&F HF/HST, 14-18 M HF/HST, 14-18 F	Dental	2.0%
<b>Lead Screening</b> Target: 80% of children age 1-2 receive a blood lead screening.	HF/HST, 1 M&F HF/HST, 2-13 M&F	Physician	0.1%

## Voluntary Selection

As a result of the adverse selection adjustment that was applied in the FFS Data Summaries, the FFS data already reflects the risk of the entire Medicaid program (i.e., FFS and managed care individuals). To solely reflect the risk of the managed care program, Mercer modified the FFS data based on the projected managed care penetration levels for CY 2006. This voluntary selection adjustment modifies the FFS data to reflect the risk to the MCPs (i.e., only those individuals who enroll in a health plan).

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For the encounter and cost report data, the original base data reflects the historical penetration levels in SFY 2003-SFY 2004 and CY 2003-CY 2004, respectively. Where projected managed care penetration levels differ from the historical values, the data was brought back to reflect the risk of the entire Medicaid program, and then adjusted forward (as the FFS data was) to reflect projected managed care levels. The percentages listed below reflect the adjustments by county.

County	Projected Penetration	Voluntary Selection Adjustment		
		FFS	Encounter	Cost Report
Butler	95%	N/A	2.8%	2.8%
Clark	95%	-0.6%	5.5%	4.2%
Clermont	15%	-9.1%	N/A	N/A
Cuyahoga	95%	N/A	0.4%	0.4%
Franklin	95%	N/A	1.7%	1.7%
Greene	15%	-9.1%	N/A	N/A
Hamilton	95%	N/A	2.8%	2.5%
Lorain	95%	N/A	3.5%	3.5%
Lucas	95%	N/A	0.4%	0.4%
Mahoning	95%	-0.6%	N/A	N/A
Montgomery	95%	N/A	1.7%	1.4%
Pickaway	15%	-9.1%	N/A	N/A
Stark	95%	-0.6%	5.6%	2.3%
Summit	95%	N/A	0.4%	0.4%
Trumbull	95%	-0.6%	N/A	N/A
Warren	15%	-9.1%	N/A	N/A
Wood	15%	-9.1%	N/A	N/A

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## Non-State Plan Services

According to the CMS Final Medicaid Managed Care Rule that was implemented August 13, 2003, non-state plan services (NSPS) may not be included in the base data for rate setting. Mercer reviewed NSPS information included in the MCP cost reports. This information was used to calculate an adjustment for NSPS, including eye examinations, chiropractic and psychological services, and routine transportation. The adjustment was applied to the Specialists and Other categories of service in the encounter and cost report data, as appropriate.

		CY 2003	
MCP	Rate Cohort	Category of Service Affected	Adjustment
MCP A	All	Other	-11.3%
	HF, 19-44 M HF, 19-44 F HF, 45+ M&F HST, 19-64 F	Other	-6.4%
MCP C	All except delivery	Other	-11.2%
MCP D	All except delivery	Other	-25.2%
MCP E	All except delivery	Other	-8.8%

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		CY 2004	
MCP	Rate Cohort	Category of Service Affected	Adjustment
MCP A	HF, 19-44 M HF, 19-44 F HF, 45+ M&F HST, 19-64 F	Specialists	-2.1%
	All	Other	-11.3%
	HF, 19-44 M HF, 19-44 F HF, 45+ M&F HST, 19-64 F	Other	-2.0%
MCP B	HF, 19-44 M HF, 19-44 F HF, 45+ M&F HST, 19-64 F	Other	-36.4%
MCP C	All except delivery	Other	-13.5%
MCP D	All except delivery	Other	-21.5%
MCP F	All except delivery	Other	-12.3%

## Credibility by Data Source

For new and voluntary counties, FFS data is considered the most credible data source. In these counties, 100% credibility was placed on FFS data. For Preferred Option and mandatory counties, managed care data is considered most credible. MCP reported encounter and cost report data were blended. The credibility placed on cost reports was generally 50% and credibility placed on encounter data was generally 50%. Since Clark and Stark were voluntary counties prior to March 2003 and June 2003 respectively, FFS data was generally given 40% credibility, cost report data generally given 30% credibility, and encounter data generally given 30% credibility. There were cases in which credibility weightings were adjusted by COS to mitigate discrepancies between cost report and encounter data reporting and to reflect results more consistent with expectations of an efficiently run MCP.

## C-Section/Vaginal Percent

Mercer received MCP caesarean and vaginal rates from CY 2004 encounter data. Based on the analysis for all MCPs combined, Mercer used a 23.5% caesarean rate and a 76.5% vaginal rate.

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## MCP Administration/Contingencies

Based on a review of MCP reported administration expenses, the MCP administration/contingencies allowance will remain at 12% of premium prior to the franchise fee. Consistent with the CY 2005 rates, 1% of the pre-franchise fee capitation rate will be put at risk, contingent upon MCPs meeting performance requirements. For plans new to managed care in Ohio, the administration schedule will be as follows.

	<b>Admin</b>	<b>At-Risk</b>
Plan Year 1 (months 1-12)	13%	0%
Plan Year 2 (months 13-24)	12%	0%
Plan Year 3 (months 25-36)	12%	1%

In addition, the total capitation rate was adjusted to incorporate the new 4.5% MCP franchise fee requirement.

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## Appendix D2 – Rate Setting Methodology for CY 2006 Regional Rates

In addition to the county rates, Mercer also developed estimated CY 2006 capitation rates for eight new managed care regions. Final region-specific rates will be developed after the effective dates are set for each region. The basic rate-setting methodology for the region-specific rates was similar to the methodology used for the county rates. The following outlines how the regional rate methodology differed.

### Regional Delivery System Definitions

For regional rate development, counties were bucketed into mandatory, Preferred Option, voluntary, or new as outlined in Appendix B. However, the new county category was expanded to include all counties that are not mandatory, Preferred Option or voluntary. The data for all counties within the region was used to develop the regional rate. Please see page D2-4 for a map defining the counties within each region.

### Data Sources

The data sources that were used in each region depended on the credible data sources available for each specific county within that region. In regions where there are stable managed care programs, managed care data for those counties was combined with the FFS data for those counties without established managed care programs.

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## Voluntary Selection

The projected penetration percentages are based on a September 1, 2006 start date for the mandatory managed care regions. If the start date differs, the table below will be impacted.

Region	Enrollment	Projected Penetration	Voluntary Selection Adjustment		
			FFS	Encounter	Cost Report
Central	Preferred Option	95%	N/A	1.7%	1.7%
	Voluntary	15%	-9.1%	N/A	N/A
	New	15%	-9.1%	N/A	N/A
East-Central	Mandatory	95%	N/A	0.4%	0.4%
	Voluntary	15%	-9.1%	N/A	N/A
	New	15%	-9.1%	N/A	N/A
Northeast	Mandatory	95%	N/A	0.4%	0.4%
	Preferred Option	95%	N/A	3.5%	3.5%
	New	15%	-9.1%	N/A	N/A
Northeast-Central	New	92%*	-0.9%	N/A	N/A
Northwest	Mandatory	95%	N/A	0.4%	0.4%
	Voluntary	15%	-9.1%	N/A	N/A
	New	15%	-9.1%	N/A	N/A
Southeast	New	15%	-9.1%	N/A	N/A
Southwest	Preferred Option	95%	N/A	2.8%	2.5%
	Voluntary	15%	-9.1%	N/A	N/A
	New	15%	-9.1%	N/A	N/A
West-Central	Preferred Option	95%	N/A	1.7%	1.4%
	Voluntary	15%	-9.1%	N/A	N/A
	New	15%	-9.1%	N/A	N/A

\*This assumption has been developed based on Mahoning and Trumbull being mandatory counties as of January 1, 2006.

## Credibility by Data Source

For regions composed of only new and voluntary counties, 100% credibility was placed on the FFS data. For regions with available FFS and managed care data, the FFS encounter and cost report data were blended. The credibility between FFS and managed care data was determined based on the proportion of the membership anticipated to be in FFS and managed care. In general, the credibility placed on cost report data varied from 40-50%, the credibility placed on encounter data ranged from 40-50%, and the credibility placed on FFS data ranged from 4-20%. There were cases in which credibility weightings were adjusted by COS to mitigate discrepancies between cost reports and encounter data reporting and to reflect results more consistent with expectations of an efficiently run MCP.

## Relational Modeling

Relational modeling was used to adjust the premiums by rate cohort to produce a relatively consistent age/sex slope among the regions. The relational modeling adjustments shift dollars across rate cohorts within a region but do not change the composite results by region or in

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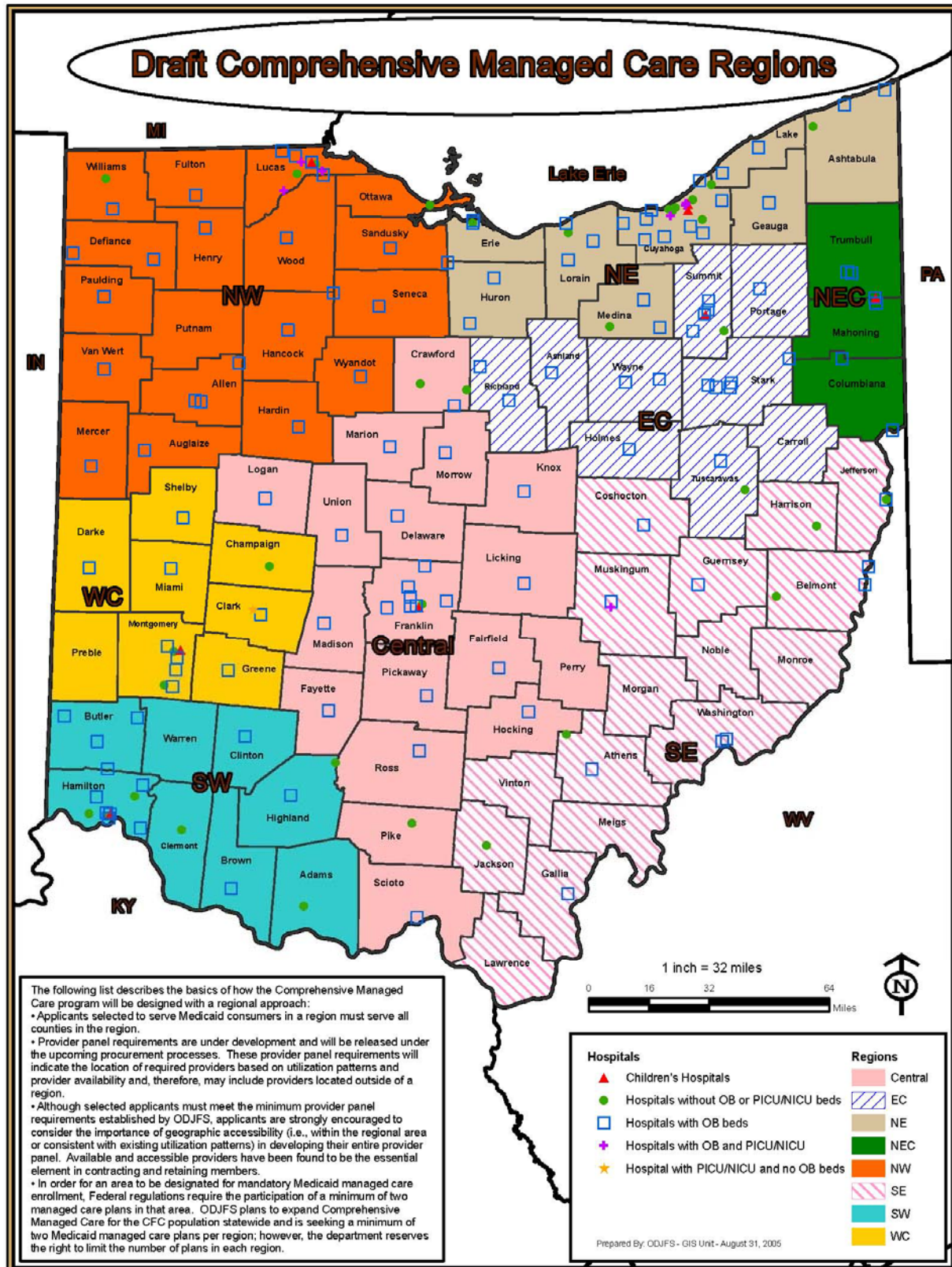
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aggregate. Through the use of the adjustments, the range of variances among the regions and rate cohorts was reduced while maintaining budget neutrality.

The relational modeling adjustments were applied to the net medical rates in the CRCS to develop new adjusted medical rates. An administration load factor was then applied as a percent of premium.

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## Appendix E – FFS Data Summaries

*Please see attached PDF file.*

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## Appendix F – Encounter Data Summaries

*Please see attached PDF file.*

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## Appendix G – Cost Report Summaries

*Please see attached PDF file.*

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Appendix H – Calendar Year 2006 County Rate Summary

*Please see attached PDF file.*

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Appendix I – CY 2006 County Rate Increase Analysis

*Please see attached PDF file.*

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Appendix J – CY 2006 Estimated Regional Rate Summary

*Please see attached PDF file.*