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MANAGED CARE COST AVOIDANCE MODEL

MISSOURI DEPARTMENT OF SOCIAL SERVICES

MO HEALTHNET DIVISION

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Government Human Services Consulting

MARSH & McLENNAN COMPANIES

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Overview

The State of Missouri (State) contracted with Mercer Government Human Services Consulting, a division of Mercer Health & Benefits LLC (Mercer), to develop historical estimates of costs avoided by the Missouri HealthNet Division (MHD) managed care (MC) program (retrospective analysis). In addition, Mercer has developed a cost estimate to enroll "managed care like" enrollees that are currently in the Missouri fee-for-service (FFS) program in a full-risk, MC delivery model (prospective analysis). This report provides:

- Retrospective analysis which provides the actual cost avoided with the implementation of the MO HealthNet MC Program as compared to the similar FFS population during State Fiscal Years (SFYs) 2010, 2011, 2012, and 2013.
- An overview of the cost avoidance modeling methodology.
- Detail on how each cost line is considered.
- Results from the cost avoidance model.
- Prospective analysis which shows the potential savings going forward if MC is implemented in the FFS areas.
- An overview of the prospective modeling methodology.
- Results from the prospective model.

Model Goals and Philosophy

The goal of the retrospective cost avoidance model is to determine whether total MHD costs for eligibles enrolled in MC is lower than would have been the case in the absence of MC. In practice, costs avoided are impossible to calculate exactly since the same eligibles cannot participate under two different care delivery systems at the same time. For this reason, the cost avoidance model develops costs for a benchmark FFS population to compare to MC costs.

Adjustments must be made to the costs of this benchmark population in order to make it as comparable to the MC eligibles and benefits as possible. When reviewing the costs and services that may be impacted by MC, a key question is whether the costs would continue to be paid at the same level if MC was eliminated. If a certain cost category is not materially impacted by the implementation of a MC delivery system (for example, graduate medical education (GME) payments), this category does not impact the costs avoided and should not impact the model calculations. Once all adjustments are made, the cost per member per month (PMPM) is compared between the MC program and the benchmark to determine if savings are being generated.

The retrospective cost avoidance model is a tool for reviewing the historical financial impact of participants in the MC program. The results of the retrospective model cannot be used as a projection of cost savings attributable to potential MC expansions. Financial expectations for MC expansions need to consider:

- FFS costs of the expansion population.
- Eligibility criteria for the populations in the expansion.
- Rural versus urban geography.
- Provider acceptance of MC.
- Time to affect provider practice patterns and member behavior.

The prospective analysis contained in the latter sections of this report is an estimate of costs to enroll the current FFS "managed care like" population in a MC delivery model for managed care services.

Overview of Retrospective Cost Avoidance Results

Table 1

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Total
FFS Benchmark Costs	$1.524 billion	$1.517 billion	$1.579 billion	$1.644 billion	$6.264 billion
MC Costs	$1.501 billion	$1.481 billion	$1.578 billion	$1.596 billion	$6.156 billion
Savings	$23 million	$36 million	$2 million	$48 million	$108 million
Percent Savings	1.5%	2.4%	0.1%	2.9%	1.7%

The costs reflected in Table 1 and throughout this report reflect the total expenditures incurred and/or projected for the program, regardless of funding stream. The reader should be aware the funding reflects a combination of State and federal dollars.

The underlying covered services of the prospective and retrospective analyses are different, so we caution the readers to not compare PMPM, total dollar costs, or savings from the prospective and retrospective analyses. The cost for the prospective analysis was developed assuming the same populations and covered services as are currently provided under the Missouri Medicaid MC program. The retrospective analysis adjusts the MC costs to be consistent with the FFS Medicaid program for all services regardless of the delivery model. For example, the FFS program provides coverage for a retroactive time period which is not covered under the MC program. In the retrospective analysis, we have adjusted the MC costs to include costs for the retroactive time period to make the comparison to FFS more accurate. There are also other similar adjustments included in the retrospective analysis that are not included in the prospective analysis that make comparing the PMPM, dollar costs, or savings between the two analyses problematic. Mercer has prepared the prospective projections exclusively for the State of Missouri to estimate the cost of enrolling the current "managed care like" population in a MC delivery model. **In summary, the retrospective analysis provides a comparison of the costs**

for managed care and "managed care like" populations for all FFS and MC services regardless of the delivery model. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability from the estimates.

Lastly, the State understands that Mercer is not engaged in the practice of law and this report, which may include commenting on legal issues or regulations, does not constitute and is not a substitute for legal advice. Accordingly, Mercer recommends that the State secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

The information contained in this document is not intended by Mercer to be used, and cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

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Retrospective Analysis

Eligibility

Only “managed care like” eligibles in the FFS population were used in the development of the benchmark eligibility counts. These individuals are in regions of the State where MC has not been implemented, but would otherwise be enrolled in MHD MC based on age and other eligibility criteria. The eligibility counts for the FFS benchmark and MC populations are derived from a number of data reports provided by the State. These eligibility counts include unique eligibles as measured on the last day of a given month, regardless of whether the person was eligible for the entire month. MC eligibles are counted based on the number of capitation payments made to managed care organizations (MCOs) that month, including any mass retroactive payments, and can misrepresent the actual count of enrolled MC eligibles for a given month.

For this reason, the State has been using the MC full-time-equivalent (FTE) data source, which tracks capitation payments by date of service, to develop MC eligibility counts. This data source calculates day-by-day eligibility for the month, allowing for partial months of eligibility. However, this differs from how the FFS eligibility is counted, which assigns a full month of eligibility to all people eligible at a certain point in time. The State performed a study on monthly MC eligibility patterns to adjust these FTE counts to reflect unique eligibles at a point in time in the same way that the FFS eligibility is reported. This study was supplied for SFYs 2010 through 2013 and the results were consistent with the prior analysis. This adjustment would ensure consistent counting of FFS and MC eligibles and would eliminate the potential distortion of the PMPM savings calculations. The State did conduct this eligibility analysis and we have applied a conversion factor to the MC eligibles to ensure consistency between the benchmark and MC eligibility counts.

Medical Costs

Consistent with eligibility, only “managed care like” eligible medical costs were used in the development of the benchmark medical costs. The source of these costs was the State’s Table 23 reports, which includes costs paid during a particular SFY, regardless of when a service was delivered. All HCBS waiver services were excluded from the development of the medical costs; to the extent they were identifiable in the Table 23 reports. The remainder of this section addresses how particular cost categories affect the cost avoidance calculations and several adjustments made to Table 23 costs in developing appropriate benchmark and MC PMPM metrics.

As mentioned previously in this report, the philosophy of the cost avoidance model is to include cost categories in the comparison between MC and the FFS benchmark only if they would be impacted by the elimination of MC.

Following are summaries of how Mercer assumed various medical cost categories be treated in the model. Additional line item detail is included in Appendix A.

- **Medical services covered under MC** – Services such as Inpatient, Outpatient, Nursing Facilities, Dental, Mental Health, and other services are covered under both the MC and FFS benchmark delivery systems for "managed care like" individuals. Costs and utilization of these services are impacted by the existence of MC, so these services should be included in the cost avoidance calculations.
- **Medical services carved out from MC** – Some adult dental, transplants, prescription drug costs, mental health services for foster children, and other services for MC eligibles are carved out from the MC program and are covered through FFS. The utilization and cost of these services are impacted by the existence of MC and should be included in the cost avoidance calculations. In the model, these FFS carve-out costs for MC eligibles are moved from the FFS benchmark costs (included in Table 23) to the MC costs.
- **Other medical cost transactions** – The State makes various other payments to providers outside of the direct billing of medical services for both MC and FFS eligibles. Some payments, such as Federally Qualified Health Care and Rural Health Clinic cost settlements, are calculated using actual MC and FFS utilization and/or payments to providers. Therefore, these items should be included in the cost avoidance calculations. Other payments, such as GME payments, are calculated using methods and data that are the same for both MC and FFS eligibles. Therefore, such items are not impacted by the existence of MC and should not impact the cost avoidance calculations. A line-by-line justification of each of these costs is included in Appendix A.

Other Medical Cost Recommendations

In order to make the medical costs of the benchmark population as comparable to the MC eligibles and benefits as possible, Mercer made the following adjustments.

Mass Adjustments

Table 23 reports provide medical costs based on payment date. The State makes various retroactive mass payment adjustments, both positive and negative, to both FFS and MC to adjust for changes to the MO HealthNet program. These payments can represent adjustments for dates of service one or two years prior to the year of the mass adjustment payment and may or may not be applicable to FFS and MC, which skews the cost avoidance calculations.

In order to remain consistent with the Table 23 base data and other financial adjustments, the mass adjustments were kept in the SFY in which the adjustment was made. The amount of the mass adjustments was provided by the State and the field "completed date" was used as the basis to assign the adjustment to the appropriate SFY. FFS mass adjustments were also further

adjusted to reflect that 66% of the mass adjustments were assumed to be aged, blind or disabled (ABD) payments, which were not included in the final reporting.

Table 2 summarizes the level of the mass adjustments by SFY and program.

Table 2

Mass Adjustments SFY 2010 - 2013		
Year	**FFS**	**MC**
2010	$54,388	$130,574
2011	$(228,266)	$0
2012	$68,949	$0
2013	$962,849	$13,975,560 *

* ACA PCP adjustment actual completed date for the FFS program occurred in August 2013 but was included in the MC adjustments during SFY 2013. It is our understanding the ACA PCP payments were included in the Table 23 data for FFS providers, so we included the adjustment in SFY 2013 for MC to be consistent.

Retroactive Eligibility and the FFS Window

The time period before a MO HealthNet eligible enrolls in a MCO (FFS Window) is the financial responsibility of the FFS program. The member has 30 days to choose a plan or be auto-assigned, though Mercer understands that this period is frequently less than 30 days. The costs eligibles incur during the FFS Window could be different than the average member cost, which would generate more or less cost avoidance than is truly attributable to MC. For example, an individual enrolling in the MO HealthNet program because of an inpatient stay would have higher than average costs during the FFS Window, while an individual without an established primary care physician and no acute health needs would likely have lower than average costs. For these reasons, Mercer recommended that MHD perform a study to determine what percentage of membership and health costs are associated with the FFS Window and move that membership and those costs to the MC portion of the cost avoidance calculations. In that way, the MC program costs will be calculated considering the entire enrollment period of its members, just as the FFS population costs are calculated. Without this adjustment the FFS costs would be overstated while MC costs would be understated.

In addition to the FFS Window, the FFS program retains financial responsibility for MC enrollees for any time periods where the member receives MO HealthNet eligibility for a period prior to their application date (retroactive eligibility). The retroactive eligibility is usually driven by a period of inpatient or other intensive service utilization, so these enrollees will usually have higher than average costs during the retroactive period. Similar to the FFS Window issue, Mercer moved the membership and costs associated with retroactive eligibility to the MC portion of the cost calculations. The State identified the eligibles and medical costs associated with both of these items.

The data Mercer received from Missouri for the retroactive eligibility and FFS window adjustment for SFY 2013 was significantly different than the data for the older time period. Due to these differences, Mercer also reviewed data from another state Medicaid MC program related to retroactive eligibility and FFS window costs. We found the Missouri SFY 2013 data produced a retroactive eligibility and FFS window adjustment factor that was more consistent with the other state's data than Missouri's data from the older time periods. We used the retroactive eligibility and FFS window factors based on the Missouri SFY 2013 data for all years in the analysis. Mercer moved the eligibility and costs out of the FFS benchmark medical costs to the MC medical costs. During this period, the retroactive eligibility factor ranged from 2.2% to 2.5% of the MC annual total cost.

Special Needs Population

Medicaid members that are in a MC eligibility category and reside in a MC area that have special health care needs can opt out of the MC program and receive their health care through the FFS program. Since these members have chosen to opt out of MC, it is appropriate to remove the costs and enrollment data for this population from the analysis. The State provided data on the members that chose to opt out of the MC program and their costs were significantly higher than the average MC enrollee.

To ensure consistency between the MC and FFS benchmark costs, an adjustment was applied to remove an "opt out like" proxy population from the FFS data as similar eligibles would be covered under the FFS program in the "managed care like" population. To estimate the enrollment for the "opt out like" population, Mercer used the percentage of opt out enrollment from the MC program and applied that percentage to the "managed care like" membership in the FFS data. The PMPM costs developed for the MC opt out population were applied to the estimated enrollment to develop a cost estimate to remove costs from the FFS side. This approach removes the population that did opt out of MC and also removes a similar proxy population and costs from the FFS program. The remaining populations left in both the MC and the FFS benchmark data is the non-opt out special needs populations.

Behavioral Health Carve-Out

Currently, certain behavioral health services are not the responsibility of the MC program and these services are provided in the FFS Medicaid program. The MC program provides the standard behavioral health services, while the FFS program provides the specialty and intensive behavioral health services. The FFS behavioral health services include benefits provided by the Department of Mental Health including Community Psychiatric Rehabilitation (CPR), Comprehensive Substance Treatment and Rehabilitation (CSTAR) and Targeted Case Management (TCM) services. Missouri estimated the FFS behavioral health costs provided for the members enrolled in the Medicaid MC program and these costs were moved from the FFS benchmark medical costs to the MC medical costs. The amount of behavioral health costs moved to the MC program is referred to as the behavioral health carve-out. Please note, behavioral health services such as psychiatric, psychotherapy, hospital-based medical detox,

and psychiatric inpatient hospital services are covered under the benefit package provided by the MCOs and did not need to be moved from the FFS benchmark program.

Table 3 shows the behavioral health FFS PMPM carve-out amounts for CPR, CSTAR and TCM programs by year.

Table 3

Group	SFY 2010	SFY 2011	SFY 2012	SFY 2013
MC COA 1&4	$11.84	$11.93	$14.89	$13.91
FFS COA 1&4	$13.82	$17.04	$21.55	$19.47
Statewide COA 1&4	$12.50	$13.62	$17.11	$15.77
MC COA 5	$8.40	$8.92	$10.79	$10.42
FFS COA 5	$6.54	$7.20	$8.13	$8.91
Statewide COA 5	$7.69	$8.27	$9.78	$9.84

* COA defined as Category of Aid

Geographic Adjustment

Mercer and numerous other organizations have observed that medical program costs, including those for Medicaid, are usually lower in more rural areas than in urban areas. In Missouri specifically, the Central Region is considered to be a rural region of the state and the East and West regions are considered to be primarily urban. The MC capitation rates for SFY 2015 in the Central region are 3.1% lower than the combined East and West Regions. In addition, when FFS data was examined for the I-70 corridor MC expansion in January 2008, Mercer estimated the cost of delivering services to these counties through MC would be about 3% lower than the existing Central Region counties. At that time the Central region costs were already approximately an additional 3% below the urban areas of Missouri, resulting in a total differential of approximately 6%.

Mercer also evaluated the current ABD population in Missouri to determine the geographic cost differences, since the ABD population is enrolled in the FFS program across the entire state. The most recent ABD data that Mercer had readily available included dates of service from Calendar 2005 through Calendar Year 2008. This ABD data was utilized to calculate a geographic cost differential by comparing costs observed in the FFS counties against costs observed in the MC counties, taking into consideration a constant enrollment mix. Using this data, the MC counties consistently reflected a higher cost than the FFS counties. The average geographic adjustment using the ABD data over the four year period was 9.6%.

For a third comparison point of geographic cost differentials, calendar year 2012 Missouri Medicare per capita expenditures for areas outside of St. Louis and Kansas City were 4.6%

lower than those two urban areas as derived from the 2012 FFS Medicare data for aged beneficiaries, published by the Centers for Medicare and Medicaid Services (CMS).

Mercer also evaluated the age and gender mix of the "managed care like" populations in the rural and urban areas of Missouri. This analysis indicated the demographic mix of the rural and urban areas was approximately the same and therefore no demographic adjustment was incorporated in the analysis.

Since the FFS benchmark is being developed using medical costs from a rural population, it is appropriate to apply an upward adjustment to those costs to make the population comparable to the more urban MC population. This adjustment brings the FFS benchmark to a level comparable to the average MC geographic cost factor. Mercer made a 5% upward adjustment to the FFS benchmark, based on the data and analyses described in the preceding paragraphs.

Administrative Costs

While the administrative costs for MCOs are included in the monthly capitation payments, the State incurs additional administrative costs for MC eligibles associated with contract management, pharmacy management, Medical Management Information Systems (MMIS), and other services. These State costs for MC eligibles are included in the cost avoidance model, just as they are for the FFS eligibles.

MC has higher administrative costs as compared to FFS, but achieves lower overall medical expenses due to enhanced care management activities. Administrative costs for the MC program are approximately 250% higher than the FFS administration costs during the period SFY 2010–SFY 2013. Administrative expenses experienced in the MHD MC program are consistent with other MC programs and are priced to result in medical loss ratios in excess of the 85% minimum implemented in other health care lines of business. Increased administrative expenses are the result of MCOs taking on much of the State's administrative burden, such as claims processing, adjudication and payment; provider network development; provider credentialing, and member services which cannot be as highly leveraged with smaller enrollment than experienced by the State in FFS. Additionally, the MCOs have the added administrative expenses of the care management staff and systems which are typically not present or limited in FFS.

Results

Appendix B provides the State's detailed cost avoidance model analysis for SFYs 2010–2013. Over the last several years, the State's model has demonstrated that the MC program is consistently providing savings relative to projected costs for the same population absent MC (benchmark costs). The cost avoidance results are summarized in the table below for each SFY:

Table 4

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Total
FFS Benchmark Costs	$1.524 billion	$1.517 billion	$1.579 billion	$1.644 billion	$6.264 billion
MC Costs	$1.501 billion	$1.481 billion	$1.578 billion	$1.596 billion	$6.156 billion
Savings	$23 million	$36 million	$2 million	$48 million	$108 million
Percent Savings	1.5%	2.4%	0.1%	2.9%	1.7%

Recall that the previous analysis demonstrated savings for SFY 2009 of 2.7%. A more detailed comparison of the FFS benchmark and the MC expenditures demonstrates a significant PMPM savings in medical costs that more than offsets the increased administration expenses and profit load included for the MCOs. This information is provided on the following page in Table 5.

Table 5

	State Fiscal Year 2010		State Fiscal Year 2011		State Fiscal Year 2012		State Fiscal Year 2013		4 Year Average	
	Benchmark PMPM	**MC PMPM**	**Benchmark PMPM**	**MC PMPM**	**Benchmark PMPM**	**MC PMPM**	**Benchmark PMPM**	**MC PMPM**	**Benchmark PMPM**	**MC PMPM**
Medical Total	$288.19	$265.03	$281.15	$256.36	$294.48	$276.86	$313.45	$283.77	$294.32	$270.50
State Administration	$13.37	$4.25	$10.94	$3.25	$13.34	$3.36	$11.82	$4.60	$12.37	$3.87
Target MC Profit		$5.77		$5.33		$5.68		$5.70		$5.62
State MC Oversight		$21.94		$20.24		$21.60		$21.66		$21.36
Total Admin/Profit	**$13.37**	**$31.97**	**$10.94**	**$28.81**	**$13.34**	**$30.65**	**$11.82**	**$31.97**	**$12.37**	**$30.85**
Grand Total	**$301.55**	**$296.99**	**$292.08**	**$285.16**	**$307.81**	**$307.51**	**$325.27**	**$315.74**	**$306.68**	**$301.35**
Total Savings		**$4.56**		**$6.92**		**$0.31**		**$9.53**		**$5.33**

The reduced saving results for SFY 2012 are heavily influenced by a fairly significant MC rate increase during that fiscal year. During this time, the FFS program also saw a significant increase in expenses although to a lesser level than MC. We expect that the costs avoided by year will fluctuate; however, averaging the cost avoided over the SFYs results in savings below experiences demonstrated in other Medicaid programs for similar populations. A typical range of savings for these programs is between 3% and 6% of expected costs. This range is reflective of populations comparable to the managed care populations in Missouri and is based on Mercer's experience in over thirty state Medicaid programs and other public literature reviews.

The four-year average PMPM administrative costs for the FFS program were $12.37 and $30.85 for the MCOs. Given that MC spends on average $18.48 PMPM more ($30.85–$12.37) on administration/profit than FFS and generated $5.33 PMPM of average savings, medical costs would need to be reduced by the amount of the administration differential $18.48 plus the $5.33 in savings or a total of $23.81 PMPM. As a result, for every dollar of MC savings, medical costs were reduced by $4.47 PMPM ($23.81/$5.33). This is not inconsistent with expectations for MC programs. In order for MC programs to generate savings over FFS programs, they must save more in medical costs than the additional administration costs for the MC programs.

In general, the level of savings experienced in Medicaid programs varies based on many factors:

- Rural versus urban population.
- Temporary Assistance for Needy Families versus Aged, Blind or Disabled population.
- Level of provider acceptance of MC.
- Effectiveness of MC health plans.
- Maturity of MC program.
- Sophistication of existing FFS care management.

As noted above, the average savings experienced in managed care in Missouri is below the general range of savings for similar programs. The lower savings in Missouri may be attributable to several factors:

- The retrospective portion of the Missouri cost avoidance analysis is inclusive of all Medicaid services received by the Medicaid recipients whether or not managed care has a direct impact on the delivery of those services. The average savings of 3% to 6% is reflective of the costs that are the responsibility of the managed care program only. Therefore, the Missouri savings number is diluted by the services outside of the direct responsibility of the health plans where no savings are generated
- Missouri carves out the retail pharmacy benefit from the managed care program. The typical savings range would include a mixture of managed care programs where the pharmacy services are the responsibility of managed care and where the services are the responsibility of the states. Managed care programs generally are able to produce savings for pharmacy services as compared to the FFS programs where management is limited.

- Missouri's FFS program is not entirely unmanaged. The FFS program includes strong management of the pharmacy services and administers health homes that should serve to dilute the savings experience when compared to mostly unmanaged FFS programs.
- Missouri also has unique reimbursement structures for facility services compared to other state programs that may impede the ability of managed care to manage the cost and/or utilization of those services.

The cost avoidance model is an historical financial analysis of the MC program and is not a direct comparison between the existing FFS and MC populations and delivery systems. The model does not provide an assessment or estimate of potential savings associated with MC expansion opportunities. Savings estimates for potential expansions need to be independently developed taking into consideration the above factors and the experience demonstrated in the existing FFS program, as this would be the basis of any capitation rate development for expansion populations. The prospective analysis provided in the next section is more appropriate for savings projections for expansion populations.

3

Prospective Analysis

Overview of Prospective Analysis

The goal of the prospective analysis is to develop a cost estimate of enrolling the "managed care like" population in a MC delivery model. This "managed care like" population is currently receiving Medicaid services in the Missouri FFS program. This prospective analysis develops a cost estimate for calendar year 2015 as opposed to comparing historical costs for all services of FFS versus MC which is contained in the retrospective section of this report.

The underlying covered services of the prospective and retrospective analyses are somewhat different so we caution the readers to not compare PMPM, total dollar costs, or savings from the prospective and retrospective analyses. The costs for the prospective analysis were developed assuming the same populations and covered services as are currently provided under the MO HealthNet MC Program. The retrospective analysis adjusts the MC costs to be consistent with the FFS Medicaid program for all services regardless of the delivery model. For example, the FFS program provides coverage for a retroactive time period which is not covered under the MC program. In the retrospective analysis, we have adjusted the MC costs to include costs for the retroactive time period to make the comparison to FFS more accurate. There are also other similar adjustments included in the retrospective analysis that are not included in the prospective analysis that make comparing the PMPM, dollar costs, or savings between the two analyses problematic. **In summary, the prospective analysis provides projections for the costs which are the responsibility of the MCOs consistent with the typical rate development for the MO HealthNet MC Program.**

Eligibility

Similar to the retrospective analysis discussed earlier in this report, only "managed care like" eligibles in the FFS population were used in the development of the eligibility counts. These individuals are in regions of the State where MC has not been implemented, but would otherwise be enrolled in MHD MC based on age and other eligibility criteria. The eligibility counts for the FFS populations are derived from the State's Table 23 reports. These eligibility counts include unique eligibles as measured on the last day of a given month, regardless of whether the person was eligible for the entire month.

Medical Costs

Consistent with eligibility, only "managed care like" eligible medical costs were used in the development of the FFS benchmark medical costs. The source of these costs was also the State's Table 23 reports, which includes costs paid during a particular SFY, regardless of when a service was delivered. Appendix D includes a mapping of which Table 23 categories were

included or excluded to develop our "managed care like" medical costs. The remainder of this section addresses how we adjusted the FFS cost levels to project the costs under a MC delivery model.

Base Data

The State's Table 23 reports for the "managed care like" eligible population from SFY 2013 were used as the base data for this analysis. The Table 23 data was adjusted to remove any services that are currently not covered under the MC contract. As stated earlier in the report, the process used for the prospective analysis only includes services currently covered under the MC contracts and represents a significant departure from the methodology used in the retrospective analysis. Also, we have removed the medical costs and enrollment data for the MC opt-out and "opt-out like" special needs populations from the FFS portion of the prospective analysis. This adjustment is consistent with the adjustment described earlier in the retrospective section of this report.

Program Changes

There were several program changes that were implemented between SFY 2013 (our base data period) and the projection period of calendar year 2015. Since these program changes happened after SFY 2013, our base data does not include the costs for these changes and, therefore, estimates of their impacts were developed. The base data has been adjusted to reflect for the following program changes:

- Change in Primary Care Physician (PCP) payments due to the Affordable Care Act (ACA). Missouri will not continue the enhanced PCP payments beyond calendar year 2014 so the enhanced PCP fees were removed from the base data.
- Ambulance fee schedule and mileage reimbursement.
- Expanded foster care children coverage up to 26.

The methodologies used to estimate the impacts of these program changes relied heavily on the methods used for development of MHD's SFY 2015 MC rates.

Trend

Trend accounts for changes in health care utilization and the cost of services over time. In order to project costs from the base year to the projection year, Mercer applied trend factors by category of service (COS). The overall trend factors applied by COS are provided in the following table.

Table 6: Trend Factors Applied by COS

COS	
Inpatient	1.3%
Outpatient	5.2%
Emergency Room	5.2%
Professional	1.8%
Other Services	2.2%

These trends are primarily based on recent, overall trends seen in the MO HealthNet Medicaid program and are supplemented with information on projections from other state programs and publicly available information regarding expansion population projections.

Managed Care Savings

Medicaid savings due to MC are expected under this program. As part of its goals, Missouri expects the MCOs to improve the quality of care of the beneficiaries and to ultimately reduce the utilization of services and/or shift services to a more appropriate setting. Adjustments were developed to reflect the management of care that MCOs are expected to provide to enrollees.

A MC medical savings factor of .836 was applied to the projected FFS medical costs. This factor was applied to all service categories. This factor considers the experience seen in other MC programs with similar populations and is consistent with the underlying managed care savings observed in the retrospective analysis of this report if we limit the savings calculation to only include medical services covered under the managed care program.

Administrative/Underwriting Gain

The administration/underwriting gain represents the estimate we add to medical costs to account for the MC plans administration and underwriting gains (profit). The administration/underwriting gain load is expressed as a percentage of the gross capitation rate. The administrative load includes the costs incurred by the MC organization, including but not limited to salary expense, marketing, claims processing, member services, provider network, and credentialing and care management activities. The percentage was developed by considering:

- MO HealthNet MCO experience in existing MC regions.
- Administration expenses reported in the Missouri Department of Insurance, Financial Institution and Professional Registration (DIFP) statements.
- Risk based capital requirements and actual levels reported by health plans through the Missouri DIFP statements.
- Additional administrative requirements due to the ACA.
- Administration expense benchmarks for other Medicaid programs.

The administration/underwriting gain load incorporated into the MC prospective cost estimates is 12.0%.

Health Insurer Fee

ACA places an $8 billion annual fee on the health insurance industry starting in 2014. The health insurer fee grows to $14.3 billion in 2018 and is indexed to the rate of premium growth thereafter. The health insurer fee is considered an excise tax and is nondeductible for income tax purposes. The fee will be allocated to qualifying health insurers based on their respective market share of premium revenue in the previous year (for example, the 2014 health user fee will be based on 2013 premium revenue). This health insurer fee is a legitimate cost of doing business in the State of Missouri for Medicaid health plans, and reasonable to include in the prospective analysis.

The health insurer fee adjustment is expressed as a percentage of the gross capitation rate (that is, premium). Mercer applied a 2.814% factor for consideration of the health insurer fee for Calendar Year (CY) 2015. This estimate was based on publicly available research related to the impact of this fee in the state of Missouri. As the health insurer fee amount will vary by insurer and the actual amount for 2015 has only recently been provided to the MCOs by the IRS, we estimated the fee based on the best information available at the time of this report.

Results

Appendix C provides the detailed model for the prospective analysis for CY 2015. The CY 2015 prospective MC and FFS cost estimates are summarized in the following table:

Table 7

	Projected Expenditures
FFS Costs	$633.6 million
MC Costs	$619.4 million
CY 2015 Savings	$14.2 million
Percent Savings	2.2%

The projected expenditures and savings above reflect what may be expected of a mature MC program. We would not anticipate that these savings would be achieved in the early years of expansion. For this potential expansion population, we would anticipate savings ranging from 0–2% in year one, 1–3% in year two and savings in the typical range of 3–6% in years three and beyond.

The savings associated with the MC delivery model shown in the table above are slightly higher than the savings observed in the retrospective analysis shown in the earlier sections of this report. The MC savings factors applied in the prospective analysis are “typical” savings achieved in Medicaid MC programs. There are program-specific items that can impact the actual savings compared to the typical savings level. For example, the level of the MCO’s provider contracts as

compared to a state's FFS levels can impact the level of savings achieved in the MC program. If the MCO's provider contracts are high in relation to the state FFS reimbursement levels, the MC savings will be reduced without corresponding reductions in medical expenses as a result of effective care management. Also, the comprehensiveness of the services included under the MCO contract can impact the overall savings. For example, having some mental health services carved out of the contract eliminates potential savings on the mental health component of the expenses.

APPENDIX A

Cost Category Recommended Treatment

FFS Costs	**Impacted by MC (See notes below)**
Nursing Facilities	Yes, so include in calculations (1)
Inpatient	Yes, so include in calculations (1)
Outpatient	Yes, so include in calculations (1)
Dental Services	Yes, so include in calculations (1)
Pharmacy	Yes, so include in calculations (1) (Net of pharmacy rebates, comparable to the development of MC capitation)
Physician Related	Yes, so include in calculations (1)
In-Home Services	Yes, so include in calculations (1)
Rehab and Specialty Services	Yes, so include in calculations (1)
Buy-In Premiums	No, so exclude from calculations (2)
Mental Health Services and State Institutions	Yes, so include in calculations (1) and (3)
Early Periodic Screening, Diagnosis, and Treatment Services	Yes, so include in calculations (1)
Less:	
MC Carveouts	Yes, move from FFS to MC (4)
Third Party Liability (TPL) Recoveries	Yes, so include in calculations (5)
FFS Mass Adjustments	Yes, so include in calculations (6)
Prior Qtr. Coverage/FFS Window	Yes, so include in calculations (7)
EPSDT Targeted Case Management	Yes, so include in calculations (7)
Add:	
Federally Qualified Health Centers (FQHC) Cost Settlements	Yes, so include in calculations (8)
Rural Health Clinic (RHC) Cost Settlements	Yes, so include in calculations (8)
Direct Medicaid Hospital Payments	Exclude from calculations (9)
Outlier Payments	Yes, so include in calculations (8)
GME Payments	No, calculations should not generate savings (10)

FFS Costs	**Impacted by MC (See notes below)**
Enhanced GME Payments	No, calculations should not generate savings (10)
Geographic Adjustment (5%)	Adjustment to benchmark (11)
Administrative Services	Yes, so include in calculations (12)
MC Costs	Impacted by MC? (See notes below)
MC Capitation Payments	**Yes, so include in calculations (13)**
MC Delivery Payments	Yes, so include in calculations (13)
MC Neonatal Intensive Care Unit (NICU) Payments	Yes, so include in calculations (13)
Health Plan Target Profit	Yes, so include in calculations (13)
Administrative Costs:	
Health Plan Administration	Yes, so include in calculations (13)
State MC Oversight	Yes, so include in calculations (12)
Less:	
MC Reimbursement Allowance	No, remove from MC calculation (14)
MC Mass Adjustments	Yes, so include in calculations (6)
Add:	
MC Carveouts	Yes, move from FFS to MC (4)
MC Prior Qtr. Coverage/FFS Window	Yes, so include in calculations (7)
MC EPSDT Targeted Case Management	Yes, so include in calculations (7)
MC FQHC Interim Payments	Yes, so include in calculations (8)
MC RHC Interim Payments	Yes, so include in calculations (8)
MC FQHC Cost Settlements	Yes, so include in calculations (8)
MC RHC Cost Settlements	Yes, so include in calculations (8)
MC Direct Medicaid Hospital Payments	Exclude from calculations (9)
MC Outlier Payments	Yes, so include in calculations (8)
MC GME Payments	No, calculations should not generate savings (10)
MC Enhanced GME Payments	No, calculations should not generate savings (10)

Notes

1. These services are the responsibility of MCOs for MC eligibles; the costs and mix of these services are impacted by the existence of MC.

2. Buy-In Premiums are for Medicare Part A and Part B coverage and are not applicable to MC eligibles.
3. State Institutions are public facilities that provide behavioral health services. Most of these costs are for CSTAR, community psychiatric rehabilitation, targeted care management, and foster care behavioral health services. A small portion of the State Institutions services, (those provided through an Intermediate Care Facility for the Mentally Retarded), are not available to the FFS "managed care like" population and are excluded from the calculations.
4. MC carve-outs are services provided through FFS to MC eligibles. These costs are moved from the FFS benchmark to the MC cost. The carve-outs have been removed from their respective cost categories.
5. MC capitation rates are developed net of health plan TPL. Therefore, any FFS recoveries should also be credited to the benchmark costs.
6. The State makes various retroactive mass payment adjustments. In order to remain consistent with the other financial results, any significant mass adjustments were calculated on a paid basis which was reflected in completed date category of the mass adjustments file from the State. FFS mass adjustments were also further adjusted to reflect that 66% of the mass adjustments were assumed to be ABD payments, which were not included in the final reporting.
7. The eligibles and costs associated with MC eligibles prior to the time of enrollment in a MC plan have been removed from the FFS benchmark and added to MC.
8. These payments made to providers by the State are based on FFS reimbursement for FFS eligibles and MC reimbursement for MC eligibles. Therefore, the existence of MC impacts these payments, which should be included in the cost avoidance calculations.
9. While the formula for calculating Direct Medicaid Hospital Payments for a particular day of service does not vary between MC and FFS, the total level of hospital days PMPM is reduced by MC. However, reflection of utilization differences between MC and FFS would take several years to be reflected in actual Direct Medicaid Hospital Payments. Additionally, more than half of these costs offset tax payments previously made to the State. As a result, these costs have not been reflected in the cost avoidance model.
10. GME payments are not measurably impacted by MC practices or the level of provider reimbursement. These costs have been reflected in the model, but at equivalent levels for the benchmark and MC so that no savings is generated as a result of these payments.
11. The Geographic Adjustment makes the overall medical geographic cost factor of the rural FFS benchmark population equivalent to the average factor for the more urban MC program.
12. State costs for administrative services are included on this line and are allocated between MC eligibles, "managed care like" FFS eligibles, and other FFS eligibles based on cost or membership metrics. Dedicated State resources and expenses to the oversight of MC are fully reflected as a MC expenditure for State Managed Care Oversight.
13. Costs for MC Capitation Payments, Health Plan Target Profit, and Health Plan Administration are all provided for in the State capitation payments made to the MC health plans. MC Delivery Payments are made for each member delivery event and include a

component for Target Profit and Administration. MC NICU Payments are made where NICU delivery criteria are met.

14. The Managed Care Reimbursement Allowance (MRA) can no longer be assessed on the Medicaid MC health plans. Since the MRA was included in the 2009 capitation payments to the health plans, and the same type of FFS mechanism is not reflected in the benchmark, these costs were removed from the MC capitation payments.

APPENDIX B

Retrospective Analysis Detailed Exhibits by SFY

Appendix B: Retrospective Model

SFY 2013 Summary of FFS Benchmark and Managed Care PMPMs

Fee For Services Benchmark Expenditures

	Title XIX		CHIP	
	Expenditures	PMPM	Expenditures	PMPM
Nursing Facilities	**$ 139,846**	**$ 0.06**	**$ -**	**$ -**
Inpatient	$ 216,960,475	$ 95.43	$ 6,187,120	$ 19.39
Add: Outlier Payments	$ -	$ -	$ -	$ -
GME payments	$ 10,743,833	$ 4.73	$ 975,179	$ 3.06
Enhanced GME payments	$ 13,520,689	$ 5.95	$ 1,227,224	$ 3.85
Less: Transplant Carve Outs	$ (19,847)	$ (0.01)	$ (107)	$ (0.00)
Total Inpatient	**$ 241,205,150**	**$ 106.09**	**$ 8,389,416**	**$ 26.30**
Outpatient	**$ 151,389,849**	**$ 66.59**	**$ 11,934,926**	**$ 37.41**
Dental Services	$ 9,643,668	$ 4.24	$ 1,755,021	$ 5.50
Less: Dental Carve Out	$ (721)	$ (0.00)	$ -	$ -
Total Dental	**$ 9,642,946**	**$ 4.24**	**$ 1,755,021**	**$ 5.50**
Pharmacy	$ 382,849,787	$ 168.39	$ 51,900,615	$ 162.69
Less: Pharmacy Rebates	$ (160,248,730)	$ (70.48)	$ (21,723,945)	$ (68.10)
Pharmacy Carve Outs	$ (138,284,107)	$ (60.82)	$ (19,755,203)	$ (61.93)
Protease Inhibitor Carve Outs	$ (1,167,819)	$ (0.51)	$ (9,704)	$ (0.03)
Pharmacy J codes/OP Drugs	$ (9,502,814)	$ (4.18)	$ (1,221,031)	$ (3.83)
Smoking Cessation	$ (1,876)	$ (0.00)	$ (16)	$ (0.00)
Total Pharmacy	**$ 73,644,440**	**$ 32.39**	**$ 9,190,717**	**$ 28.81**
Physician Related	$ 170,892,573	$ 75.16	$ 12,950,151	$ 40.60
Add: FQHC Cost Settlements	$ (38,211)	$ (0.02)	$ (3,331)	$ (0.01)
RHC Cost Settlements	$ 942,753	$ 0.41	$ 82,173	$ 0.26
Less: Optical Carve Out	$ -	$ -	$ -	$ -
Safe and Care Exams Carve Out	$ (13,985)	$ (0.01)	$ (840)	$ (0.00)
DOH Lab Carve Out	$ (179,636)	$ (0.08)	$ (127)	$ (0.00)
Environmental Lead Carve Out	$ (19,378)	$ (0.01)	$ (806)	$ (0.00)
Abortion	$ -	$ -	$ -	$ -
Total Physician	**$ 171,584,117**	**$ 75.47**	**$ 13,027,221**	**$ 40.84**
In-Home Services	**$ 2,097,048**	**$ 0.92**	**$ 16,374**	**$ 0.05**
Rehab and Specialty Services	**$ 20,767,575**	**$ 9.13**	**$ 2,002,501**	**$ 6.28**
Statewide CPR/CSTAR/TCM	$ 107,472,085	$ 47.27	$ 8,168,376	$ 25.61
Less: CPR Carve Out	$ (41,258,817)	$ (18.15)	$ (3,499,658)	$ (10.97)
CSTAR Carve Out	$ (16,274,904)	$ (7.16)	$ (951,848)	$ (2.98)
Targeted Case Management Carve Out	$ (5,677,072)	$ (2.50)	$ (872,955)	$ (2.74)
Subtotal: CPR/CSTAR/TCM Carve Outs	$ (63,210,794)	$ (27.80)	$ (5,324,462)	$ (16.69)
Total FFS County CPR/CSTAR/TCM	**$ 44,261,292**	**$ 19.47**	**$ 2,843,914**	**$ 8.91**
Less: MH COA 4 Carve Out (I/P, O/P, and Medical)	**$ (21,462,447)**	**$ (9.44)**	**$ -**	**$ -**
EPSDT Services	$ 102,411,130	$ 45.04	$ 9,783,866	$ 30.67
Less: Therapy Carve Outs	$ (2,361,597)	$ (1.04)	$ (472,419)	$ (1.48)
Less: EPSDT Targeted Case Management	$ (1,526,910)	$ (0.67)	$ -	$ -
Total EPSDT Services	**$ 98,522,623**	**$ 43.33**	**$ 9,311,447**	**$ 29.19**
TPL Recoveries	**$ (35,768,445)**	**$ (15.73)**	**$ (3,117,687)**	**$ (9.77)**
FFS Mass Adjustments	**$ 962,849**	**$ 0.42**	**$ -**	**$ -**
Managed Care Opt-Out	**$ (4,617,380)**	**$ (2.03)**	**$ (251,039)**	**$ (0.79)**
Prior Qtr Coverage/FFS Window	**$ (39,368,246)**	**$ (17.32)**	**$ (1,096,118)**	**$ (3.44)**
Geographic Adjustment	**$ 34,436,835**	**$ 15.15**	**$ 2,590,214**	**$ 8.12**
Administrative Services	**$ 27,418,639**	**$ 12.06**	**$ 3,100,186**	**$ 9.72**
FFS Grand Total Benchmark Expenditures	**$ 774,856,689**	**$340.80**	**$ 59,697,094**	**$ 187.13**
Average FFS Benchmark Eligibles		**189,468**		**26,584**
Annual FFS Benchmark Cost Per Eligible		**$ 4,090**		**$ 2,246**

Appendix B: Retrospective Model

SFY 2013 Summary of Managed Care PMPMs

Managed Care Expenditures

	Title XIX		CHIP	
	Expenditures	PMPM	Expenditures	PMPM
Managed Care Capitation Payments	$ 819,327,353	$ 180.34	$ 65,375,607	$ 127.99
Managed Care Delivery Payments	$ 81,304,554	$ 17.90	$ 129,049	$ 0.25
Managed Care NICU Payments	$ 48,123,935	$ 10.59	$ -	$ -
Managed Care Profit	$ 26,953,291	$ 5.93	$ 1,860,928	$ 3.64
Administrative Costs:				
Managed Care Capitation Admin component	$ 102,422,506	$ 22.54	$ 7,071,525	$ 13.84
Managed Care State Administrative Costs	$ 20,905,106	$ 4.60	$ 2,363,710	$ 4.63
Total Administrative Costs	$ 123,327,612	$ 27.15	$ 9,435,236	$ 18.47
Managed Care Reimbursement Allowance	$ -	$ -	$ -	$ -
Managed Care Prior Quarter Coverage/FFS Window	$ 39,368,246	$ 8.67	$ 1,096,118	$ 2.15
Managed Care Mass Adjustments	$ 13,975,560	$ 3.08	$ -	$ -
Managed Care Carveouts	$ 236,225,021	$ 52.00	$ 26,784,714	$ 52.44
Managed Care EPSDT Targeted Case Management	$ 1,526,910	$ 0.34	$ -	$ -
Managed Care FQHC Interim Payments	$ 32,438,639	$ 7.14	$ 2,359,323	$ 4.62
Managed Care RHC Interim Payments	$ 11,492,233	$ 2.53	$ 835,852	$ 1.64
Managed Care FQHC Cost Settlements	$ (118,541)	$ (0.03)	$ (8,622)	$ (0.02)
Managed Care RHC Cost Settlements	$ 1,920,885	$ 0.42	$ 139,710	$ 0.27
Managed Care Outlier Payments	$ (118,038)	$ (0.03)	$ (8,585)	$ (0.02)
Managed Care GME Payments	$ 21,468,543	$ 4.73	$ 1,561,448	$ 3.06
Managed Care Enhanced GME Payments	$ 27,017,313	$ 5.95	$ 1,965,020	$ 3.85
Managed Care Grand Total Expenditures	**$ 1,484,233,516**	**$326.69**	**$ 111,525,798**	**$ 218.34**
Average Managed Care Eligibles		**378,598**		**42,566**
Annual Managed Care Cost Per Eligible		**$ 3,920**		**$ 2,620**

Managed Care Savings Estimates

FFS Benchmark PMPM		**$ 340.80**		**$ 187.13**
Managed Care PMPM		**$ 326.69**		**$ 218.34**
Managed Care Savings[1]	**$ 64,100,716**	**$ 14.11**	**$ (15,939,357)**	**$ (31.21)**
Managed Care Savings %		**4.14%**		**-16.68%**
Total Savings	**$ 48,161,359**	**2.93%**		

[1] Managed Care expenditure savings are estimates based on PMPM differential over Managed Care Eligibles

Appendix B: Retrospective Model

SFY 2012 Summary of FFS Benchmark and Managed Care PMPMs

Fee For Services Benchmark Expenditures

	Title XIX		CHIP	
	Expenditures	PMPM	Expenditures	PMPM
Nursing Facilities	**$ 134,134**	**$ 0.06**	**$ -**	**$ -**
Inpatient	$ 205,876,553	$ 89.42	$ 6,191,849	$ 19.34
Outlier Payments	$ 955,208	$ 0.41	$ 82,588	$ 0.26
GME payments	$ 9,459,020	$ 4.11	$ 1,374,843	$ 4.30
Enhanced GME payments	$ 10,923,737	$ 4.74	$ 1,587,736	$ 4.96
Less: Transplant Carve Outs	$ (74,607)	$ (0.03)	$ -	$ -
Total Inpatient	**$ 227,139,912**	**$ 98.65**	**$ 9,237,015**	**$ 28.86**
Outpatient	**$ 145,177,319**	**$ 63.05**	**$ 11,521,572**	**$ 36.00**
Dental Services	$ 9,758,007	$ 4.24	$ 1,738,506	$ 5.43
Less: Dental Carve Out	$ (687)	$ (0.00)	$ -	$ -
Total Dental	**$ 9,757,320**	**$ 4.24**	**$ 1,738,506**	**$ 5.43**
Pharmacy	$ 372,603,867	$ 161.83	$ 51,026,405	$ 159.42
Less: Pharmacy Rebates	$ (157,504,609)	$ (68.41)	$ (21,569,540)	$ (67.39)
Pharmacy Carve Outs	$ (133,696,824)	$ (58.07)	$ (19,066,783)	$ (59.57)
Protease Inhibitor Carve Outs	$ (1,269,478)	$ (0.55)	$ (19,739)	$ (0.06)
Pharmacy J codes/OP Drugs	$ (8,339,406)	$ (3.62)	$ (805,325)	$ (2.52)
Smoking Cessation	$ (1,139)	$ (0.00)	$ (21)	$ (0.00)
Total Pharmacy	**$ 71,792,410**	**$ 31.18**	**$ 9,564,997**	**$ 29.88**
Physician Related	$ 164,666,169	$ 71.52	$ 12,800,794	$ 39.99
Add: FQHC Cost Settlements	$ 172,731	$ 0.08	$ 14,934	$ 0.05
RHC Cost Settlements	$ 508,150	$ 0.22	$ 43,935	$ 0.14
Less: Optical Carve Out	$ (564)	$ (0.00)	$ -	$ -
Safe and Care Exams Carve Out	$ (22,375)	$ (0.01)	$ (724)	$ (0.00)
DOH Lab Carve Out	$ (297,835)	$ (0.13)	$ (3,068)	$ (0.01)
Environmental Lead Carve Out	$ (27,959)	$ (0.01)	$ (766)	$ (0.00)
Abortion	$ -	$ -	$ -	$ -
Total Physician	**$ 164,998,317**	**$ 71.66**	**$ 12,855,105**	**$ 40.16**
In-Home Services	**$ 1,853,117**	**$ 0.80**	**$ 34,204**	**$ 0.11**
Rehab and Specialty Services	**$ 17,632,043**	**$ 7.66**	**$ 1,925,870**	**$ 6.02**
Statewide CPR/CSTAR/TCM	$ 118,222,889	$ 51.35	$ 8,258,709	$ 25.80
Less: CPR Carve Out	$ (50,208,236)	$ (21.81)	$ (3,707,408)	$ (11.58)
CSTAR Carve Out	$ (13,214,933)	$ (5.74)	$ (1,108,068)	$ (3.46)
Targeted Case Management Carve Out	$ (5,183,764)	$ (2.25)	$ (840,216)	$ (2.63)
Subtotal: CPR/CSTAR/TCM Carve Outs	$ (68,606,933)	$ (29.80)	$ (5,655,692)	$ (17.67)
Total FFS County CPR/CSTAR/TCM	**$ 49,615,956**	**$ 21.55**	**$ 2,603,018**	**$ 8.13**
Less: MH COA 4 Carve Out (I/P, O/P, and Medical)	**$ (20,140,919)**	**$ (8.75)**	**$ -**	**$ -**
EPSDT Services	$ 96,125,774	$ 41.75	$ 9,804,669	$ 30.63
Less: Therapy Carve Outs	$ (3,583,905)	$ (1.56)	$ (614,249)	$ (1.92)
Less: EPSDT Targeted Case Management	$ (1,377,530)	$ (0.60)	$ -	$ -
Total EPSDT Services	**$ 91,164,338**	**$ 39.59**	**$ 9,190,420**	**$ 28.71**
TPL Recoveries	**$ (37,873,968)**	**$ (16.45)**	**$ (3,274,592)**	**$ (10.23)**
FFS Mass Adjustments	**$ (68,949)**	**$ (0.03)**	**$ -**	**$ -**
Managed Care Opt-Out	**$ (6,604,409)**	**$ (2.87)**	**$ (589,366)**	**$ (1.84)**
Prior Qtr Coverage/FFS Window	**$ (38,267,129)**	**$ (16.62)**	**$ (1,081,499)**	**$ (3.38)**
Geographic Adjustment	**$ 32,796,337**	**$ 14.24**	**$ 2,538,133**	**$ 7.93**
Administrative Services	**$ 31,270,629**	**$ 13.58**	**$ 3,577,597**	**$ 11.18**
FFS Grand Total Benchmark Expenditures	**$ 740,376,458**	**$321.56**	**$ 59,840,978**	**$ 186.96**
Average FFS Benchmark Eligibles		**191,870**		**26,673**
Annual FFS Benchmark Cost Per Eligible		**$ 3,859**		**$ 2,243**

Appendix B: Retrospective Model

SFY 2012 Summary of Managed Care PMPMs

Managed Care Expenditures

	Title XIX		CHIP	
	Expenditures	PMPM	Expenditures	PMPM
Managed Care Capitation Payments	$ 838,511,081	$ 182.04	$ 66,918,076	$ 127.72
Managed Care Delivery Payments	$ 78,800,365	$ 17.11	$ 148,810	$ 0.28
Managed Care NICU Payments	$ 42,178,161	$ 9.16	$ -	$ -
Managed Care Profit	$ 27,258,227	$ 5.92	$ 1,905,309	$ 3.64
Administrative Costs:				
Managed Care Capitation Admin component	$ 103,581,264	$ 22.49	$ 7,240,175	$ 13.82
Managed Care State Administrative Costs	$ 15,479,343	$ 3.36	$ 1,770,954	$ 3.38
Total Administrative Costs	$ 119,060,607	$ 25.85	$ 9,011,129	$ 17.20
Managed Care Reimbursement Allowance	$ -	$ -	$ -	$ -
Managed Care Prior Quarter Coverage/FFS Window	$ 38,267,129	$ 8.31	$ 1,081,499	$ 2.06
Managed Care Mass Adjustments	$ -	$ -	$ -	$ -
Managed Care Carveouts	$ 236,062,632	$ 51.25	$ 26,166,367	$ 49.94
Managed Care EPSDT Targeted Case Management	$ 1,377,530	$ 0.30	$ -	$ -
Managed Care FQHC Interim Payments	$ 29,288,097	$ 6.36	$ 2,141,324	$ 4.09
Managed Care RHC Interim Payments	$ 10,849,425	$ 2.36	$ 793,228	$ 1.51
Managed Care FQHC Cost Settlements	$ 174,906	$ 0.04	$ 12,788	$ 0.02
Managed Care RHC Cost Settlements	$ 942,160	$ 0.20	$ 68,884	$ 0.13
Managed Care Outlier Payments	$ 823,646	$ 0.18	$ 60,219	$ 0.11
Managed Care GME Payments	$ 18,923,075	$ 4.11	$ 2,250,529	$ 4.30
Managed Care Enhanced GME Payments	$ 21,853,290	$ 4.74	$ 2,599,021	$ 4.96
Managed Care Grand Total Expenditures	**$ 1,464,370,331**	**$317.92**	**$ 113,157,184**	**$ 215.97**
Average Managed Care Eligibles		**383,843**		**43,663**
Annual Managed Care Cost Per Eligible		**$ 3,815**		**$ 2,592**

Managed Care Savings Estimates

FFS Benchmark PMPM		**$ 321.56**		**$ 186.96**
Managed Care PMPM		**$ 317.92**		**$ 215.97**
Managed Care Savings[1]	**$ 16,776,713**	**$ 3.64**	**$ (15,201,355)**	**$ (29.01)**
Managed Care Savings %		**1.13%**		**-15.52%**
Total Savings	**$ 1,575,359**	**0.10%**		

[1] Managed Care expenditure savings are estimates based on PMPM differential over Managed Care Eligibles

Appendix B: Retrospective Model

SFY 2011 Summary of FFS Benchmark and Managed Care PMPMs

Fee For Services Benchmark Expenditures

	Title XIX		CHIP	
	Expenditures	PMPM	Expenditures	PMPM
Nursing Facilities	**$ 119,942**	**$ 0.05**	**$ -**	**$ -**
Inpatient	$ 204,039,524	$ 88.41	$ 6,236,410	$ 19.61
Add: Outlier Payments	$ 863,346	$ 0.37	$ 74,915	$ 0.24
GME payments	$ 8,923,491	$ 3.87	$ 1,191,526	$ 3.75
Enhanced GME payments	$ 9,893,590	$ 4.29	$ 1,321,060	$ 4.15
Less: Transplant Carve Outs	$ (161,504)	$ (0.07)	$ (2,553)	$ (0.01)
Total Inpatient	**$ 223,558,448**	**$ 96.87**	**$ 8,821,357**	**$ 27.73**
Outpatient	**$ 148,317,349**	**$ 64.26**	**$ 11,379,904**	**$ 35.78**
Dental Services	$ 9,373,481	$ 4.06	$ 1,675,389	$ 5.27
Less: Dental Carve Out	$ (2,230)	$ (0.00)	$ -	$ -
Total Dental	**$ 9,371,251**	**$ 4.06**	**$ 1,675,389**	**$ 5.27**
Pharmacy	$ 335,931,156	$ 145.55	$ 43,089,728	$ 135.48
Less: Pharmacy Rebates	$ (128,447,482)	$ (55.65)	$ (16,475,897)	$ (51.80)
Pharmacy Carve Outs	$ (128,198,353)	$ (55.55)	$ (16,579,681)	$ (52.13)
Protease Inhibitor Carve Outs	$ (1,144,278)	$ (0.50)	$ (16,832)	$ (0.05)
Pharmacy J codes/OP Drugs	$ (7,671,368)	$ (3.32)	$ (724,407)	$ (2.28)
Smoking Cessation	$ (59)	$ (0.00)	$ -	$ -
Total Pharmacy	**$ 70,469,616**	**$ 30.53**	**$ 9,292,912**	**$ 29.22**
Physician Related	$ 152,233,950	$ 65.96	$ 11,951,411	$ 37.58
Add: FQHC Cost Settlements	$ 356,869	$ 0.15	$ 30,967	$ 0.10
RHC Cost Settlements	$ 666,776	$ 0.29	$ 57,858	$ 0.18
Less: Optical Carve Out	$ (713)	$ (0.00)	$ -	$ -
Safe and Care Exams Carve Out	$ (22,804)	$ (0.01)	$ (767)	$ (0.00)
DOH Lab Carve Out	$ (571,037)	$ (0.25)	$ (950)	$ (0.00)
Environmental Lead Carve Out	$ (29,158)	$ (0.01)	$ (322)	$ (0.00)
Abortion	$ (567)	$ (0.00)	$ -	$ -
Total Physician	**$ 152,633,316**	**$ 66.13**	**$ 12,038,197**	**$ 37.85**
In-Home Services	**$ 1,659,991**	**$ 0.72**	**$ 18,089**	**$ 0.06**
Rehab and Specialty Services	**$ 13,977,792**	**$ 6.06**	**$ 1,652,155**	**$ 5.19**
Statewide CPR/CSTAR/TCM	$ 95,060,031	$ 41.19	$ 6,950,337	$ 21.85
Less: CPR Carve Out	$ (39,036,139)	$ (16.91)	$ (2,993,431)	$ (9.41)
CSTAR Carve Out	$ (11,934,259)	$ (5.17)	$ (891,438)	$ (2.80)
Targeted Case Management Carve Out	$ (4,764,643)	$ (2.06)	$ (773,900)	$ (2.43)
Subtotal: CPR/CSTAR/TCM Carve Outs	$ (55,735,041)	$ (24.15)	$ (4,658,769)	$ (14.65)
Total FFS County CPR/CSTAR/TCM	**$ 39,324,990**	**$ 17.04**	**$ 2,291,568**	**$ 7.20**
Less: MH COA 4 Carve Out (I/P, O/P, and Medical)	**$ (20,414,629)**	**$ (8.85)**	**$ -**	**$ -**
EPSDT Services	$ 90,352,334	$ 39.15	$ 9,482,412	$ 29.81
Less: Therapy Carve Outs	$ (2,399,528)	$ (1.04)	$ (460,720)	$ (1.45)
Less: EPSDT Targeted Case Management	$ (1,318,130)	$ (0.57)	$ -	$ -
Total EPSDT Services	**$ 86,634,676**	**$ 37.54**	**$ 9,021,692**	**$ 28.36**
TPL Recoveries	**$ (36,226,594)**	**$ (15.70)**	**$ (3,143,500)**	**$ (9.88)**
FFS Mass Adjustments	**$ 228,266**	**$ 0.10**	**$ -**	**$ -**
Managed Care Opt-Out	**$ (7,831,603)**	**$ (3.39)**	**$ (606,634)**	**$ (1.91)**
Prior Qtr Coverage/FFS Window	**$ (35,529,584)**	**$ (15.39)**	**$ (967,733)**	**$ (3.04)**
Geographic Adjustment	**$ 31,373,807**	**$ 13.59**	**$ 2,448,041**	**$ 7.70**
Administrative Services	**$ 25,716,111**	**$ 11.14**	**$ 2,890,786**	**$ 9.09**
FFS Grand Total Benchmark Expenditures	**$ 703,383,146**	**$304.77**	**$ 56,812,223**	**$ 178.62**
Average FFS Benchmark Eligibles		**192,328**		**26,505**
Annual FFS Benchmark Cost Per Eligible		**$ 3,657**		**$ 2,143**

Appendix B: Retrospective Model

SFY 2011 Summary of Managed Care PMPMs

Managed Care Expenditures

	Title XIX		CHIP	
	Expenditures	PMPM	Expenditures	PMPM
Managed Care Capitation Payments	$ 787,765,712	$ 168.63	$ 60,656,495	$ 116.16
Managed Care Delivery Payments	$ 90,494,024	$ 19.37	$ 171,693	$ 0.33
Managed Care NICU Payments	$ 34,460,249	$ 7.38	$ -	$ -
Managed Care Profit	$ 25,929,545	$ 5.55	$ 1,728,074	$ 3.31
Administrative Costs:				
Managed Care Capitation Admin component	$ 98,532,271	$ 21.09	$ 6,566,679	$ 12.58
Managed Care State Administrative Costs	$ 15,159,347	$ 3.25	$ 1,704,084	$ 3.26
Total Administrative Costs	$ 113,691,618	$ 24.34	$ 8,270,764	$ 15.84
Managed Care Reimbursement Allowance	$ -	$ -	$ -	$ -
Managed Care Prior Quarter Coverage/FFS Window	$ 35,529,584	$ 7.61	$ 967,733	$ 1.85
Managed Care Mass Adjustments	$ -	$ -	$ -	$ -
Managed Care Carveouts	$ 216,351,268	$ 46.31	$ 22,445,002	$ 42.98
Managed Care EPSDT Targeted Case Management	$ 1,318,130	$ 0.28	$ -	$ -
Managed Care FQHC Interim Payments	$ 24,858,148	$ 5.32	$ 1,721,673	$ 3.30
Managed Care RHC Interim Payments	$ 9,083,853	$ 1.94	$ 629,147	$ 1.20
Managed Care FQHC Cost Settlements	$ 435,152	$ 0.09	$ 30,139	$ 0.06
Managed Care RHC Cost Settlements	$ 1,364,869	$ 0.29	$ 94,531	$ 0.18
Managed Care Outlier Payments	$ 802,483	$ 0.17	$ 55,580	$ 0.11
Managed Care GME Payments	$ 18,062,299	$ 3.87	$ 1,956,172	$ 3.75
Managed Care Enhanced GME Payments	$ 20,025,904	$ 4.29	$ 2,168,833	$ 4.15
Managed Care Grand Total Expenditures	**$ 1,380,172,837**	**$295.44**	**$ 100,895,834**	**$ 193.22**
Average Managed Care Eligibles		**389,297**		**43,515**
Annual Managed Care Cost Per Eligible		**$ 3,545**		**$ 2,319**

Managed Care Savings Estimates

FFS Benchmark PMPM		**$ 304.77**		**$ 178.62**
Managed Care PMPM		**$ 295.44**		**$ 193.22**
Managed Care Savings[1]	**$ 43,565,474**	**$ 9.33**	**$ (7,625,083)**	**$ (14.60)**
Managed Care Savings %		**3.06%**		**-8.18%**
Total Savings	**$ 35,940,391**	**2.37%**		

[1] Managed Care expenditure savings are estimates based on PMPM differential over Managed Care Eligibles

Appendix B: Retrospective Model

SFY 2010 Summary of FFS Benchmark and Managed Care PMPMs

Fee For Services Benchmark Expenditures

	Title XIX		CHIP	
	Expenditures	PMPM	Expenditures	PMPM
Nursing Facilities	**$ 124,221**	**$ 0.05**	**$ -**	**$ -**
Inpatient	$ 208,897,397	$ 91.29	$ 5,595,795	$ 18.26
Add: Outlier Payments	$ 814,306	$ 0.36	$ 64,698	$ 0.21
GME payments	$ 10,867,428	$ 4.75	$ 877,748	$ 2.86
Enhanced GME payments	$ 11,277,041	$ 4.93	$ 910,832	$ 2.97
Less: Transplant Carve Outs	$ (1,169,633)	$ (0.51)	$ (310,624)	$ (1.01)
Total Inpatient	**$ 230,686,539**	**$ 100.81**	**$ 7,138,450**	**$ 23.29**
Outpatient	**$ 155,477,106**	**$ 67.94**	**$ 12,056,819**	**$ 39.34**
Dental Services	$ 9,356,201	$ 4.09	$ 1,604,603	$ 5.24
Less: Dental Carve Out	$ (630,619)	$ (0.28)	$ (411)	$ (0.00)
Total Dental	**$ 8,725,582**	**$ 3.81**	**$ 1,604,191**	**$ 5.23**
Pharmacy	$ 269,071,429	$ 117.59	$ 34,700,174	$ 113.23
Less: Pharmacy Rebates	$ (82,954,124)	$ (36.25)	$ (10,697,987)	$ (34.91)
Pharmacy Carve Outs	$ (102,234,831)	$ (44.68)	$ (13,288,651)	$ (43.36)
Protease Inhibitor Carve Outs	$ (930,962)	$ (0.41)	$ (18,991)	$ (0.06)
Total Pharmacy	**$ 82,951,512**	**$ 36.25**	**$ 10,694,546**	**$ 34.90**
Physician Related	$ 156,569,524	$ 68.42	$ 11,448,741	$ 37.36
Add: FQHC Cost Settlements	$ 271,628	$ 0.12	$ 21,581	$ 0.07
RHC Cost Settlements	$ 1,175,224	$ 0.51	$ 93,374	$ 0.30
Less: Optical Carve Out	$ (72,921)	$ (0.03)	$ (84)	$ (0.00)
Safe and Care Exams Carve Out	$ (59,003)	$ (0.03)	$ (3,493)	$ (0.01)
DOH Lab Carve Out	$ (25,124)	$ (0.01)	$ (483)	$ (0.00)
Environmental Lead Carve Out	$ (35,034)	$ (0.02)	$ (113)	$ (0.00)
Abortion	$ -	$ -	$ -	$ -
Total Physician	**$ 157,824,295**	**$ 68.97**	**$ 11,559,523**	**$ 37.72**
In-Home Services	**$ 1,592,769**	**$ 0.70**	**$ 10,445**	**$ 0.03**
Rehab and Specialty Services	**$ 14,418,127**	**$ 6.30**	**$ 1,471,430**	**$ 4.80**
Statewide CPR/CSTAR/TCM	$ 85,529,807	$ 37.38	$ 6,212,812	$ 20.27
Less: CPR Carve Out	$ (36,803,872)	$ (16.08)	$ (2,452,206)	$ (8.00)
CSTAR Carve Out	$ (10,274,636)	$ (4.49)	$ (807,680)	$ (2.64)
Targeted Case Management Carve Out	$ (6,822,110)	$ (2.98)	$ (948,724)	$ (3.10)
Subtotal: CPR/CSTAR/TCM Carve Outs	$ (53,900,617)	$ (23.55)	$ (4,208,610)	$ (13.73)
Total FFS County CPR/CSTAR/TCM	**$ 31,629,190**	**$ 13.82**	**$ 2,004,202**	**$ 6.54**
Less: MH COA 4 Carve Out (I/P, O/P, and Medical)	**$ (33,825,730)**	**$ (14.78)**	**$ -**	**$ -**
EPSDT Services	$ 89,683,100	$ 39.19	$ 8,975,621	$ 29.29
Less: Therapy Carve Outs	$ (3,395,222)	$ (1.48)	$ (460,894)	$ (1.50)
Less: EPSDT Targeted Case Management	$ (1,261,351)	$ (0.55)	$ -	$ -
Total EPSDT Services	**$ 85,026,527**	**$ 37.16**	**$ 8,514,726**	**$ 27.78**
TPL Recoveries	**$ (33,999,213)**	**$ (14.86)**	**$ (2,701,311)**	**$ (8.81)**
FFS Mass Adjustments	**$ 54,388**	**$ 0.02**	**$ -**	**$ -**
Managed Care Opt-Out	**$ (10,128,423)**	**$ (4.43)**	**$ (1,324,202)**	**$ (4.32)**
Prior Qtr Coverage/FFS Window	**$ (33,489,689)**	**$ (14.64)**	**$ (859,278)**	**$ (2.80)**
Geographic Adjustment	**$ 31,746,137**	**$ 13.87**	**$ 2,419,048**	**$ 7.89**
Administrative Services	**$ 31,120,456**	**$ 13.60**	**$ 3,444,053**	**$ 11.24**
FFS Grand Total Benchmark Expenditures	**$ 719,933,795**	**$ 314.61**	**$ 56,032,643**	**$ 182.84**
Average FFS Benchmark Eligibles		**190,693**		**25,539**
Annual FFS Benchmark Cost Per Eligible		**$ 3,775**		**$ 2,194**

Appendix B: Retrospective Model

SFY 2010 Summary of Managed Care PMPMs

Managed Care Expenditures

	Title XIX		CHIP	
	Expenditures	PMPM	Expenditures	PMPM
Managed Care Capitation Payments	$ 870,143,951	$ 191.07	$ 63,935,252	$ 127.59
Managed Care Delivery Payments	$ 93,331,421	$ 20.49	$ 204,032	$ 0.41
Managed Care NICU Payments	$ -	$ -	$ -	$ -
Managed Care Profit	$ 27,371,459	$ 6.01	$ 1,822,139	$ 3.64
Administrative Costs:				
Managed Care Capitation Admin component	$ 104,011,546	$ 22.84	$ 6,924,127	$ 13.82
Managed Care State Administrative Costs	$ 19,330,689	$ 4.24	$ 2,139,298	$ 4.27
Total Administrative Costs	$ 123,342,234	$ 27.08	$ 9,063,425	$ 18.09
Managed Care Reimbursement Allowance	$ (21,096,997)	$ (4.63)	$ (1,404,443)	$ (2.80)
Managed Care Prior Quarter Coverage/FFS Window	$ 33,489,689	$ 7.35	$ 859,278	$ 1.71
Managed Care Mass Adjustments	$ 130,574	$ 0.03	$ -	$ -
Managed Care Carveouts	$ 196,279,695	$ 43.10	$ 18,292,355	$ 36.50
Managed Care EPSDT Targeted Case Management	$ 1,261,351	$ 0.28	$ -	$ -
Managed Care FQHC Interim Payments	$ 25,200,592	$ 5.53	$ 1,677,622	$ 3.35
Managed Care RHC Interim Payments	$ 6,526,855	$ 1.43	$ 434,498	$ 0.87
Managed Care FQHC Cost Settlements	$ 364,489	$ 0.08	$ 24,264	$ 0.05
Managed Care RHC Cost Settlements	$ 2,057,746	$ 0.45	$ 136,986	$ 0.27
Managed Care Outlier Payments	$ 860,066	$ 0.19	$ 57,255	$ 0.11
Managed Care GME Payments	$ 21,627,998	$ 4.75	$ 1,435,212	$ 2.86
Managed Care Enhanced GME Payments	$ 22,443,197	$ 4.93	$ 1,489,308	$ 2.97
Managed Care Grand Total Expenditures	**$ 1,403,334,320**	**$308.15**	**$ 98,027,182**	**$ 195.62**
Average Managed Care Eligibles		**379,510**		**41,758**
Annual Managed Care Cost Per Eligible		**$ 3,698**		**$ 2,347**

Managed Care Savings Estimates

FFS Benchmark PMPM		**$ 314.61**		**$ 182.84**
Managed Care PMPM		**$ 308.15**		**$ 195.62**
Managed Care Savings[1]	**$ 29,454,281**	**$ 6.47**	**$ (6,407,833)**	**$ (12.79)**
Managed Care Savings %		**2.06%**		**-6.99%**
Total Savings	**$ 23,046,448**	**1.51%**		

[1] Managed Care expenditure savings are estimates based on PMPM differential over Managed Care Eligibles

APPENDIX C

Prospective Analysis Detailed Exhibit

Appendix C:
Calendar Year 2015
Prospective Model

	Fee For Service			Managed Care		
	Title XIX	CHIP	Total	Title XIX	CHIP	Total
Initial Member Months[1]	2,273,613	319,008	2,592,621	2,273,613	319,008	2,592,621
Initial Base Data[2]	$ 250.67	$ 125.75	$ 235.30	$ 250.67	$ 125.75	$ 235.30
Trend to CY 2015[3]	$ 15.77	$ 8.62	$ 14.89	$ 15.77	$ 8.62	$ 14.89
Managed Care Savings[4]	$ -	$ -	$ -	$ (43.70)	$ (22.04)	$ (41.03)
Add Program Changes[5]	$ (6.28)	$ (2.39)	$ (5.80)	$ (5.25)	$ (2.00)	$ (4.85)
Add Administrative Services[6]	$ -	$ -	$ -	$ 29.66	$ 15.05	$ 27.86
Add Health Insurer Fee[7]	$ -	$ -	$ -	$ 7.16	$ 3.63	$ 6.72
PMPM Subtotal	$ 260.16	$ 131.98	$ 244.39	$ 254.31	$ 129.02	$ 238.89
Total Expenditures[8]	**$ 591.5**	**$ 42.1**	**$ 633.6**	**$ 578.2**	**$ 41.2**	**$ 619.4**

Total Savings[8]: $ 14.2

Savings Percentage: 2.2%

[1] SFY 2013 Enrollment counts from the State's Table 23 reports
[2] Existing FFS PMPMs from cost avoidance study at SFY 2013 levels
[3] Utilized FFS Category of Service trend factors to project to CY 2015
[4] Applied an overall 16.4% managed care savings factor to the Existing Fee For Service Expenditures
[5] Applied program change adjustments for: Removal of ACA PCP - Physician, Removal of ACA PCP - Family Planning, Ambulance Fee Schedule for Mileage Reimbursement, and Former Foster Care Children - Coverage up to Age 26
[6] Added admin assumption based on Missouri's SFY 2015 managed care rates
[7] Added health insurer fee based on SFY 2015 and SFY 2016 managed care rate assumptions
[8] Total expenditures cited in millions

APPENDIX D

Table 23 Service Crosswalk

Appendix D

Category of Service	Component	Include/Exclude
Nursing Facilities	Nursing Facilities	Include
Inpatient	Inpatient	Include
	Outlier Payments	Exclude
	GME payments	Exclude
	Enhanced GME payments	Exclude
	Transplant Carve Outs	Include
Outpatient	Outpatient	Include
Dental Services	Dental Services	Include
	Dental Carve Out	Include
Pharmacy	Pharmacy	Exclude
	Pharmacy Rebates	Exclude
	Pharmacy Carve Outs	Exclude
	Protease Inhibitor Carve Outs	Exclude
	Pharmacy J codes/OP Drugs	Exclude
	Smoking Cessation	Exclude
Total Physician	Physician Related	Include
	FQHC Cost Settlements	Exclude
	RHC Cost Settlements	Exclude
	Optical Carve Out	Include
	Safe and Care Exams Carve Out	Include
	DOH Lab Carve Out	Include
	Environmental Lead Carve Out	Include
	Abortion	Include
In-Home Services	In-Home Services	Include
Rehab and Specialty Services	Rehab and Specialty Services	Include
State Institutions	State Institutions	Include
	Mental Health Services	Include
	CPR Carve Out	Include
	CSTAR Carve Out	Include
	Targeted Case Management Carve Out	Include
MH COA 4 Carve Out	MH COA 4 Carve Out (I/P, O/P, and Medical)	Include
EPSDT Services	EPSDT Services	Include
	Therapy Carve Outs	Include
	EPSDT Targeted Case Management	Include
TPL Recoveries	TPL Recoveries	Include
FFS Mass Adjustments	FFS Mass Adjustments	Include
Managed Care Opt Out	Managed Care Opt Out	Include
Prior Qtr Coverage/FFS Window	Prior Qtr Coverage/FFS Window	Include
Geographic Adjustment	Geographic Adjustment	Exclude
Administrative Services	Administrative Services	Exclude

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