



Hoosier Care Connect

Capitation Rate Development and Certification

Aged, Blind and Disabled Managed Care Program

April 1, 2015 through December 31, 2015

State of Indiana

Family and Social Services Administration

Office of Medicaid Policy and Planning

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BACKGROUND

The State of Indiana is planning to develop a new managed care program, Hoosier Care Connect, for Aged, Blind, and Disabled (ABD) enrollees. The program does not cover those with Medicare eligibility, those with developmental disabilities, and those who are receiving long term care services through an institution or waiver program for more than 30 days.

Milliman has been retained by the State of Indiana, Family and Social Services Administration, to provide actuarial consulting services related to the development of capitation rates for Hoosier Care Connect.

The Request for Information (RFI) was issued April 16, 2014. The information in this letter is intended as supporting information for the RFP.

CERTIFICATION NOTES

Actuarially sound capitation rates were developed using published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board, the Centers for Medicare and Medicaid Services (CMS), and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements. Specifically, the following were referenced:

- AAA health practice council practice note published in August 2005, titled: *Actuarial Certification of Rates for Medicaid Managed Care Programs*.
- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been published as of the capitation rate certification date.
- Federal regulation 42 CFR 438.6(c).
- Throughout this document, the term “actuarially sound” may be defined as follows:

“Medicaid capitation rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates – including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income – provide for all reasonable, appropriate, and attainable costs, including health benefits; health benefit settlement expenses; marketing and administrative expenses; any government-mandated assessments, fees, and taxes; and the cost of capital.”

This report provides documentation of the actuarially sound capitation rates and has been developed to comply with the requirements outlined above. Appendix D contains the signed actuarial certification of the capitation rates.

FISCAL IMPACT SUMMARY

Table 1 illustrates the certified low and high capitation rates for the adult, child, and retroactive Medicare eligible (dual) populations. These rates are effective from April 1, 2015 through December 31, 2015.

Table 1 State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Low and High Capitation Rate Range		
Population	Low	High
Adult	\$ 1,083.14	\$ 1,141.81
Child	653.18	674.83
Dual	229.95	239.65

Notes

1. Illustrated rates do not include enhanced reimbursement rates for hospitals paid under the hospital assessment fee program.
2. Illustrated rates do not reflect the ACA health insurer fee, which will not be payable during the first contract year.

Table 2 compares the estimated state and federal expenditures under the current program to the Hoosier Care Connect rates illustrated in Table 1 for the rate period April 1, 2015 to December 31, 2015.

Table 2 State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Estimated Budget Expenditure Change (Millions) April 1, 2015 through December 31, 2015			
Low Rate Range Population	Projected Capitation Expenditures	Current Program Expenditures	Increase/ (Decrease)
Adult	\$649.2	\$671.0	(21.8)
Child	102.9	106.0	(3.1)
Dual	1.6	1.0	0.6
Total State and Federal	\$753.7	\$778.0	(24.3)
Total Federal Only (FMAP 66.52%)	501.4	517.5	(16.2)
Total State	252.3	260.5	(8.1)

High Rate Range Population	Projected Capitation Expenditures	Current Program Expenditures	Increase/ (Decrease)
Adult	\$684.4	\$671.0	13.4
Child	106.3	106.0	0.3
Dual	1.6	1.0	0.7
Total State and Federal	\$792.3	\$778.0	14.4
Total Federal Only (FMAP 66.52%)	527.1	517.5	9.5
Total State	265.3	260.5	4.8

Notes

1. Illustrated expenditures do not include enhanced reimbursement rates for hospitals paid under the hospital assessment fee program.
2. The current program expenditures scenario estimates expenditures without the implementation of ABD risk-based managed care.
3. Estimates are based on both fee-for-service and encounter data expenditures.
4. Expenditure changes do not reflect any change in the pharmacy rebates.

Projections were developed based on historical data from SFY 2012 and SFY 2013. Certain adjustments were made to the base data to reflect recent Medicaid program changes. These changes are outlined below.

- Most of the eligible population is currently enrolled in the fee-for-service (FFS) ABD program. The current expenditure estimate for these populations is based on FFS experience.
- For the MA-U population, the current expenditure estimate is based on encounter data from the Hoosier Healthwise (HHW) program.
- Due to the recent 1634 transition, spend down enrollees with income at or below 100% FPL have transitioned to full Medicaid eligibility. Historical spend down claims not paid by Medicaid were repriced to reflect elimination of the spend down liability.

OVERVIEW OF RATE DEVELOPMENT

The main sections of this report contain the documentation related to the actuarial models, covered populations, covered services, base data adjustments, and the capitation rate development.

Appendix A summarizes SFY 2012 and SFY 2013 experience for the current Indiana Medicaid populations that will be eligible for Hoosier Care Connect. These data summaries generally use unadjusted claims and encounter data. Adjustments made to these summaries are described in the “Adjustments to the Base Data” section.

Appendix B documents the grouping logic used to define the categories of service used in the actuarial models.

Appendix C illustrates the development of the April 1, 2015 – December 31, 2015 Hoosier Care Connect capitation rates.

Appendix D provides the actuarial certification of the Hoosier Care Connect capitation rates.

Appendix E illustrates conditions associated with the Hoosier Care Connect population as identified by the CDPS algorithm.

DATA AND ACTUARIAL MODELS

DATA

This base data used for rate development is comprised of SFY 2012 and SFY 2013 experience for the Indiana Medicaid Aged, Blind, and Disabled (ABD) populations to be transitioned to managed care. Data includes claims for services incurred during this time period and submitted to the state through February 28, 2014. The encounter and claims experience was provided to Milliman by the fiscal agent, Hewlett Packard (HP).

One of the populations to be included in Hoosier Care Connect was in managed care under Hoosier Healthwise during the base data time period: the MA-U population. The experience data for this population was developed based on encounter claims. All other populations are currently being served on a FFS basis, and experience data for these populations was developed using Medicaid FFS claims.

Historical cost and utilization has been stratified by category of service for each population. All actuarial models illustrate costs at Medicaid reimbursement.

Hospital expenditures are illustrated excluding the enhanced reimbursement for hospitals.

Pharmacy expenditures are illustrated before reduction for rebates received from manufacturers. The state is currently receiving rebates that, in aggregate, are estimated to constitute 51.5% of the value of pharmacy expenditures (aggregate *net* pharmacy expenditures are 48.5% of the values illustrated in the cost models) and 38.0% of expenditures illustrated in the office administered drug category of service (aggregate *net* office administered drug expenditures are 62.0% of the values illustrated in the cost models).

ACTUARIAL MODELS

Overview

Experience data was stratified by population and category of service. Populations and categories of service are further described in the “Covered Populations” and “Categories of Service” sections.

The populations will be combined into two rate groups: Disabled Child and Disabled Adult. The experience from all covered populations has been blended into two composite populations by enrollment during the base period. Experience has been illustrated separately for SFY 2012 and SFY 2013. For each fiscal year, both utilization and cost per service information are illustrated for each population and category of service.

In addition to the two rate cells, a third rate has been developed, which will be paid for individuals discovered to be retroactively Medicare eligible. Although those known to be eligible for Medicare will not be enrolled in Hoosier Care Connect, some individuals may be enrolled initially and the managed care organization will receive either the disabled adult or disabled child capitation rate. If Medicare eligibility is later granted on a retroactive basis, the individual will be immediately dis-enrolled from Hoosier Care Connect. The managed care organizations will be responsible for recovering medical expenditures payable by Medicare for the months of retroactive Medicare eligibility. Similarly, the state will recoup the capitation rate paid for months with retroactive Medicare eligibility and pay a reduced dual-eligible capitation rate.

Medicaid claims experience for retroactive duals did not appropriately reflect Medicare payment recoveries as these recoveries are performed outside the claims system. As a result, actual experience for retroactive Medicare eligible individuals was not used in the development of the dual eligible capitation rate. Claims experience for Medicare eligible individuals with coverage that was not retroactive was used in the cost model for this population.

MA-U encounter data was re-adjudicated by the fiscal agent, Hewlett Packard (HP), to 100% of the Medicaid fee schedule. Where the claim was not re-adjudicated by HP (\$0 claim paid by the plans), Milliman has adjusted reimbursement.

Hospital reimbursement illustrated in this report does not reflect enhanced reimbursement.

Spend down claims that reflected a reduction in the Medicaid paid amount due to enrollee spend-down liability were re-adjudicated to reflect the average cost of the service for a FFS enrollee with full Medicaid eligibility.

The models are designed to illustrate base claims and encounter experience, and do not include the adjustments that are applied prior to development of the final April 1, 2015 to December 31, 2015 rate ranges.

Adjustments not reflected in the base experience models in this report are listed below:

- Trend
- Claims completion adjustments
- Program adjustments that occurred after completion of the base period
- Loss of pharmacy copay with implementation of risk-based managed care
- Managed care adjustments
- Contracting adjustments
- TPL recoveries recovered through the “pay and chase” method
- Administrative, profit, and contingency margin

Adjustments are made for these items in the capitation rate development.

Data Elements

This section describes the data elements illustrated in each table.

Member Months: This value represents the number of enrollee months in each population group during the experience period. A member’s age was determined as of the first day of the month enrolled.

Annual Utilization per 1,000: This value represents annual utilization per 1,000 members for each type of service. The value was developed by dividing total units for each service by member months and multiplying by 12 times 1,000. Unit definitions vary by type of service.

Average Cost per Service: This value represents the average amount that was paid per unit for the service provided. This reflects adjustments for third party payments submitted in the coordination of benefits file (cost avoidance), but does not include recoveries after claim payment (pay and chase).

Cost per Member per Month (PMPM): This value represents the net benefit cost for each type of service. It was developed by multiplying the annual utilization per 1,000 and the average cost per service, then dividing by 12,000.

COVERED POPULATIONS

This section describes the populations that are proposed to be covered by Hoosier Care Connect during the April 1, 2015 to December 31, 2015 rate period.

EXCLUDED POPULATIONS

The state proposes to include non-dual aged, blind, and disabled enrollees who are not in need of long term care services. Individuals with any of the following are excluded:

- Institutional level of care (except for Nursing Home stays of 30 days or less)
- Home and community based services waiver level of care
- Money follows the person grant level of care
- Medicare eligibility (the program excludes both full dual and partial eligible enrollees).

AID CATEGORIES INCLUDED IN HOOSIER CARE CONNECT

The following historical aid categories are proposed to be mandated into Hoosier Care Connect effective April 1, 2015. These aid categories were effective during the base period, SFY 2012 and SFY 2013.

Table 3 State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Historical Aid Categories Covered Under Hoosier Care Connect	
Aid Category	Description
MA A	Aged
MA B	Blind
MA D	Disabled
MA DW, DI	M.E.D.Works: Disabled Working Individual
MA U	Coverage for SSI recipients in low income families

As of the 1634 transition effective June 1, 2014, aid category MA-U was eliminated. Many of the MA-U enrollees are expected to transition to the new MASI Category, which was established for Medicaid enrollees receiving SSI payments. Please note that foster children, breast and cervical cancer enrollees, refugees, and all Medicaid enrollees with limited benefits (such as family planning service enrollees) are excluded from the program.

CURRENT PROGRAMS

Those who will be included in Hoosier Care Connect were served in one of the following programs during the base period:

- **MA-U Hoosier Healthwise:** SSI recipients who were enrolled in Hoosier Healthwise (HHW), Indiana's risk-based managed care program for low income families and pregnant women during the base data time period. These individuals moved into the MASI category as of June 1, 2014, when Indiana's 1634 conversion resulted in auto-enrollment of all SSI recipients.
- **Spend Down:** Adults with disabilities and income below 100% FPL who are currently enrolled on Indiana's ABD spend down program. These individuals will gain full Medicaid eligibility due to Indiana's 1634 conversion and elimination of the spend-down program. Additionally, adults with disabilities and income below 300% FPL who were receiving MRO services and were enrolled in Indiana's ABD spend down program are expected to gain full Medicaid eligibility through the new 1915(i) program.
- **MED Works:** Individuals aged 16 to 64 who are working and disabled with income below 350% of the federal poverty level.
- **Care Select:** These individuals have at least one chronic medical condition which qualifies them for enrollment in Care Select, the State's current managed FFS program. The eligible conditions include asthma, diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, chronic kidney disease, severe mental illness, and serious emotional disturbance and depression.
- **Other Community Non-Dual Disabled:** Adults and children qualifying for Medicaid because of disability who are not receiving long term care services through an institution or waiver program.

Appendix A contains three actuarial models for each of the populations above: one for adults (age 21 and over), one for children, and one for Medicare eligible individuals.

RATE GROUP DEFINITIONS

The State proposes to define the following two rate cells:

- Disabled Adult (Age 21 and older)
- Disabled Child (Under Age 21)

A separate rate will be paid for the retroactive Medicare eligible individuals.

1634 CONVERSION

The State of Indiana converted from 209(b) status to 1634 status as of June 1, 2014. The state auto-enrolled SSI recipients into disabled aid categories, including those who were previously in MA-U.

The auto-enrollment may also uncover additional un-enrolled SSI recipients. The base actuarial models have not been adjusted for this potential new population. For purposes of rate development, it has been assumed that the morbidity will be consistent with current enrollment.

Finally, as of June 1, 2014, the State raised the disability income standard to 100% FPL, allowing spend down recipients with incomes under 100% FPL to convert to full Medicaid eligibility.

POPULATION PROFILE

Appendix E has been provided to illustrate the prevalence of certain conditions for the covered populations in SFY 2013. This information is intended to assist managed care organizations in preparing care management programs. CDPS + Rx Version 5.4 (CDPS) was used to identify individuals with the listed conditions. The CDPS algorithm assigns individuals certain conditions with levels of severity from super low to very high. For the purposes of Appendix E, individuals are included in the condition category if they were assigned any severity levels except super low and not well defined. The ear condition category was the only condition category in which individuals were included for a super low or not well defined condition assignment, because CDPS does not assign any other severity levels to these condition categories.

CATEGORIES OF SERVICE

Categories of service summarized in this report are defined using Medicaid service categories, DRGs, revenue codes, procedure codes, procedure code modifiers, provider specialty, and national drug codes.

CLAIMS EXCLUDED FROM THE BASE DATA

The base data represents historical claims for those services that are included in the capitation rates. Services that are not covered by the Indiana Health Coverage Programs (IHCP) are not included in the summaries. In addition, the following IHCP services were excluded:

- Medicaid Rehabilitation Option services
- Nursing home services lasting more than 30 days
- ICF/ID and PRTF services
- Hospice services provided in an institutional setting
- HCBS waiver services
- First Steps services
- School corporation services

Members who have been approved for long term institutional care, waiver services, or institutional hospice care will be disenrolled from managed care.

OVERVIEW OF SERVICE CATEGORIES

Table 4 illustrates the units and classification basis used for each category of service in the actuarial models. Additional information on the specific codes used to assign claims to service categories has been provided in Appendix B.

Table 4
State of Indiana
Office of Medicaid Policy and Planning
Hoosier Care Connect
Categories of Service

Category of Service	Units	Classification Basis
<i>Inpatient Hospital</i>		
Medical	Admits/Days	DRG
Surgical	Admits/Days	DRG
Behavioral Health	Admits/Days	DRG
<i>Outpatient Hospital</i>		
Emergency Room	Services	Revenue Code, Procedure Code
Surgery	Services	Revenue Code, Procedure Code
Pharmacy	Services	Revenue Code, Procedure Code
Other Outpatient	Services	Revenue Code, Procedure Code
<i>Ancillaries</i>		
Pharmacy	Scripts	Claim Type
Nursing Home (> 30)	Days	Category of Service
Hospice (at home)	Days	Category of Service, Revenue Code
Home Health	Services	Category of Service
DME/Medical Supplies	Units	Category of Service
Transportation	Trips	Category of Service, Provider Specialty
Dental	Procedures	Claim Type
<i>Physician</i>		
Inpatient and Outpatient Surgery	Procedures	Procedure Code, Procedure Code Modifier
Maternity Delivery	Deliveries	Procedure Code, Procedure Code Modifier
Maternity Non-Delivery	Visits	Procedure Code, Procedure Code Modifier
Office Visits/Consults	Visits	Procedure Code
Physical Exams	Visits	Procedure Code
Hospital Inpatient Visits	Visits	Procedure Code
Emergency Room Visits	Visits	Procedure Code
Radiology/Pathology	Procedures	Procedure Code, Provider Specialty
Outpatient Behavioral Health	Procedures	Procedure Code
Self-Referral	Visits	Procedure Code, Provider Specialty
Office Administered Drugs	Procedures	National Drug Code
Other Professional	Visits	Procedure Code, Procedure Code Modifier

ADJUSTMENTS TO THE BASE DATA

This section describes the adjustments made to the base data illustrated in Appendix A.

REPRICING FOR MANAGED CARE

The MA-U population was recently enrolled in managed care through the Hoosier Healthwise program. The base data used for this population was based on encounter claims. As part of the encounter claims processing, HP re-adjudicates managed care claims to the Medicaid fee schedule. Although Milliman does not audit the re-adjudications, we reviewed the data for reasonableness and consistency.

Certain adjustments were made to the encounter data regarding the reported paid amount. Adjustments were generally made to either adjust certain reported third party liability (TPL) amount on a claim or to reprice claims with no reported paid amount.

Certain claims assigned the MCO paid amounts as the TPL recovery amount. This assignment resulted in the final reported paid amount being calculated as \$0 since the MCO paid amount was then assumed to be recovered through a TPL payment. Claims identified with this issue were repriced by mapping on the TPL amount indicated on the claim in the coordination of benefit tables provided by HP.

In addition, there are claims for which HP has been unable to determine a Medicaid reimbursement level. These claims include a \$0 payment on the claim. Milliman re-priced these claims using the average cost per unit reported on the FFS data. The repricing was done on a procedure code basis for claims submitted using the HCFA-1500 form, and either a DRG, procedure code, or revenue code basis for claims submitted via the UB-04 form.

Table 5 illustrates the adjusted historical managed care data used for the office visit/consults category of service (MA-U HHW data only). The encounter data is stratified into the following three groups: not repriced, repriced with a new TPL amount, and repriced using the average FFS cost of the procedure code for the office visit/consults category of service. Each category is mutually exclusive.

Table 5									
State of Indiana									
Office of Medicaid Policy and Planning									
Hoosier Care Connect									
Office Visit/Consults Repricing Example									
Procedure Code	Data Not Repriced			Data with TPL Adjustment			Repriced Data		
	Units	CPU	Paid	Units	CPU	Paid	Units	CPU	Paid
99203	4,226	47.11	199,072	1,874	47.00	88,083	183	47.15	8,628
99204	2,683	72.87	195,511	1,127	72.81	82,052	98	72.80	7,135
99212	10,162	19.05	193,592	3,870	19.06	73,780	435	19.07	8,297
99213	75,364	\$31.62	\$2,382,762	28,710	\$31.59	\$906,988	1,797	\$31.54	\$56,679
99214	40,984	47.90	1,963,264	15,845	47.92	759,216	881	48.01	42,296
99215	4,705	64.27	302,400	1,857	64.71	120,159	261	64.67	16,879
99243	1,532	80.09	122,695	551	80.08	44,122	36	80.02	2,881
99244	1,882	119.62	225,133	671	119.79	80,376	48	119.49	5,735
99245	708	145.78	103,215	205	145.79	29,888	16	145.78	2,332
99254	742	110.64	82,095	270	110.64	29,873	15	110.64	1,660
All Other	6,890	42.53	293,064	2,901	40.66	117,964	749	51.59	38,641
Total	149,878	\$40.45	6,062,803	57,881	\$40.30	2,332,501	4,519	\$42.30	191,162

SPEND-DOWN REPRICING

Individuals in the spend-down program have a financial obligation to pay medical expenses up to a certain spend-down liability amount before Medicaid will pay for the services. These beneficiary-paid claims are included in the claims database provided by HP, but no paid amount is reported because the individual was responsible for the payment. As discussed in the “Current Programs” section, these individuals are now fully Medicaid eligible and no longer have a financial spend-down obligation. The claims previously not paid by Medicaid will be covered in the April 1, 2015 – December 31, 2015 rate period, so an adjustment was made to estimate the cost of these claims.

Claims paid by the individual were repriced using the allowed amount if it was available. If no allowed amount was available, claims were repriced using the FFS claims data estimated average cost per unit methodology described in the “Repricing for Managed Care” section. Table 6 illustrates the effect of repricing the spend-down claims in the office/visit consults category of service.

Table 6						
State of Indiana						
Office of Medicaid Policy and Planning						
Hoosier Care Connect						
Office Visit/Consults for Spend-Down Repricing Example						
Procedure Code	Data Not Repriced/Adjusted			Repriced/Adjusted Data		
	Units	CPU	Paid	Units	CPU	Paid
99203	989	45.13	44,634	222	47.15	10,466
99204	879	69.35	60,960	145	72.79	10,554
99205	265	87.27	23,127	37	92.19	3,411
99212	1,416	18.76	26,557	389	19.07	7,419
99213	10,192	30.88	314,774	2,759	31.68	87,405
99214	8,819	\$46.57	\$410,701	2,180	\$43.75	\$95,382
99215	922	62.59	57,711	159	64.44	10,246
99244	427	112.42	48,004	60	119.38	7,163
99254	391	109.37	42,763	9	110.64	996
T1015	3,530	125.84	444,208	448	136.27	61,049
All Other	1,821	59.84	108,972	417	34.66	14,451
Total	29,651	\$53.37	1,582,412	6,825	\$45.21	308,541

REMOVAL OF GRADUATE MEDICAL EDUCATION

The inpatient hospital claims and encounters have a Graduate Medical Education (GME) component. This component has been removed for purposes of the rate setting, as FSSA plans to make GME payments directly to hospitals. The GME component of inpatient hospital claims is reported separately on FFS claims but not encounters, so GME payments were estimated using SFY 2012 and SFY 2013 FFS data. The GME portion of inpatient hospital expenditures for the retroactive Medicare eligible (dual) population were assumed to be the same as the GME payments for the adult population. Table 7 illustrates the estimated GME component as a percentage of inpatient hospital claims (without the enhanced hospital reimbursement) by population and category of service.

Table 7 State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Estimated GME as a Percent of Inpatient Hospital Expenditures			
Category of Service	Adult	Child	Dual
Inpatient - Medical	5.0%	9.6%	5.0%
Inpatient - Surgical	3.1%	5.9%	3.1%
Inpatient - Behavioral Health	3.6%	0.5%	3.6%

ESTIMATION OF ENHANCED HOSPITAL REIMBURSEMENT PAYMENTS

The capitation rates developed herein do not include enhanced hospital reimbursement funded through the hospital assessment fee. A separate payment amount will be developed for the managed care organizations to reflect the higher reimbursement.

The SFY 2012 and SFY 2013 FFS data (but not the encounter data) included the enhanced hospital reimbursement amounts, so an adjustment was made to remove this portion of the hospital payment. The enhanced hospital reimbursement adjustment factors were estimated on an aggregate basis by category of service and were based on enhanced reimbursement payment information from SFY 2012. A one-time retrospective enhanced reimbursement payment was paid in June 2012, adjusting hospital payments for service dates back to July 2011. For claims related to service months that were substantially complete (July 2011 through October 2011) and initially paid prior to June 2012, the enhanced reimbursement payment amounts could be distinguished from the initial payment amounts, and this difference was used to develop factors to estimate the enhanced reimbursement payments for all months in the base data.

Table 8 illustrates the factors used to estimate the enhanced hospital reimbursement reflected in the base FFS data. The values were used as divisors to the paid amount.

Table 8 State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Estimated Enhanced Hospital Reimbursement Factors	
Category of Service	Factor
<u>Inpatient Hospital</u>	
Medical	2.71
Surgical	2.20
Behavioral Health	1.73
<u>Outpatient Hospital</u>	
Emergency Room	3.15
Surgery	2.76
Pharmacy	2.59
Other Outpatient	2.50

COMPLETION OF MISSING PHARMACY DATA

Limited pharmacy claims data is available in May 2013 and June 2013 because of the transition from HP to Catamaran as the pharmacy claims vendor. The SFY 2013 pharmacy category of service was adjusted to use the July 2011 through April 2013 average utilization per 1,000 and per member per month (PMPM) costs for May 2013 and June 2013.

Beginning January 1, 2013, two new classes of drugs, barbiturates and benzodiazepines, became covered under Medicare Part D. Because of this change in coverage for Medicare eligible individuals, only pharmacy experience incurred January 2013 through April 2013 was used to develop the average utilization per 1,000 and PMPM costs for this population. The SFY 2012 experience was assumed to be consistent with the experience in the shortened SFY 2013 time period.

ACA ENHANCED PRIMARY CARE PHYSICIAN PAYMENTS

No adjustment was made to the base data for the enhanced primary care physician (PCP) payments offered through the ACA. These payments were effective beginning January 1, 2013, which overlaps with the SFY 2013 base data. However, these payments were made directly to physicians outside of the HP claims system. The enhanced reimbursement will not be paid during the rate period, so no adjustment was needed.

RATE DEVELOPMENT

The April 1, 2015 to December 31, 2015 capitation rates were developed by applying a series of adjustments to the combined SFY 2012 and SFY 2013 base data included in Appendix A. Appendix C illustrates the application of the adjustments to the base data to develop the low and high rate capitation rates. The following sections describe the adjustments that were made.

RATE PERIOD ADJUSTMENTS

This section describes the adjustments made to the base data to project the April 1, 2015 to December 31, 2015 ABD experience in a FFS environment. The next section will describe additional adjustments performed to reflect a managed care environment.

Trend

Certain utilization trend rates were applied to the SFY 2012 and SFY 2013 base data by category of service to reflect the expectation of utilization differences between the base data and rate period. Trend rates were estimated based on experience between July 2011 and April 2014 and actuarial judgment. Different trend rates were estimated for the adult and child population. Trend rates for the retroactive Medicare eligible population are the same as the adult population. Table 9 illustrates the trend rates used to trend the base data 37.5 months to the midpoint of the rate period:

Table 9 State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Utilization Trend Rates			
Category of Service	Adult	Child	Dual
<u>Inpatient Hospital</u>			
Medical	(0.5%)	1.0%	(0.5%)
Surgical	(0.5%)	1.0%	(0.5%)
Behavioral Health	(1.0%)	(2.0%)	(1.0%)
<u>Outpatient Hospital</u>			
Emergency Room	0.5%	2.0%	0.5%
Surgery	0.5%	0.5%	0.5%
Pharmacy	0.5%	0.5%	0.5%
Other Outpatient	0.5%	0.5%	0.5%
<u>Ancillaries</u>			
Pharmacy	2.0%	1.7%	2.0%
Nursing Home	2.5%	2.5%	2.5%
Hospice	2.5%	2.5%	2.5%
Home Health	(1.0%)	(1.0%)	(1.0%)
DME / Medical Supplies	(1.0%)	(1.0%)	(1.0%)
Transportation	0.5%	1.0%	0.5%
Dental	(1.0%)	(1.0%)	(1.0%)
<u>Physician</u>			
Inpatient/Outpatient Surgery	(0.5%)	1.0%	(0.5%)
Maternity Delivery	5.0%	2.0%	5.0%
Maternity Non-Delivery	5.0%	2.0%	5.0%
Office Visits/Consults	2.5%	3.0%	2.5%
Physical Exams	2.0%	2.0%	2.0%
Hospital Inpatient Visits	(0.5%)	1.0%	(0.5%)
Emergency Room Visits	0.5%	2.0%	0.5%
Radiology / Pathology	1.5%	0.5%	1.5%
Outpatient Behavioral	(2.0%)	(2.0%)	(2.0%)
Self Referral	(2.0%)	(1.5%)	(2.0%)
Office Administered Drugs	2.0%	1.7%	2.0%
Other Professional	(2.0%)	(1.5%)	(2.0%)

The illustrated pharmacy trend includes an adjustment to reflect recent and upcoming patent expirations. It also reflects an explicit adjustment for additional costs related to Sovaldi and Olysio, which are prescribed as medically necessary as defined by OMPP.

Completion Adjustment Factor

Data summarized in this report includes all claims for services provided to enrollees during SFY 2012 and SFY 2013, as submitted through February 28, 2014.

Based on historical completion patterns, the SFY 2012 data has been judged to be substantially complete, but completion adjustments were made to reflect unpaid claims incurred in SFY 2013. The adjustment factors were estimated in a way that is appropriate for application to the composite SFY 2012 and SFY 2013 data. The adjustment factors are therefore lower than they would be if only applied to the SFY 2013 data. The completion factors vary by population and major category of service. The retroactive Medicare eligible population was assumed to have the same completion factors as the adult population. The missing pharmacy category of service claims were estimated and included with the base data and therefore no adjustment was made to the pharmacy category of service. Table 10 illustrates the completion adjustments used.

Table 10 State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Completion Adjustments			
Category of Service	Adult	Child	Dual
Inpatient Hospital	1.001	1.001	1.001
Outpatient Hospital	1.001	1.001	1.001
Pharmacy	1.000	1.000	1.000
Ancillaries (Except Pharmacy and Dental)	1.002	1.002	1.002
Physician	1.002	1.001	1.002

Reimbursement Changes

The following reimbursement changes were implemented or are expected to be implemented between the base data time period (SFY 2012 and SFY 2013) and the rate period (April 1, 2015 to December 31, 2015).

- Emergency Reimbursement Reduction Expiration
- Physician Fee Schedule Increase
- Pharmacy Dispensing Fee Increase

Adjustments for these cost-per-service based changes are illustrated in the column titled “Rate Change” in Appendix C.

Emergency Reimbursement Reduction Expiration

Effective January 1, 2014, most of the emergency reimbursement reductions introduced during the recession were allowed to expire, and rates returned to pre-reduction levels (please see IHCP bulletins BT201320 through BT201334). However, reimbursement reductions for hospitals, nursing facilities, and home health providers have been reduced from 5% to 3% rather than eliminated. The reduction for inpatient hospital claims applies only to the main DRG-related component of the reimbursement and only affects the inpatient reimbursement before adjustment for enhanced hospital reimbursement. Milliman adjusted base period reimbursement to current IHCP payment levels. Reimbursement of services for retroactive Medicare eligible individuals was assumed to remain unchanged for all categories of service except for home health, transportation, and dental. The estimated effect of the reimbursement changes is outlined in Table 11.

Table 11 State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Reimbursement Reductions			
Category of Service	Adult	Child	Dual
<u>Inpatient Hospital</u>			
Medical	1.021	1.022	1.000
Surgical	1.021	1.022	1.000
Behavioral Health	1.021	1.021	1.000
<u>Outpatient Hospital</u>			
Emergency Room	1.021	1.023	1.000
Surgery	1.020	1.020	1.000
Pharmacy	1.022	1.022	1.000
Other Outpatient	1.021	1.023	1.000
<u>Ancillaries</u>			
Pharmacy	1.000	1.000	1.000
Nursing Home	1.021	1.021	1.000
Hospice	1.000	1.000	1.000
Home Health	1.021	1.021	1.021
DME / Medical Supplies	1.053	1.053	1.000
Transportation	1.084	1.075	1.084
Dental	1.053	1.053	1.053
<u>Physician</u>			
Inpatient/Outpatient Surgery	1.002	1.003	1.000
Maternity Delivery	1.000	1.000	1.000
Maternity Non-Delivery	1.000	1.000	1.000
Office Visits/Consults	1.000	1.000	1.000
Physical Exams	1.000	1.000	1.000
Hospital Inpatient Visits	1.000	1.000	1.000
Emergency Room Visits	1.000	1.000	1.000
Radiology / Pathology	1.045	1.046	1.000
Outpatient Behavioral	1.000	1.001	1.000
Self Referral	1.030	1.028	1.000
Office Administered Drugs	1.000	1.000	1.000
Other Professional	1.002	1.003	1.000

Physician Fee Schedule Increase

The State of Indiana is expected to increase the physician fee schedule to a reimbursement rate that is effectively 75% of Medicare. This increase was estimated and applied to the factors under the physician major category of service. Reimbursement of services for retroactive Medicare eligible individuals was assumed to remain unchanged. To the extent that the state uses rates different than those estimated by Milliman, or does not implement any rate change, the capitation rates will need to be adjusted. Table 12 illustrates the estimated reimbursement factor adjustments.

Table 12 State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Physician Fee Schedule Increase			
Physician Category of Service	Adult	Child	Dual
Inpatient/Outpatient Surgery	1.25	1.25	1.00
Maternity Delivery	1.00	1.00	1.00
Maternity Non-Delivery	1.25	1.25	1.00
Office Visits/Consults	1.40	1.40	1.00
Emergency Room Visits	1.25	1.25	1.00
Radiology / Pathology	1.00	1.00	1.00
Outpatient Behavioral Health	1.25	1.25	1.00
Self Referral	1.40	1.40	1.00

Pharmacy Dispensing Fee Increase

Effective January 1, 2014, the dispensing fee for prescriptions was changed from a maximum of \$3.00 to \$3.90. The maximum dispensing fee of \$3.00 was effective starting July 1, 2011 (please see IHCP bulletins BT201120 and BT201405). An adjustment factor was estimated to reflect the payment difference between the \$3.00 maximum and new \$3.90 maximum dispensing fee for claims paid at the maximum dispensing fee in the base data. The reimbursement adjustment factor was estimated to be 1.010 for the adult and retroactive Medicare eligible rate group and 1.005 for the child rate group.

Third Party Liability Recoveries

The Medicaid program is the payer of last resort, and therefore the amount reimbursed by Medicaid will be reduced if the individual has coverage through a third party. Third party liability (TPL) collected when a provider bills the third party payer before billing Medicaid, the cost avoidance method, is already reflected in the base data. However, third party liability collected when Medicaid pays the initial claim and then must seek recoveries from the third party, the pay and chase method, is not included in the base data. Historical data was used to estimate that 0.5% of claims cost are recovered from third parties through the pay and chase process.

MANAGED CARE ADJUSTMENTS

This section describes the adjustments made to the rate-period adjusted base data to develop a low and high rate range for capitated payments necessary for coverage of the ABD individuals in a risk-based managed care environment.

Pharmacy Copayments

Pharmacy copayments will not be required under the risk-based managed care program. While children under 18 currently do not pay pharmacy copayments under the FFS program, adults in the FFS program may have to pay a \$3 copayment for certain medications. An adjustment factor was estimated to increase the pharmacy category of service cost by the amount of the copayments paid in the SFY 2012 and SFY 2013 base data. The adjustments factors were estimated to be 1.034 for the adult and retroactive Medicare eligible rate group and 1.003 for the child rate group. The child rate group adjustment factor is near 1.0 because only individuals 18 and older are currently potentially charged a copayment.

Managed Care Utilization Adjustments

The ABD population is being enrolled in risk-based managed care to improve care management. A low and high range of managed care adjustments were developed to estimate a range of reasonable utilization reductions. These adjustments were developed based on a review of potentially avoidable expenditures as identified by the Agency for Healthcare Research and Quality Prevention Quality Indicators and the New York University Emergency Department Algorithm. Additionally, the ABD population utilization rates by category of service were compared to other Medicaid programs in both FFS and risk-based managed care environments in order to assess the opportunity for reduced utilization within the ABD population. The estimated low and high managed care adjustment factors for the adult, child, and retroactive Medicare eligible populations are illustrated in Table 13. Retroactive Medicare eligible individuals were assumed to experience the same level of managed care reductions as the adult population.

Table 13						
State of Indiana Office of Medicaid Policy and Planning Hoosier Care Connect Managed Care Utilization Adjustments						
Category of Service	Adult		Child		Dual	
	Low	High	Low	High	Low	High
<u>Inpatient Hospital</u>						
Medical	0.830	0.905	0.895	0.945	0.830	0.905
Surgical	0.830	0.900	0.890	0.940	0.830	0.900
Behavioral Health	0.830	0.905	0.845	0.915	0.830	0.905
<u>Outpatient Hospital</u>						
Emergency Room	0.855	0.910	0.895	0.950	0.855	0.910
Surgery	0.910	0.955	0.960	0.985	0.910	0.955
Pharmacy	0.865	0.910	0.930	0.960	0.865	0.910
Other Outpatient	0.865	0.910	0.950	0.975	0.865	0.910
<u>Ancillaries</u>						
Pharmacy	0.855	0.905	0.895	0.925	0.855	0.905
Nursing Home	1.000	1.000	1.000	1.000	1.000	1.000
Hospice	1.000	1.000	1.000	1.000	1.000	1.000
Home Health	0.900	0.925	0.905	0.930	0.900	0.925
DME / Medical Supplies	0.900	0.925	0.920	0.955	0.900	0.925
Transportation	1.000	1.000	1.000	1.000	1.000	1.000
Dental	1.020	1.035	1.005	1.010	1.020	1.035
<u>Physician</u>						
Inpatient/Outpatient Surgery	0.850	0.915	0.910	0.955	0.850	0.915
Maternity Delivery	1.000	1.000	1.000	1.000	1.000	1.000
Maternity Non-Delivery	1.000	1.000	1.000	1.000	1.000	1.000
Office Visits/Consults	1.025	1.015	1.045	1.020	1.025	1.015
Physical Exams	3.625	3.620	1.235	1.180	3.625	3.620
Hospital Inpatient Visits	0.830	0.905	0.895	0.945	0.830	0.905
Emergency Room Visits	0.855	0.910	0.895	0.950	0.855	0.910
Radiology / Pathology	0.860	0.910	0.905	0.945	0.860	0.910
Outpatient Behavioral	0.860	0.905	0.935	0.960	0.860	0.905
Self Referral	1.000	1.000	1.000	1.000	1.000	1.000
Office Administered Drugs	0.905	0.940	0.940	0.970	0.905	0.940
Other Professional	0.905	0.950	0.960	0.980	0.905	0.950

Managed Care Contracting Adjustments

To the extent that managed care organizations contract at a different rate than the Indiana Medicaid state plan reimbursement, the capitation rates need to be adjusted to reflect this difference. It is estimated that managed care organizations will be able to contract at the state plan reimbursement levels for all categories of service other than pharmacy, in part because of the implementation of the physician fee schedule increase. The state plan maximum dispensing fee of \$3.90 is higher than what a typical managed care organizations will contract at, so an adjustment factor was estimated to reflect an expected dispensing fee reimbursement of \$2.00. The factor estimated was 0.980 for the adult and retroactive Medicare eligible population and 0.990 for the child population.

Administration and Profit

In addition to the benefit cost of covering the ABD population, a provision is necessary to cover the administrative and capital costs of the managed care organization. A variable administrative load of 9.0% was developed after a review of administrative and cost of capital amounts paid to managed care organizations in other risk-based managed care environments. The retroactive Medicare eligible administration load was set at the same dollar amount as for the adult population.

ACA Health Insurer Assessment Fee

The capitation rates illustrated in this report do not include an adjustment for the ACA health insurer assessment fee. For the first year of the program, no adjustment to the rates is anticipated because no fee should be payable until the second year of the program.

However, for managed care organizations currently serving the MA-U population through Hoosier Healthwise, the State will be required to adjust the capitation rates to provide reimbursement for the health insurer assessment fee and any associated taxes, ("Contractor's Adjusted Fee").

For managed care organizations not currently participating in the Hoosier Healthwise program, no adjustment to the capitation rate will be needed because no fee should be payable during the first contract period.

For future contract years, the State will be required to adjust the capitation rates to provide reimbursement for the health insurer assessment fee and any associated taxes, ("Contractor's Adjusted Fee"). Following its review and acceptance of each affected Contractor's Adjusted Fee documentation, the State plans to adjust each affected contractor's capitation rates. The rates may be adjusted both retrospectively and prospectively, as needed. The rate increase will be a flat percentage increase, applied to the full rate period of the payment year. The percentage increase will be determined on a plan-specific basis each year, designed to reimburse each affected contractor for the Contractor's Adjusted Fee, if any, that may become due during the rate period.

To allow for this anticipated adjustment to the capitation rates, the high end of the certified rate range may be increased by up to 4% for future rate periods.

Anticipated Future Year Rate Adjustments

The rates illustrated in this document are applicable to the first rate period, from April 1, 2015 through December 31, 2015. For future years under this contact, we anticipate adjusting the rates to reflect the following:

- Utilization trend
- Medicaid cost trend
- Anticipated managed care improvements
- The ACA Health Insurer Fee
- Other policy and program changes

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration and Office of Medicaid Policy and Planning (OMPP) to provide historical data and information to the managed care organizations to assist with understanding the development of the actuarially sound rate range for the Hoosier Care Connect program. The data and information presented may not be appropriate for any other purpose.

The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for OMPP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the State of Indiana, Family and Social Services Administration and their vendors, primarily the managed care encounter data reported to OMPP and provided to Milliman by HP. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data. OMPP and Milliman provide no guarantee, either written or implied, that the data and information is 100% accurate or error free.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and OMPP approved May 14, 2010, and last amended December 31, 2013

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The actuaries preparing this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Appendix A
SFY 2012 and SFY 2013 Data
by Population and Category of Service

State of Indiana
Office of Medicaid Policy and Planning
Hoosier Care Connect
Actuarial Cost Models - SFY 2012 and SFY 2013
Claims Paid through February 2014
Population: Adult

Average Monthly Membership:		52,724			59,347		
Category of Service	Unit Desc	Utilization per 1,000	SFY 2012	Paid PMPM	Utilization per 1,000	SFY 2013	Paid PMPM
			Cost per Unit			Cost per Unit	
Inpatient Hospital							
Medical	days	1,470	\$ 899.18	\$ 110.12	1,420	\$ 932.13	\$ 110.31
Surgical	days	602	1,918.43	96.22	597	1,956.31	97.26
Behavioral Health	days	447	537.75	20.04	431	539.55	19.38
Subtotal Inpatient Hospital				\$ 226.38			\$ 226.95
Outpatient Hospital							
Emergency Room	services	1,768	\$ 74.24	\$ 10.94	1,780	\$ 73.11	\$ 10.85
Surgery	services	809	351.41	23.68	809	349.53	23.58
Pharmacy	services	4,677	107.93	42.07	5,067	99.01	41.81
Other Outpatient	services	22,893	36.68	69.98	22,866	36.77	70.07
Subtotal Outpatient Hospital				\$ 146.67			\$ 146.31
Ancillaries							
Pharmacy	scripts	51,299	\$ 84.36	\$ 360.63	48,461	\$ 83.31	\$ 336.43
Nursing Home (<30 days)	days	191	173.80	2.76	182	181.62	2.75
Hospice (at home)	days	399	144.13	4.80	376	146.91	4.60
Home Health	services	2,655	95.39	21.11	2,385	96.73	19.23
DME / Medical Supplies	units	4,005	116.85	39.00	3,771	114.34	35.93
Transportation	trips	9,177	27.88	21.32	9,027	27.31	20.54
Dental	procs	2,920	85.00	20.68	3,226	91.18	24.51
Subtotal Ancillaries				\$ 470.30			\$ 443.99
Physician							
Inpatient and Outpatient Surgery	procs	2,609	\$ 144.44	\$ 31.40	2,610	\$ 141.40	\$ 30.75
Maternity Delivery	deliveries	7	697.78	0.39	8	699.81	0.44
Maternity Non-Delivery	visits	86	46.35	0.33	85	47.00	0.33
Office Visits/Consults	visits	8,665	52.57	37.96	8,918	53.33	39.64
Physical Exams	visits	122	67.02	0.68	122	66.81	0.68
Hospital Inpatient Visits	visits	4,067	54.26	18.39	4,118	55.22	18.95
Emergency Room Visits	visits	2,037	75.77	12.86	2,041	76.49	13.01
Radiology / Pathology	procs	14,696	24.93	30.53	15,656	24.36	31.78
Outpatient Behavioral Health	procs	3,303	52.75	14.52	2,611	60.38	13.14
Self Referral	visits	2,677	23.93	5.34	2,556	24.34	5.18
Office Administered Drugs	procs	2,249	232.19	43.51	2,146	205.60	36.78
Other Professional	visits	5,899	45.58	22.40	5,568	45.46	21.09
Subtotal Physician				\$ 218.33			\$ 211.77
Grand Total				\$ 1,061.68			\$ 1,029.02

State of Indiana
Office of Medicaid Policy and Planning
Hoosier Care Connect
Actuarial Cost Models - SFY 2012 and SFY 2013
Claims Paid through February 2014
Population: Child

Average Monthly Membership:		14,751			16,095		
Category of Service	Unit Desc	Utilization per 1,000	SFY 2012 Cost per Unit	Paid PMPM	Utilization per 1,000	SFY 2013 Cost per Unit	Paid PMPM
Inpatient Hospital							
Medical	days	450	\$ 889.20	\$ 33.36	462	\$ 946.53	\$ 36.48
Surgical	days	189	1,740.59	27.39	234	1,731.47	33.80
Behavioral Health	days	933	393.23	30.57	794	425.57	28.17
Subtotal Inpatient Hospital				\$ 91.31			\$ 98.45
Outpatient Hospital							
Emergency Room	services	871	\$ 75.63	\$ 5.49	908	\$ 78.30	\$ 5.92
Surgery	services	322	313.98	8.43	305	320.37	8.15
Pharmacy	services	1,300	76.12	8.24	1,290	96.27	10.35
Other Outpatient	services	10,443	40.40	35.16	9,748	41.15	33.43
Subtotal Outpatient Hospital				\$ 57.32			\$ 57.85
Ancillaries							
Pharmacy	scripts	18,790	\$ 156.00	\$ 244.27	18,559	\$ 155.63	\$ 240.70
Nursing Home (<30 days)	days	41	328.28	1.11	31	314.91	0.81
Hospice (at home)	days	91	141.77	1.07	107	149.46	1.33
Home Health	services	2,378	262.50	52.01	2,035	256.99	43.58
DME / Medical Supplies	units	3,623	178.61	53.93	3,629	176.56	53.40
Transportation	trips	2,711	30.81	6.96	3,008	28.40	7.12
Dental	procs	4,766	44.80	17.79	4,503	44.74	16.79
Subtotal Ancillaries				\$ 377.15			\$ 363.73
Physician							
Inpatient and Outpatient Surgery	procs	560	\$ 144.76	\$ 6.75	594	\$ 139.78	\$ 6.91
Maternity Delivery	deliveries	5	685.33	0.30	6	677.22	0.31
Maternity Non-Delivery	visits	67	43.74	0.25	59	43.81	0.22
Office Visits/Consults	visits	3,811	43.64	13.86	4,218	44.45	15.62
Physical Exams	visits	491	61.57	2.52	502	61.85	2.59
Hospital Inpatient Visits	visits	1,285	65.98	7.07	1,368	69.07	7.88
Emergency Room Visits	visits	903	59.88	4.50	941	61.03	4.78
Radiology / Pathology	procs	3,285	21.84	5.98	3,236	21.24	5.73
Outpatient Behavioral Health	procs	3,387	47.60	13.44	3,008	49.90	12.51
Self Referral	visits	1,774	23.63	3.49	1,778	23.73	3.52
Office Administered Drugs	procs	407	270.86	9.19	561	205.80	9.62
Other Professional	visits	7,822	33.85	22.06	7,756	34.92	22.57
Subtotal Physician				\$ 89.42			\$ 92.26
Grand Total				\$ 615.20			\$ 612.29

State of Indiana
Office of Medicaid Policy and Planning
Hoosier Care Connect
Actuarial Cost Models - SFY 2012 and SFY 2013
Claims Paid through February 2014
Population: Dual

Average Monthly Membership:		22,090			26,095		
Category of Service	Unit Desc	Utilization per 1,000	SFY 2012		SFY 2013		Paid PMPM
			Cost per Unit	Paid PMPM	Utilization per 1,000	Cost per Unit	
Inpatient Hospital							
Medical	days	990	\$ 107.66	\$ 8.88	948	\$ 91.31	\$ 7.21
Surgical	days	388	122.50	3.96	364	98.59	2.99
Behavioral Health	days	419	93.40	3.26	422	85.64	3.01
Subtotal Inpatient Hospital				\$ 16.11			\$ 13.21
Outpatient Hospital							
Emergency Room	services	1,679	\$ 10.90	\$ 1.53	1,663	\$ 10.87	\$ 1.51
Surgery	services	767	39.42	2.52	688	34.75	1.99
Pharmacy	services	5,276	7.28	3.20	3,597	7.34	2.20
Other Outpatient	services	23,089	3.99	7.68	19,797	4.25	7.01
Subtotal Outpatient Hospital				\$ 14.93			\$ 12.71
Ancillaries							
Pharmacy	scripts	2,241	\$ 20.29	\$ 3.79	2,241	\$ 20.29	\$ 3.79
Nursing Home (<30 days)	days	307	45.04	1.15	332	39.12	1.08
Hospice (at home)	days	-	-	-	0	152.86	0.00
Home Health	services	2,862	101.98	24.32	2,385	104.19	20.71
DME / Medical Supplies	units	4,771	26.87	10.68	4,052	24.01	8.11
Transportation	trips	14,462	15.22	18.35	12,502	14.78	15.39
Dental	procs	2,785	80.61	18.71	3,185	86.56	22.97
Subtotal Ancillaries				\$ 77.00			\$ 72.06
Physician							
Inpatient and Outpatient Surgery	procs	2,446	\$ 18.00	\$ 3.67	2,379	\$ 17.70	\$ 3.51
Maternity Delivery	deliveries	2	189.99	0.03	2	94.44	0.02
Maternity Non-Delivery	visits	16	9.30	0.01	24	9.78	0.02
Office Visits/Consults	visits	7,244	4.58	2.77	7,688	5.00	3.20
Physical Exams	visits	42	58.17	0.20	46	57.20	0.22
Hospital Inpatient Visits	visits	4,263	0.73	0.26	4,190	0.83	0.29
Emergency Room Visits	visits	1,621	3.10	0.42	1,647	3.98	0.55
Radiology / Pathology	procs	6,453	3.12	1.68	6,356	3.44	1.82
Outpatient Behavioral Health	procs	3,651	53.56	16.30	2,666	54.53	12.12
Self Referral	visits	2,387	14.84	2.95	2,227	15.44	2.87
Office Administered Drugs	procs	1,429	96.60	11.50	1,526	70.94	9.02
Other Professional	visits	4,815	6.02	2.41	4,615	5.94	2.29
Subtotal Physician				\$ 42.19			\$ 35.91
Grand Total				\$ 150.24			\$ 133.90

Appendix B

Category of Service Documentation

State of Indiana
Office of Medicaid Policy and Planning
Category of Service - Definitions

Inpatient Hospital	AP-DRGs				
Medical	009-035	382-384	551-552	631-635	822
	043-048	395-399	557	637-652	825-828
	064-074	403-404	560-563	705-716	832
	078-102	409-414	566	733-734	876
	121-145	416-423	568-570	740	880-882
	172-189	444-457	572	752	885-891
	202-208	460	574	754	894-895
	235-256	462-467	576-578	760-785	897
	271-284	469-470	580	794	900-901
	294-301	475	582	799-802	
	316-333	532-533	584	810	
	346-352	535	586-619	812-816	
	366-380	540-544	622-628	820	
	Surgical	001-008	353-365	534	583
036-042		381	536-539	585	823-824
049-063		392-394	545-550	636	829
075-077		400-402	553-556	700-704	833-875
103-120		406-408	558-559	730-732	877-879
146-171		415	564-565	737-739	883-884
191-201		439-443	567	755-759	892-893
209-234		458-459	571	786-793	896
257-270		461	573	795-798	898-899
285-293		468	575	803-809	
302-315		471-472	579	811	
334-345		476-531	581	817-819	
Behavioral Health	424-432	743-751	753		
Outpatient Hospital	Revenue Codes				
Emergency Room	450-459				
Surgery	360-369	481	490-499	750-759	790-799
Pharmacy	250-269	331-332	335	630-637	
Other Outpatient	001-249	339-359	482-489	760-789	
	270-330	370-449	500-624	800-999	
	333	460-480	640-749		

State of Indiana
Office of Medicaid Policy and Planning
Category of Service - Definitions

Ancillaries	COS State	Revenue Code	CPT-4/HCPCS Code		
Pharmacy ¹					
Nursing Home (30 Days)	1400 - 1499				
Hospice (At Home)	1800 - 1899	Not 651 652 - 653			
Home Health	1600 - 1699				
Transportation	1300 - 1399		A0001 - A0999 P9603 - P9604	S0207 - S0215 T2001 - T2007	T2049
DME / Medical Supplies	0800 - 1099				
Dental	2700 - 2899		D0001 – D9999		
Physician	CPT-4/HCPCS Code				
Inpatient and Outpatient Surgery	10000 - 36414	60000 - 69999	93451 - 93462	99143 - 99150	S2270 - S2900
	36416 - 58999	92973 - 92974	93501 - 93536	M0301	
	59525	92980 - 92998	93580 - 93581	S2053 - S2250	
Maternity Delivery	59400	59510 - 59515	59612	59618	59622
	59409 - 59410	59610	59614	59620	
Maternity Non-Delivery	59000 - 59399	59412 - 59414	59425 - 59430	59812 - 59899	
Office Visits/Consults	98966 - 98969	99241 - 99275	99358 - 99359	99366 - 99380	99499
	99201 - 99215	99321 - 99355	99361 - 99362	99441 - 99444	T1015
Physical Exams	99381 - 99404	99411 - 99429	99432	99461	
Hospital Inpatient Visits	90816 - 90829	99356 - 99357	99435 - 99436	99462 - 99469	
	99217 - 99239	99431	99440	99471 - 99472	
	99289 - 99318	99433	99460	99475 - 99480	
Emergency Room Visits	99281 - 99288				
Radiology/Pathology	70000 - 79999	80000 - 89999	P0001 - P9009	R0009 - R0999	S3600 - S3890
Outpatient Behavioral Health	90785	90801 - 90815	90843	H0001 - H0050	S0201
	90788	90832 - 90834	90845 - 90899	H1011 - H2037	
	90791 - 90792	90836 - 90840	99408 - 99409	M0064	
Self-Referral ³	92002 - 92392	92499	99172 - 99174	V2700 - V2999	
	92395 - 92396	98940 - 98943	V2020 – V2615		
Office Administered Drugs ⁴					
Other Professional ⁵	00000 - 09999	D0000 - D9999	H5200 - H5300	V5000 - V5299	
	36415	H5160	J0110 - J9999	V5362 - V5364	

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1. Pharmacy claims are identified as those in the HP adjudicated pharmacy data set.
 2. Dental claims are identified as those in the HP adjudicated dental data set.
 3. Office administered drugs are identified as claims in the HCFA data source reported with NDC code.
 4. Also includes any services provided by chiropractic, podiatric and eye care providers and not assigned by CPT-4/ HCPCS.
 5. Also includes any other services not assigned by CPT-4/ HCPCS methodology.

Appendix C

Rate Development

State of Indiana
Office of Medicaid Policy and Planning
Hoosier Care Connect
Claims Paid through February 2014 without HAF
Population: Adult

Category of Service	SFY 12/13	Annual	Base Cost Factors		8/15/15 FFS	MC Low Range Factors			8/15/15 MCO	MC High Range Factors			8/15/15 MCO		
	Paid PMPM	Trend	Trend	Completion	Rate Change	Paid PMPM	Rx Copay	MC	Contracting	Low PMPM	Rx Copay	MC	Contracting	High PMPM	
Inpatient Hospital															
Medical	\$ 110.22	-0.5%	0.984	1.001	1.021	\$ 110.87	1.000	0.830	1.000	\$ 92.02	1.000	0.905	1.000	\$ 100.34	
Surgical	96.77	-0.5%	0.984	1.001	1.021	97.35	1.000	0.830	1.000	80.80	1.000	0.900	1.000	87.61	
Behavioral Health	19.69	-1.0%	0.969	1.001	1.021	19.50	1.000	0.830	1.000	16.19	1.000	0.905	1.000	17.65	
Subtotal Inpatient Hospital	\$ 226.68					\$ 227.72				\$ 189.01				\$ 205.60	
Outpatient Hospital															
Emergency Room	\$ 10.89	0.5%	1.016	1.001	1.021	\$ 11.31	1.000	0.855	1.000	\$ 9.67	1.000	0.910	1.000	\$ 10.29	
Surgery	23.63	0.5%	1.016	1.001	1.020	24.50	1.000	0.910	1.000	22.30	1.000	0.955	1.000	23.40	
Pharmacy	41.93	0.5%	1.016	1.001	1.022	43.58	1.000	0.865	1.000	37.70	1.000	0.910	1.000	39.66	
Other Outpatient	70.03	0.5%	1.016	1.001	1.021	72.75	1.000	0.865	1.000	62.93	1.000	0.910	1.000	66.20	
Subtotal Outpatient Hospital	\$ 146.48					\$ 152.14				\$ 132.59				\$ 139.55	
Ancillaries															
Pharmacy	\$ 347.82	2.0%	1.063	1.000	1.010	\$ 373.42	1.034	0.855	0.980	\$ 323.53	1.034	0.905	0.980	\$ 342.45	
Nursing Home (<30 days)	2.76	2.5%	1.080	1.002	1.021	3.04	1.000	1.000	1.000	3.04	1.000	1.000	1.000	3.04	
Hospice (at home)	4.69	2.5%	1.080	1.002	1.000	5.08	1.000	1.000	1.000	5.08	1.000	1.000	1.000	5.08	
Home Health	20.11	-1.0%	0.969	1.002	1.021	19.94	1.000	0.900	1.000	17.94	1.000	0.925	1.000	18.44	
DME / Medical Supplies	37.37	-1.0%	0.969	1.002	1.053	38.20	1.000	0.900	1.000	34.38	1.000	0.925	1.000	35.33	
Transportation	20.91	0.5%	1.016	1.002	1.084	23.08	1.000	1.000	1.000	23.08	1.000	1.000	1.000	23.08	
Dental	22.71	-1.0%	0.969	1.000	1.053	23.16	1.000	1.020	1.000	23.63	1.000	1.035	1.000	23.98	
Subtotal Ancillaries	\$ 456.37					\$ 485.92				\$ 430.68				\$ 451.40	
Physician															
Inpatient/Outpatient Surgery	\$ 31.06	-0.5%	0.984	1.002	1.252	\$ 38.35	1.000	0.850	1.000	\$ 32.60	1.000	0.915	1.000	\$ 35.09	
Maternity Delivery	0.42	5.0%	1.165	1.002	1.000	0.49	1.000	1.000	1.000	0.49	1.000	1.000	1.000	0.49	
Maternity Non-Delivery	0.33	5.0%	1.165	1.002	1.250	0.49	1.000	1.000	1.000	0.49	1.000	1.000	1.000	0.49	
Office Visits/Consults	38.85	2.5%	1.080	1.002	1.401	58.88	1.000	1.025	1.000	60.36	1.000	1.015	1.000	59.77	
Physical Exams	0.68	2.0%	1.064	1.002	1.400	1.02	1.000	3.625	1.000	3.68	1.000	3.620	1.000	3.68	
Hospital Inpatient Visits	18.69	-0.5%	0.984	1.002	1.250	23.03	1.000	0.830	1.000	19.12	1.000	0.905	1.000	20.84	
Emergency Room Visits	12.94	0.5%	1.016	1.002	1.250	16.47	1.000	0.855	1.000	14.08	1.000	0.910	1.000	14.98	
Radiology / Pathology	31.19	1.5%	1.048	1.002	1.045	34.22	1.000	0.860	1.000	29.43	1.000	0.910	1.000	31.14	
Outpatient Behavioral	13.79	-2.0%	0.939	1.002	1.250	16.22	1.000	0.860	1.000	13.95	1.000	0.905	1.000	14.68	
Self Referral	5.26	-2.0%	0.939	1.002	1.442	7.13	1.000	1.000	1.000	7.13	1.000	1.000	1.000	7.13	
Office Administered Drugs	39.94	2.0%	1.063	1.002	1.000	42.55	1.000	0.905	1.000	38.50	1.000	0.940	1.000	39.99	
Other Professional	21.71	-2.0%	0.939	1.002	1.002	20.46	1.000	0.905	1.000	18.51	1.000	0.950	1.000	19.43	
Subtotal Physician	\$ 214.86					\$ 259.29				\$ 238.33				\$ 247.71	
Grand Total	\$ 1,044.39					\$ 1,125.08				\$ 990.61				\$ 1,044.26	
CY 2015 Base PMPM:		\$ 1,125.08					CY 2015 Base PMPM:		\$ 990.61			CY 2015 Base PMPM:		\$ 1,044.26	
TPL Recoveries:		(5.63)					TPL Recoveries:		(4.95)			TPL Recoveries:		(5.22)	
Managed Care Adjustment:		0.00					Admin & Profit:		97.48			Admin & Profit:		102.76	
CY 2015 FFS PMPM:		\$ 1,119.46					CY 2015 Capitated PMPM:		\$ 1,083.14			CY 2015 Capitated PMPM:		\$ 1,141.81	

State of Indiana
Office of Medicaid Policy and Planning
Hoosier Care Connect
Claims Paid through February 2014 without HAF
Population: Child

Category of Service	SFY 12/13 Paid PMPM	Annual Trend	Trend	Base Cost Factors		8/15/15 FFS Paid PMPM	MC Low Range Factors			8/15/15 MCO Low PMPM	MC High Range Factors			8/15/15 MCO High PMPM
				Completion	Rate Change		Rx Copay	MC	Contracting		Rx Copay	MC	Contracting	
Inpatient Hospital														
Medical	\$ 34.98	1.0%	1.032	1.001	1.022	\$ 36.94	1.000	0.895	1.000	\$ 33.06	1.000	0.945	1.000	\$ 34.91
Surgical	30.73	1.0%	1.032	1.001	1.022	32.46	1.000	0.890	1.000	28.89	1.000	0.940	1.000	30.51
Behavioral Health	29.32	-2.0%	0.939	1.001	1.021	28.13	1.000	0.845	1.000	23.77	1.000	0.915	1.000	25.74
Subtotal Inpatient Hospital	\$ 95.04					\$ 97.52				\$ 85.71				\$ 91.15
Outpatient Hospital														
Emergency Room	\$ 5.72	2.0%	1.064	1.001	1.023	\$ 6.23	1.000	0.895	1.000	\$ 5.57	1.000	0.950	1.000	\$ 5.91
Surgery	8.29	0.5%	1.016	1.001	1.020	8.60	1.000	0.960	1.000	8.26	1.000	0.985	1.000	8.47
Pharmacy	9.34	0.5%	1.016	1.001	1.022	9.71	1.000	0.930	1.000	9.03	1.000	0.960	1.000	9.32
Other Outpatient	34.25	0.5%	1.016	1.001	1.023	35.65	1.000	0.950	1.000	33.87	1.000	0.975	1.000	34.76
Subtotal Outpatient Hospital	\$ 57.60					\$ 60.19				\$ 56.73				\$ 58.47
Ancillaries														
Pharmacy	\$ 242.41	1.7%	1.053	1.000	1.005	\$ 256.53	1.003	0.895	0.990	\$ 227.98	1.003	0.925	0.990	\$ 235.63
Nursing Home (<30 days)	0.95	2.5%	1.080	1.002	1.021	1.06	1.000	1.000	1.000	1.06	1.000	1.000	1.000	1.06
Hospice (at home)	1.21	2.5%	1.080	1.002	1.000	1.31	1.000	1.000	1.000	1.31	1.000	1.000	1.000	1.31
Home Health	47.61	-1.0%	0.969	1.002	1.021	47.20	1.000	0.905	1.000	42.72	1.000	0.930	1.000	43.90
DME / Medical Supplies	53.65	-1.0%	0.969	1.002	1.053	54.84	1.000	0.920	1.000	50.45	1.000	0.955	1.000	52.37
Transportation	7.04	1.0%	1.032	1.002	1.075	7.83	1.000	1.000	1.000	7.83	1.000	1.000	1.000	7.83
Dental	17.27	-1.0%	0.969	1.000	1.053	17.61	1.000	1.005	1.000	17.70	1.000	1.010	1.000	17.79
Subtotal Ancillaries	\$ 370.15					\$ 386.37				\$ 349.04				\$ 359.87
Physician														
Inpatient/Outpatient Surgery	\$ 6.84	1.0%	1.032	1.001	1.253	\$ 8.85	1.000	0.910	1.000	\$ 8.06	1.000	0.955	1.000	\$ 8.46
Maternity Delivery	0.31	2.0%	1.064	1.001	1.000	0.33	1.000	1.000	1.000	0.33	1.000	1.000	1.000	0.33
Maternity Non-Delivery	0.23	2.0%	1.064	1.001	1.250	0.31	1.000	1.000	1.000	0.31	1.000	1.000	1.000	0.31
Office Visits/Consults	14.78	3.0%	1.097	1.001	1.400	22.73	1.000	1.045	1.000	23.75	1.000	1.020	1.000	23.18
Physical Exams	2.56	2.0%	1.064	1.001	1.400	3.81	1.000	1.235	1.000	4.71	1.000	1.180	1.000	4.50
Hospital Inpatient Visits	7.49	1.0%	1.032	1.001	1.250	9.67	1.000	0.895	1.000	8.66	1.000	0.945	1.000	9.14
Emergency Room Visits	4.65	2.0%	1.064	1.001	1.250	6.19	1.000	0.895	1.000	5.54	1.000	0.950	1.000	5.88
Radiology / Pathology	5.85	0.5%	1.016	1.001	1.046	6.22	1.000	0.905	1.000	5.63	1.000	0.945	1.000	5.88
Outpatient Behavioral	12.95	-2.0%	0.939	1.001	1.251	15.23	1.000	0.935	1.000	14.24	1.000	0.960	1.000	14.62
Self Referral	3.50	-1.5%	0.954	1.001	1.439	4.82	1.000	1.000	1.000	4.82	1.000	1.000	1.000	4.82
Office Administered Drugs	9.42	1.7%	1.053	1.001	1.000	9.93	1.000	0.940	1.000	9.33	1.000	0.970	1.000	9.63
Other Professional	22.33	-1.5%	0.954	1.001	1.003	21.39	1.000	0.960	1.000	20.54	1.000	0.980	1.000	20.97
Subtotal Physician	\$ 90.90					\$ 109.47				\$ 105.89				\$ 107.69
Grand Total	\$ 613.68					\$ 653.56				\$ 597.38				\$ 617.19
CY 2015 Base PMPM:		\$ 653.56		CY 2015 Base PMPM:		\$ 597.38		CY 2015 Base PMPM:		\$ 617.19				
TPL Recoveries:		(3.27)		TPL Recoveries:		(2.99)		TPL Recoveries:		(3.09)				
Managed Care Adjustment:		22.70		Admin & Profit:		58.79		Admin & Profit:		60.74				
CY 2015 FFS PMPM:		\$ 672.99		CY 2015 Capitated PMPM:		\$ 653.18		CY 2015 Capitated PMPM:		\$ 674.83				

State of Indiana
Office of Medicaid Policy and Planning
Hoosier Care Connect
Claims Paid through February 2014 without HAF
Population: Dual

Category of Service	SFY 12/13	Annual		Base Cost Factors		8/15/15 FFS	MC Low Range Factors			8/15/15 MCO	MC High Range Factors			8/15/15 MCO
	Paid PMPM	Trend	Trend	Completion	Rate Change	Paid PMPM	Rx Copay	MC	Contracting	Low PMPM	Rx Copay	MC	Contracting	High PMPM
Inpatient Hospital														
Medical	\$ 7.98	-0.5%	0.984	1.001	1.000	\$ 7.86	1.000	0.830	1.000	\$ 6.52	1.000	0.905	1.000	\$ 7.11
Surgical	3.44	-0.5%	0.984	1.001	1.000	3.39	1.000	0.830	1.000	2.81	1.000	0.900	1.000	3.05
Behavioral Health	3.13	-1.0%	0.969	1.001	1.000	3.03	1.000	0.830	1.000	2.52	1.000	0.905	1.000	2.74
Subtotal Inpatient Hospital	\$ 14.54					\$ 14.28				\$ 11.85				\$ 12.90
Outpatient Hospital														
Emergency Room	\$ 1.52	0.5%	1.016	1.001	1.000	\$ 1.54	1.000	0.855	1.000	\$ 1.32	1.000	0.910	1.000	\$ 1.40
Surgery	2.24	0.5%	1.016	1.001	1.000	2.27	1.000	0.910	1.000	2.07	1.000	0.955	1.000	2.17
Pharmacy	2.66	0.5%	1.016	1.001	1.000	2.70	1.000	0.865	1.000	2.34	1.000	0.910	1.000	2.46
Other Outpatient	7.32	0.5%	1.016	1.001	1.000	7.44	1.000	0.865	1.000	6.44	1.000	0.910	1.000	6.77
Subtotal Outpatient Hospital	\$ 13.73					\$ 13.96				\$ 12.16				\$ 12.81
Ancillaries														
Pharmacy	\$ 3.79	2.0%	1.063	1.000	1.010	\$ 4.07	1.034	0.855	0.980	\$ 3.53	1.034	0.905	0.980	\$ 3.73
Nursing Home (<30 days)	1.11	2.5%	1.080	1.002	1.000	1.21	1.000	1.000	1.000	1.21	1.000	1.000	1.000	1.21
Hospice (at home)	0.00	2.5%	1.080	1.002	1.000	0.00	1.000	1.000	1.000	0.00	1.000	1.000	1.000	0.00
Home Health	22.37	-1.0%	0.969	1.002	1.021	22.18	1.000	0.900	1.000	19.96	1.000	0.925	1.000	20.51
DME / Medical Supplies	9.29	-1.0%	0.969	1.002	1.000	9.02	1.000	0.900	1.000	8.12	1.000	0.925	1.000	8.34
Transportation	16.75	0.5%	1.016	1.002	1.084	18.48	1.000	1.000	1.000	18.48	1.000	1.000	1.000	18.48
Dental	21.02	-1.0%	0.969	1.000	1.053	21.44	1.000	1.020	1.000	21.87	1.000	1.035	1.000	22.19
Subtotal Ancillaries	\$ 74.33					\$ 76.39				\$ 73.15				\$ 74.46
Physician														
Inpatient/Outpatient Surgery	\$ 3.58	-0.5%	0.984	1.002	1.000	\$ 3.53	1.000	0.850	1.000	\$ 3.00	1.000	0.915	1.000	\$ 3.23
Maternity Delivery	0.02	5.0%	1.165	1.002	1.000	0.03	1.000	1.000	1.000	0.03	1.000	1.000	1.000	0.03
Maternity Non-Delivery	0.02	5.0%	1.165	1.002	1.000	0.02	1.000	1.000	1.000	0.02	1.000	1.000	1.000	0.02
Office Visits/Consults	3.00	2.5%	1.080	1.002	1.000	3.25	1.000	1.025	1.000	3.33	1.000	1.015	1.000	3.30
Physical Exams	0.21	2.0%	1.064	1.002	1.000	0.22	1.000	3.625	1.000	0.81	1.000	3.620	1.000	0.81
Hospital Inpatient Visits	0.28	-0.5%	0.984	1.002	1.000	0.27	1.000	0.830	1.000	0.23	1.000	0.905	1.000	0.25
Emergency Room Visits	0.49	0.5%	1.016	1.002	1.000	0.50	1.000	0.855	1.000	0.42	1.000	0.910	1.000	0.45
Radiology / Pathology	1.75	1.5%	1.048	1.002	1.000	1.84	1.000	0.860	1.000	1.58	1.000	0.910	1.000	1.68
Outpatient Behavioral	14.03	-2.0%	0.939	1.002	1.000	13.20	1.000	0.860	1.000	11.35	1.000	0.905	1.000	11.95
Self Referral	2.91	-2.0%	0.939	1.002	1.000	2.73	1.000	1.000	1.000	2.73	1.000	1.000	1.000	2.73
Office Administered Drugs	10.16	2.0%	1.063	1.002	1.000	10.82	1.000	0.905	1.000	9.79	1.000	0.940	1.000	10.17
Other Professional	2.34	-2.0%	0.939	1.002	1.000	2.21	1.000	0.905	1.000	2.00	1.000	0.950	1.000	2.10
Subtotal Physician	\$ 38.79					\$ 38.62				\$ 35.30				\$ 36.71
Grand Total	\$ 141.39					\$ 143.25				\$ 132.47				\$ 136.88
CY 2015 Base PMPM:		\$ 143.25		CY 2015 Base PMPM:		\$ 132.47		CY 2015 Base PMPM:		\$ 136.88				
TPL Recoveries:		0.00		TPL Recoveries:		0.00		TPL Recoveries:		0.00				
Managed Care Adjustment:		0.00		Admin & Profit:		97.48		Admin & Profit:		102.76				
CY 2015 FFS PMPM:		\$ 143.25		CY 2015 Capitated PMPM:		\$ 229.95		CY 2015 Capitated PMPM:		\$ 239.65				

Appendix D

Actuarial Certification

**STATE OF INDIANA
OFFICE OF MEDICAID POLICY AND PLANNING
Hoosier Care Connect Risk Based Managed Care
Capitation Rates Effective April 1, 2015 through December 31, 2015**

Actuarial Certification

I, Robert M. Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established from time to time by the Actuarial Standards Board. I have been employed by the State of Indiana and am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification meet the requirements defined in 42 CFR 438.6(c), including:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract.

For the purposes of this certification “actuarial soundness” is defined as follows:

Medicaid capitation rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates – including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income – provide for all reasonable, appropriate, and attainable costs, including health benefits; health benefit settlement expenses; marketing and administrative expenses; any government-mandated assessments, fees, and taxes; and the cost of capital.

The assumptions used in the development of the “actuarially sound” capitation rates have been documented in my correspondence with the State of Indiana. The “actuarially sound” capitation rate ranges that are associated with this certification are effective for the rate period April 1, 2015 through December 31, 2015.

The “actuarially sound” capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the “actuarially sound” capitation rates, I have relied upon data and information provided by the State. I have relied upon the State for audit of the data. However, the data was received for reasonableness and consistency.

The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the “actuarially sound” capitation rates that are associated with this certification.



ELECTRONIC
SIGNATURE

Robert M. Damler, FSA
Member, American Academy of Actuaries

July 24, 2014

Date

APPENDIX E

CDPS Population Profile

State of Indiana
Office of Medicaid Policy and Planning
Hoosier Care Connect
Population Profile: State Fiscal Year 2013
CDPS & MRx Version 5.4
Members with 6+ months of enrollment

	All Members N = 77,500	Adult N = 61,000	Child N = 16,500
CDPS			
Psychiatric	47.4%	47.1%	48.7%
Cardiovascular	43.1%	52.3%	8.7%
Pulmonary	33.6%	36.7%	21.9%
Skeletal and Connective	29.3%	33.6%	13.5%
Gastrointestinal	26.6%	31.1%	9.7%
Nervous System	22.4%	24.0%	16.4%
Diabetes	20.1%	25.1%	1.5%
Ear	15.0%	13.1%	22.3%
Metabolic	13.8%	14.0%	13.1%
Skin	12.2%	13.8%	6.1%
Renal	11.4%	12.1%	9.1%
Substance Abuse	11.4%	14.2%	1.0%
Cancer	11.0%	13.2%	2.5%
Infectious Disease	7.3%	8.9%	1.2%
Eye	6.7%	8.1%	1.4%
Genital	4.6%	5.5%	1.3%
Hematological	4.4%	4.9%	2.3%
Cerebrovascular	3.5%	3.5%	3.3%
Developmental Disability	3.4%	1.9%	9.3%
MRx			
Psychosis/Bipolar/ Depression	11.4%	13.5%	3.5%
Cardiac	6.8%	5.9%	10.4%
Seizure disorders	4.2%	4.6%	2.5%
Parkinsons / Tremor	2.5%	3.0%	0.6%
Anti-coagulants	2.5%	3.1%	0.2%
Malignancies	1.4%	1.6%	0.5%
Infections, high	0.8%	0.8%	0.7%
Diabetes	0.6%	0.7%	0.4%
Inflammatory /Autoimmune	0.3%	0.3%	0.1%
Hepatitis	0.2%	0.3%	0.0%
ESRD / Renal	0.1%	0.1%	0.0%
Tuberculosis	0.1%	0.1%	0.1%
HIV	0.1%	0.1%	0.0%
Hemophilia/von Willebrands	0.0%	0.0%	0.1%
Multiple Sclerosis / Paralysis	0.0%	0.0%	0.0%