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Government Human Services Consulting

District of Columbia Rate Development Process for the Contract Period August 1, 2007 through July 31, 2008

The District of Columbia (District) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges covering the August 1, 2007 to July 31, 2008 (fiscal year 2008) contract period for the District of Columbia Healthy Families Plan (DCHFP). This document presents an overview of the methodology used in Mercer's managed care rate development for Medicaid populations and services covered under this contract.

Rate Methodology

Overview

Capitation rate ranges for the DCHFP program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). One of the key considerations in the rate range development was the base data.

Mercer and the District discussed available data sources for rate range setting. These include Medicaid fee-for-service (FFS) data from 1997-98 prior to the implementation of managed care, current health plan reported DCHFP financial data, and recently collected DCHFP encounter data. Since the FFS data has become increasingly outdated, the financial data was used as the primary base data source supplemented by the recently collected encounter data. Each data source was reviewed to ensure it matched the populations and benefit package defined in the RFP.

To develop capitation rate ranges, adjustments were applied to each base data source, which reflect:

- completion factors to account for unpaid claims at the time of the data submission,
- trend factors to forecast the expenditures and utilization to the appropriate contract period,
- prospective and historic program changes not fully reflected in the base data,
- data smoothing, and
- administration loading.

The various steps in the rate range development process are described in the following paragraphs.

Base Data

Since the District's most recent FFS data is from October 1, 1997 through September 30, 1998, Mercer and the District explored alternative data sources for this rate range development. In order to reflect more recent experience, the financial data received from the DCHFP health plans

was incorporated as the primary data source for rate range setting. This data was certified as accurate by financial representatives of each current health plan. Financial data provides per member per month (PMPM) medical expenses by major service category for each of the District's rate cells. Mercer reviewed the plan-reported data for accuracy and consistency of reporting. This review is discussed in more detail in the Financial Data section below.

The District has been working with the health plans on encounter data submission over the last four years. Mercer reviewed the current encounter data submissions to determine the potential use for rate range setting. The encounter data provides valuable information on the average utilization and unit cost of services covered under the contract. Encounter data is also recommended by CMS as a source of utilization data for rate range setting. The DCHFP encounter data has vastly improved over the last couple years, but work still remains to be done, especially related to providers with subcontracted relationships with the health plans. Therefore, this data source was used to supplement the financial data in the rate range development process.

Financial Data

Mercer validated and incorporated the fiscal year (FY) August 1, 2004 through July 31, 2005 (FY05) and the FY August 1, 2005 through July 31, 2006 (FY06) financial data as the primary data source in this rate range setting process. The financial data reflects the actual medical expenses to the Managed Care Organizations (MCOs) including the subcapitation payments to providers for each of the rate cells. The expenses are net of pharmaceutical rebates and Third Party Liability. Mercer reviewed the financial data to ensure it was appropriate to incorporate into the rate development. Specifically, Mercer reviewed the following issues:

- completeness and accuracy of the submitted financial reports,
- consistency between submitted financial data and annual Department of Insurance filings for calendar year (CY) 2005 and year-to-date 2006,
- assurance that pharmacy rebates were reasonable and removed from the data,
- assurance that reinsurance premiums and recoveries were accurately reflected in the financial data,
- assurance that submitted financial data was specific to State Plan services only, and
- consistency of data among health plans' submissions on a rate cell basis.

Adjustments were made to the financial data to reflect the complete cost of an actuarially equivalent population for the DCHFP contract.

Incurred-but-not-Reported Claims Adjustments – Mercer reviewed the remaining liability associated with incurred-but-not-reported claims for FY06 individually for each of the current health plans. The overall adjustment for FY06 using paid claims data through October 2006 was 2.3% and is reflected in the databook.

Redistribution of Subcapitation Payments – Since the health plans reimburse providers using different payment arrangements, Mercer adjusted each plan’s reported financial data, as necessary, to reflect a uniform payment methodology. Some health plan data needed to be adjusted for subcapitation arrangements to better allocate costs across the various rate cells. Since many of the subcapitation arrangements do not vary the rates by age/sex, the subcapitation expenditures were redistributed to each rate cell in a budget neutral fashion according to the historical cost distribution in FFS.

The aggregated FY05 and FY06 financial data submitted by the health plans are included as Attachment A-1 and A-2 respectively.

Encounter Data

To support the rate range setting efforts, Mercer summarized the District’s encounter data from October 1, 2005 through July 31, 2006 by rate cell and category of service (COS). This time period was selected as the health plans have focused efforts on submitting complete and accurate data from October 2005 onward. In order to ensure the encounter data reflected all covered services, Mercer performed high-level validation checks on the data.

Mercer compared the encounter data to the historical financial data from October 1, 2005 through July 31, 2006 to ensure all costs were reflected. In total, the paid amounts in the encounter data are lower than the reported financial data for the corresponding time period. The primary area of difference is related to services where health plans have subcontracted providers such as physician services. The comparison showed that approximately 85% of the financial data is reflected in the encounter data. Pharmacy data was not included in the comparison because Pharmacy encounter data is not currently being captured.

Certain covered expenses were not captured in the encounter data due to reporting or data collection issues. Mercer reviewed the additional data and made adjustments to include all services covered under the contract.

Recipient Claims Reported Outside of Encounter Data – A small subset of claims were submitted in an Excel workbook due to provider difficulties with the HIPAA 837 format of the encounter records. These claims included expenses for services such as Dental, Transportation and Vision. The supplemental file identified the recipient associated with the encounter, so Mercer added these claims to the appropriate COS and rate cell.

Pharmacy Data – Currently, pharmacy data is not submitted through the encounter data collection system. Pharmacy data is, however, collected in the financial reports submitted by the health plans. For this rate range development process, Mercer relied solely on the financial data for the pharmacy rate. Therefore, there are no expenses included for pharmacy in the encounter data exhibits.

Completion Factors – Since the encounter data has very limited runout (one to two months), Mercer calculated completion factors to account for incurred claims not reflected in the encounter data. Due to dating conventions within the encounter data, Mercer relied on the financial lags as the source of the completion factors. Mercer estimated the incurred claims for FY06 in the financial data and compared it to the total paid claims for services incurred October 1, 2005 through July 31, 2006 in the financial data with similar runout. The ratio of paid claims to incurred claims in the financial data resulted in the completion factor for the encounter data. This ratio was calculated by major service category separately for each health plan's data. Mercer applied these completion factors to the encounter data by service category and health plan. In total, the additional incurred claims for FY06 were estimated at \$8.7 million or an additional 8.7% of the reported encounter data.

Net Reinsurance Costs – The health plans have been purchasing reinsurance coverage for high cost inpatient claims. Mercer reviewed the historical experience from FY05 and FY06 to determine the average net reinsurance PMPM (premiums minus recoveries). Based on this review, Mercer applied reinsurance adjustment factors to the Inpatient – Physical Health COS. The adjustments resulted in an increase of 0.71% in expenses or \$772,000.

The aggregated FY06 encounter data submitted by the health plans is included as Attachment B-1.

Rate Category Groupings

The base data sets are split into cohorts that represent different age/gender bands, which inherently represent different levels of risk. The following is a list of the eleven rate cells for the DCHFP program.

- Male and Female < 1
- Female 13 – 18
- Female 19 – 36
- Female 37 +
- Male and Female 50 – 64 Expansion Population
- Mother's Month of Delivery
- Male and Female 1 – 12
- Male 13 – 18
- Male 19 – 36
- Male 37 +
- Infant's Month of Birth

These cells were selected based on a review of the historical cost structures within these age/gender bands. The separate maternity payments reflect the increased cost and financial risk of these events. Mercer developed a rate range for each of these eleven rate cells.

The Male and Female 50 – 64-year-old expansion population was added to the DCHFP program effective March 1, 2005. The financial data contains five months of information from FY05 and all 12 months from FY06 for this population.

Data Smoothing

As part of the rate development process, Mercer reviewed financial data from multiple years (FY05 and FY06) of the program to arrive at the overall financial data source for rate setting. The goal of the blending process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially-sound capitation rates. Mercer has applied credibility weighting as appropriate to blend data from the two fiscal years focusing on the most recent year of data.

Mercer also blended the rates based on the financial and encounter data. As mentioned earlier, the encounter data is still under development and has therefore been weighted 10% for non-pharmacy services with the remaining 90% weighted on the financial data. The pharmacy rate component is entirely weighted on the financial data, since encounters are not currently collected for pharmacy services.

Trend Development

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop the trend assumptions. These sources included, but were not limited to:

- health care economic indices such as Consumer Price Index for the South-Atlantic region,
- trends exhibited in the financial data submitted by the health plans,
- provider related issues raised by the current DCHFP health plans, and
- trends in other state Medicaid programs for similar TANF populations.

Programmatic Changes

Programmatic change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base year. Mercer will apply programmatic change adjustments to incorporate factors not fully reflected in the base data. These adjustments were mutually exclusive and made only once in the rate-setting process. Since the changes were effective after August 1, 2005, the impact was not fully reflected in the base data thus warranting consideration in the rate development.

Changes to the District's Medicaid Fee Schedule – The District modified the Medicaid dental fee schedule effective January 1, 2006 to pay approximately the 75th percentile of usual, customary and reasonable fees, based on research and input from the dental provider community. As of January 1, 2006, the District requires the contracted health plans to reimburse dental providers at the Medicaid fee schedule. Since this fee schedule took effect during the FY06 time period, an additional adjustment was necessary to fully reflect the impact of the fee schedule change. Mercer analyzed the financial impact of the new fee schedule after January 1, 2006 compared to the dental costs for children from August 1, 2005 through December 31, 2005. Based on this

analysis, Mercer calculated a 29% increase to the dental rates for children under 18 to fully reflect this new fee schedule. This adjustment brought the historical health plan fee schedules in line with the Medicaid fee schedule.

Removal of Pharmacy Expenses Covered under Medicare Part D – Effective January 1, 2006, Medicare assumed coverage responsibility for the majority of pharmaceuticals through the Medicare Part D program. The DCHFP program contains adults who are Medicare eligible. Mercer analyzed the pharmacy expenses submitted by the health plans for this population. Mercer compared the pharmacy expenses reported for August through December 2005 to pharmacy expenses after January 2006 with expenses for the drugs covered by Medicare Part D. As a result, Mercer applied downward adjustments to the pharmacy costs in the amount of 0.5% to 19 – 36 Females, 0.5% to 19 – 36 Male, 1.5% to 37+ Females, 4.5% to 37+ Males, and 6.5% to the 50 – 64 Expansion Population.

The dental fee schedule change and the impact of Medicare Part D increased the base PMPM by 0.8%. Please note the programmatic change adjustments have not been reflected in the historical databook contained in the attachments. These adjustments will be applied along with trend and admin to calculate the final rates.

Managed Care Assumptions

In the development of the rate ranges, Mercer and the District discussed areas for improvements in managed care efficiency. Since the program has been operating under a managed care contract for several years, these adjustments are limited to specific targeted areas:

- **50 – 64-year-old Expansion Population:** This population has been covered under managed care since March 1, 2005. The costs for this population have been reduced over the 17 months represented in our data due to the continuity of coverage for this population. Mercer and the District believe additional cost containment is achievable and have accounted for this in the rate range.
- **Provider Contracting:** Based on a review of the provider contractual arrangements among the current health plans, Mercer and the District believe costs could be contained through more aggressive provider contracting. This determination is based on a comparison among the current health plans and also other state experience, and is accounted for in the rate range.

Administration Loading

Mercer and the District reviewed the components of the administrative allowance to evaluate the administrative rates paid to the MCOs. The review focused on the reporting and organizational requirements detailed in the DCHFP contract. Mercer modeled the cost structure for these requirements to determine the administrative load necessary for an average plan in this program. Since this contract also includes the 40,000 members covered under the District's Health Care Alliance program, Mercer considered this enrollment along with the 90,000 current DCHFP members in assessing the administrative load. Based on the analysis and comparisons with other

state Medicaid programs' administrative allowances, Mercer assumed an overall administration load of approximately 12.5% for the final premium rates. This percentage varied between the non-maternity (13.5%) and the maternity (6.0%) rate cells to account for the different premium levels.

Additional Comments

Mercer developed these rates in accordance with the CMS requirements under 42 CFR 438.6(c). Health plans are advised that the use of these rates may not be appropriate for their particular circumstance. Mercer recommends that any health plan considering contracting with the District 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 District.

Exhibit A-1

**Report #1: Medical Expenses PMPM for the DCHFP Population
Statement for the Time Period of 08/01/2004 - 07/31/2005 for All Health Plans**

PMPM - ADJUSTED	< 1 M & F	1 - 12 M & F	13 - 18 FEMALE	13 - 18 MALE	19 - 36 FEMALE	19 - 36 MALE	37+ FEMALE	37+ MALE	50 - 64 M&F	INFANT'S MONTH OF BIRTH	MOTHER'S MONTH OF DELIVERY	TOTAL PMPM
MEMBERMONTHS OR DELIVERIES	47,595	497,222	100,582	89,173	200,042	24,334	106,713	21,554	2,557	2,793	2,835	1,089,773
MEDICAL EXPENSES												
01 Inpatient Hospital - Physical Health	\$ 49.49	\$ 12.01	\$ 15.47	\$ 26.81	\$ 37.51	\$ 22.63	\$ 90.07	\$ 75.91	\$ 332.89	\$ 2,835.68	\$ 3,800.48	\$ 46.91
02 Inpatient Hospital - Mental Health	\$ 0.00	\$ 2.03	\$ 12.29	\$ 10.81	\$ 2.27	\$ 4.83	\$ 8.07	\$ 12.15	\$ 11.60	\$ -	\$ 20.91	\$ 4.58
03 Outpatient Hospital - Physical Health (ER Included)	\$ 36.55	\$ 16.37	\$ 20.37	\$ 14.29	\$ 38.46	\$ 16.36	\$ 59.31	\$ 49.20	\$ 82.96	\$ 64.11	\$ 331.29	\$ 27.54
04 Outpatient Hospital - Mental Health	\$ 0.19	\$ 0.25	\$ 1.09	\$ 0.82	\$ 0.41	\$ 2.30	\$ 0.88	\$ 1.48	\$ 4.30	\$ -	\$ 0.25	\$ 0.54
05 Physician - Physical Health	\$ 55.02	\$ 19.47	\$ 25.41	\$ 16.57	\$ 45.69	\$ 15.29	\$ 54.88	\$ 43.20	\$ 71.04	\$ 361.58	\$ 872.78	\$ 33.31
06 Physician - Mental Health	\$ 0.19	\$ 1.41	\$ 1.71	\$ 1.62	\$ 1.44	\$ 0.72	\$ 2.73	\$ 1.82	\$ 8.64	\$ -	\$ 4.84	\$ 1.56
07 Pharmacy	\$ 14.05	\$ 8.77	\$ 9.25	\$ 14.55	\$ 23.54	\$ 14.37	\$ 66.65	\$ 54.28	\$ 95.09	\$ 3.27	\$ 11.76	\$ 19.16
08 Transportation	\$ 3.16	\$ 4.37	\$ 2.41	\$ 1.83	\$ 4.18	\$ 2.14	\$ 6.49	\$ 4.05	\$ 9.54	\$ 3.61	\$ 32.53	\$ 4.15
09 EPSDT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10 Dental	\$ 0.85	\$ 5.22	\$ 7.86	\$ 6.02	\$ 1.97	\$ 7.19	\$ 1.98	\$ 1.99	\$ 1.25	\$ -	\$ 0.98	\$ 4.40
11 Other (DME, Home Health, Vision, Lab. & X-Ray)	\$ 8.64	\$ 3.38	\$ 4.64	\$ 3.16	\$ 12.25	\$ 4.81	\$ 22.57	\$ 17.84	\$ 18.52	\$ 24.10	\$ 147.49	\$ 8.02
14 TOTAL EXPENSES	\$ 168.15	\$ 73.28	\$ 100.50	\$ 96.49	\$ 167.71	\$ 90.65	\$ 313.62	\$ 261.92	\$ 635.82	\$ 3,292.35	\$ 5,223.31	\$ 150.17

Exhibit A-2

**Report #1: Medical Expenses PMPM for the DCHFP Population
Statement for the Time Period of 08/01/2005 - 07/31/2006 for All Health Plans**

PMPM - ADJUSTED	< 1 M & F	1 - 12 M & F	13 - 18 FEMALE	13 - 18 MALE	19 - 36 FEMALE	19 - 36 MALE	37+ FEMALE	37+ MALE	50 - 64 M&F	INFANT'S MONTH OF BIRTH	MOTHER'S MONTH OF DELIVERY	TOTAL PMPM
MEMBERMONTHS OR DELIVERIES	47,171	491,751	105,041	94,472	203,818	27,003	110,600	22,357	11,978	2,840	2,880	1,114,192
MEDICAL EXPENSES												
01 Inpatient Hospital - Physical Health	\$ 102.74	\$ 13.54	\$ 14.15	\$ 26.84	\$ 36.08	\$ 32.68	\$ 78.06	\$ 98.65	\$ 185.17	\$ 2,959.30	\$ 4,428.01	\$ 52.04
02 Inpatient Hospital - Mental Health	\$ 0.11	\$ 1.70	\$ 16.20	\$ 8.62	\$ 2.36	\$ 4.14	\$ 6.62	\$ 4.85	\$ 14.07	\$ 4.97	\$ 24.17	\$ 4.52
03 Outpatient Hospital - Physical Health (ER Included)	\$ 44.47	\$ 18.73	\$ 24.95	\$ 16.69	\$ 46.69	\$ 19.02	\$ 66.40	\$ 47.84	\$ 87.38	\$ 79.73	\$ 488.12	\$ 32.87
04 Outpatient Hospital - Mental Health	\$ 0.21	\$ 0.32	\$ 1.63	\$ 0.69	\$ 0.36	\$ 0.19	\$ 0.68	\$ 0.75	\$ 2.81	\$ 0.25	\$ 1.26	\$ 0.55
05 Physician - Physical Health	\$ 61.43	\$ 20.52	\$ 26.39	\$ 17.48	\$ 49.18	\$ 16.07	\$ 57.42	\$ 48.19	\$ 82.07	\$ 414.95	\$ 949.32	\$ 36.07
06 Physician - Mental Health	\$ 0.60	\$ 1.91	\$ 2.23	\$ 2.03	\$ 2.30	\$ 0.97	\$ 3.77	\$ 1.74	\$ 3.29	\$ 0.17	\$ 1.08	\$ 2.14
07 Pharmacy	\$ 12.76	\$ 9.32	\$ 10.76	\$ 8.96	\$ 27.35	\$ 10.76	\$ 66.28	\$ 54.67	\$ 135.33	\$ 0.36	\$ 0.80	\$ 20.82
08 Transportation	\$ 2.77	\$ 3.91	\$ 2.10	\$ 1.70	\$ 3.54	\$ 1.58	\$ 6.47	\$ 4.31	\$ 7.88	\$ 3.66	\$ 32.79	\$ 3.78
09 EPSDT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10 Dental	\$ 0.02	\$ 7.85	\$ 11.94	\$ 8.76	\$ 2.81	\$ 3.03	\$ 1.84	\$ 2.31	\$ 2.37	\$ -	\$ 1.30	\$ 6.18
11 Other (DME, Home Health, Vision, Lab. & X-Ray)	\$ 10.53	\$ 3.75	\$ 5.27	\$ 3.41	\$ 12.23	\$ 4.88	\$ 20.14	\$ 18.26	\$ 28.71	\$ 25.04	\$ 227.68	\$ 8.57
14 TOTAL EXPENSES	\$ 235.65	\$ 81.54	\$ 115.62	\$ 95.17	\$ 182.88	\$ 93.30	\$ 307.69	\$ 281.55	\$ 549.08	\$ 3,488.44	\$ 6,154.54	\$ 167.55

Exhibit B-1

**Report #1: Medical Expenses PMPM for the DCHFP Population
Statement for the Time Period of 10/01/2005 - 07/31/2006 for All Health Plans**

PMPM - ADJUSTED	< 1 M & F	1 - 12 M & F	13 - 18 FEMALE	13 - 18 MALE	19 - 36 FEMALE	19 - 36 MALE	37+ FEMALE	37+ MALE	50 - 64 M&F	INFANT'S MONTH OF BIRTH	MOTHER'S MONTH OF DELIVERY	TOTAL PMPM
MEMBERMONTHS OR DELIVERIES	41,553	407,937	87,455	78,466	170,347	20,635	91,757	19,650	12,057	2,393	2,310	929,857
MEDICAL EXPENSES												
01 Inpatient Hospital - Physical Health	\$ 81.39	\$ 12.37	\$ 11.21	\$ 25.94	\$ 35.12	\$ 21.77	\$ 67.81	\$ 92.53	\$ 124.90	\$ 2,343.62	\$ 4,537.28	\$ 46.80
02 Inpatient Hospital - Mental Health	\$ 8.61	\$ 0.45	\$ 2.91	\$ 1.24	\$ 0.29	\$ 0.98	\$ 2.75	\$ 0.41	\$ 4.30	\$ 3.17	\$ -	\$ 1.38
03 Outpatient Hospital - Physical Health (ER Included)	\$ 44.75	\$ 17.88	\$ 24.11	\$ 15.23	\$ 44.15	\$ 13.60	\$ 58.49	\$ 41.76	\$ 71.67	\$ 32.18	\$ 445.62	\$ 30.56
04 Outpatient Hospital - Mental Health	\$ 0.16	\$ 0.34	\$ 1.91	\$ 1.31	\$ 0.80	\$ 0.18	\$ 1.45	\$ 0.13	\$ 2.18	\$ 0.05	\$ 0.24	\$ 0.77
05 Physician - Physical Health	\$ 41.67	\$ 10.95	\$ 12.80	\$ 8.72	\$ 26.70	\$ 9.81	\$ 34.13	\$ 32.74	\$ 41.11	\$ 279.23	\$ 1,469.45	\$ 22.68
06 Physician - Mental Health	\$ 1.32	\$ 4.03	\$ 10.67	\$ 5.68	\$ 1.99	\$ 1.59	\$ 3.33	\$ 1.06	\$ 2.27	\$ -	\$ 1.25	\$ 4.10
07 Pharmacy*	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
08 Transportation	\$ 1.19	\$ 0.74	\$ 1.62	\$ 0.69	\$ 6.29	\$ 1.01	\$ 9.66	\$ 2.01	\$ 5.05	\$ 0.30	\$ 42.52	\$ 2.93
09 EPSDT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10 Dental	\$ 0.02	\$ 7.20	\$ 8.99	\$ 7.11	\$ 2.20	\$ 2.02	\$ 1.40	\$ 1.42	\$ 0.89	\$ -	\$ 1.16	\$ 5.23
11 Other (DME, Home Health, Vision, Lab, & X-Ray)	\$ 5.05	\$ 2.38	\$ 6.22	\$ 2.59	\$ 14.91	\$ 3.02	\$ 15.27	\$ 7.83	\$ 14.90	\$ 4.53	\$ 63.81	\$ 6.91
14 TOTAL EXPENSES	\$ 184.15	\$ 56.33	\$ 80.46	\$ 68.50	\$ 132.45	\$ 53.98	\$ 194.31	\$ 179.89	\$ 267.28	\$ 2,663.07	\$ 6,561.35	\$ 121.35

*Pharmacy costs are not reported through the encounter data. The financial data will be the source for the pharmacy rate development.