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Managed Care Cost Avoidance Model

Missouri Department of Social Services
MO HealthNet Division

MERCER

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Contents

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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 review and recommend changes to the model the State uses to estimate costs avoided by the Missouri HealthNet Division (MHD) managed care program. Mercer reviewed both the model methodology and its calculations and held multiple discussions with MHD staff. This report provides:

- An overview of the cost avoidance modeling methodology
- Detail on how each cost line is considered
- Recommendations on model revisions
- Results from the State's cost avoidance model after revisions based on Mercer recommendations

Model Goals and Philosophy

The goal of the cost avoidance model is to determine whether total MHD costs for eligibles enrolled in managed care is lower than would have been the case in the absence of managed care. 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 fee-for-service (FFS) population to compare to managed care costs.

Adjustments must be made to the costs of this benchmark population in order to make it as comparable to the managed care eligibles and benefits as possible. When reviewing the costs and services that may be impacted by managed care, a key question is whether the costs would continue to be paid at the same level if managed care was eliminated. If a certain cost category is not materially impacted by the implementation of a managed care delivery system (e.g., 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 managed care program and the benchmark to determine if savings are being generated.

The cost avoidance model is a tool for reviewing the historical financial impact of the managed care program. The results of the State's model cannot be used as a projection of cost savings attributable to potential managed care expansions. Financial expectations for managed care 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 managed care
- Time to affect provider practice patterns and member behavior

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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 managed care has not been implemented, but would otherwise be enrolled in MHD managed care based on age and other eligibility criteria. The eligibility counts for the FFS benchmark and managed care 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. Managed care eligibles are counted on Table 23 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 managed care eligibles for a given month.

For this reason, the State has been using the managed care full-time-equivalent (FTE) data source, which tracks capitation payments by date of service, to develop managed care eligibility counts. This data source calculates day-by-day eligibility for the month, allowing for partial months of eligibility. However, this is different than how Table 23 counts the FFS eligibles, which assigns a full month of eligibility to all people eligible at a certain point in time. Mercer recommended the State perform a study on monthly managed care eligibility patterns to adjust these FTE counts to reflect unique eligibles at a point in time in the same way that the Table 23 FFS eligibles are reported. This adjustment would ensure consistent counting of FFS and managed care eligibles and would eliminate the potential distortion of the PMPM savings calculations. The State did conduct this eligibility analysis and has applied a conversion factor to the managed care eligibles to ensure consistency between the benchmark and managed care eligibility counts.

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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 also the State's Table 23 reports, which includes costs paid during a particular State fiscal year (SFY), regardless of when a service was delivered. 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 managed care PMPM metrics.

As mentioned previously in this report, the philosophy of the cost avoidance model is to include cost categories in the comparison between managed care and the FFS benchmark only if they would be impacted by the elimination of managed care. Following are summaries of how Mercer recommended various medical cost categories be treated in the model. Additional line item detail is included in Appendix A. Appendix B includes a MHD presentation describing the cost avoidance model.

- **Medical services covered under managed care** — Services such as Inpatient, Nursing Facilities, Dental, Mental Health and other services are covered under both the managed care and FFS benchmark delivery systems for managed care like individuals. Costs and utilization of these services are impacted by the existence of managed care, so these services should be included in the cost avoidance calculations.
- **Medical services carved out from managed care** — Some adult dental, transplants, mental health services for foster children and other services for managed care eligibles are carved out from the managed care program and are covered through FFS. The utilization and cost of these services may be moderately impacted by the existence of managed care and should be included in the cost avoidance calculations. In the model, these FFS carve-out costs for managed care eligibles are moved from the FFS benchmark costs (included in Table 23) to the managed care costs.

- **Other medical cost transactions** — The State makes various other payments to providers outside of the direct billing of medical services for both managed care and FFS eligibles. Some payments, such as Federally Qualified Health Care and Rural Health Clinic cost settlements, are calculated using actual managed care 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 managed care and FFS eligibles. Therefore, such items are not impacted by the existence of managed care 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 managed care eligibles and benefits as possible, Mercer made the following recommendations to further refine the State's model.

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 managed care 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 managed care, which skews the cost avoidance calculations. Mercer recommended that any significant mass adjustments be reallocated from the year of payment to the year(s) of service the payments are applicable to. The MHD reviewed historical mass adjustments and has made adjustments for timing in its model.

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 managed care. 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 managed care portion of the cost avoidance calculations. In that way, the managed care program costs will be calculated considering the entire enrollment period of its members, just as the FFS population costs are calculated.

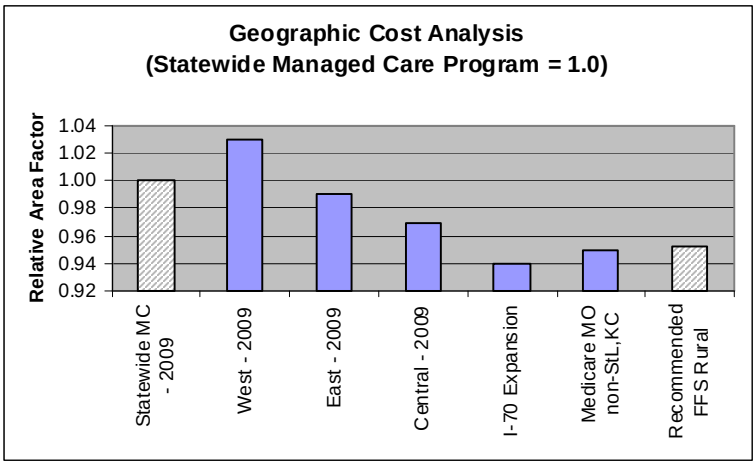
In addition to the FFS Window, the FFS program retains financial responsibility for managed care enrollees for any time periods where the member receives MO HealthNet eligibility for a period prior to their application date (retroactive eligibility). The retroactive eligibility is usually driven by a 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 recommends that the membership and costs associated with retroactive eligibility be moved to the managed care portion of the cost calculations.

The State identified the eligibles and medical costs associated with both of these recommendations and moved the eligibility of costs out of the benchmark medical costs to the managed care medical costs.

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, Central Region managed care capitation rates are lower than the more urban East and West Regions. In addition, when FFS data was examined for the I-70 corridor managed care expansion in January 2008, Mercer estimated the cost of delivering services to these counties through managed care would be about 3% lower than the existing Central Region counties. Finally, Missouri Medicare expenditures per person for areas outside of St. Louis and Kansas City have been about 5% lower than those two urban areas.

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 managed care population. This adjustment brings the FFS benchmark to a level comparable to the average managed care geographic cost factor. Mercer recommended making a 5% upward adjustment to the benchmark, considering the data points described in the preceding paragraph and illustrated in the graph below. This 5% modification would adjust the experience for the rural FFS region from a 0.95 relative level to the 1.00 Statewide (East, West and Central regions) managed care relative level.



Data Source	Geographic Factor
Statewide MC - 2009	1.00
West - 2009	1.03
East - 2009	0.99
Central - 2009	0.97
I-70 Expansion	0.94
Medicare MO non-StL,KC	0.95
Recommended FFS Rural	0.95

The State did apply this geographic adjustment to the benchmark medical costs in its model.

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Administrative Costs

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

Mercer has had several conversations with State staff about appropriate methodologies to allocate shared administrative expenses, such as the MMIS, between managed care and FFS. In addition, we have discussed appropriate methodologies to allocate FFS-only expenses between managed care like eligibles and other FFS eligibles when developing administrative costs for the FFS benchmark. The State has followed Mercer recommendations, when possible, to allocate administrative costs between managed care, FFS managed care like and other FFS eligibles to ensure the comparison between managed care and benchmark costs is appropriate.

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Results

Appendix C provides the State's detailed cost avoidance model analysis for SFY 2009. Over the last several years, the State's model has demonstrated that the managed care program is consistently providing savings relative to projected costs for the same population absent managed care (benchmark costs). The SFY 2009 cost avoidance results are summarized below:

	Expenditures
FFS Benchmark Costs	$1.430 billion
Managed Care Costs	$1.392 billion
SFY 2009 Savings	$38 million
Percent Savings	2.7%

A more detailed comparison of the benchmark and the managed care expenditures demonstrates a significant PMPM savings in medical costs that more than offsets the increased administration expenses and profit load included for the managed care health plans.

SFY 2009 FFS Benchmark PMPMs		**SFY 2009 Managed Care PMPMs**	
Medical Total	$281.63	Medical Total	$252.88
State Administration	$12.97	Health Plan Admin	$23.21
		Target Profit	$6.11
		State MC Oversight	$4.48
Grand Total	**$294.60**	**Grand Total**	**$286.68**
		Total Savings	**$7.92**

These savings results are consistent with 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. 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 managed care
- Effectiveness of managed care health plans
- Maturity of managed care program
- Sophistication of existing FFS care management

The cost avoidance model is an historical financial analysis of the managed care program and is not a direct comparison between the existing FFS and managed care populations and delivery systems. The model does not provide an assessment or estimate of potential savings associated with managed care 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.

Appendix A

Cost Category Recommended Treatment

FFS Costs	Impacted by Managed Care? (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 managed care 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	Yes, so include in calculations (1)
State Institutions	Yes, so include in calculations (3)
Early Periodic Screening, Diagnosis, and Treatment Services	Yes, so include in calculations (1)

Less:	
Managed Care Carveouts	Yes, move from FFS to managed care (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)

FFS Costs	Impacted by Managed Care? (See notes below)
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)
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)

Managed Care Costs	Impacted by Managed Care? (See notes below)
Managed Care (MC) Capitation Payments	Yes, so include in calculations (13)
MC Delivery 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 managed care (4)
MC Prior Qtr Coverage/FFS Window	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 managed care eligibles; the costs and mix of these services are impacted by the existence of managed care.

2. Buy-In Premiums are for Medicare Part A and Part B coverage and are not applicable to managed care 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 manage care like population and are excluded from the calculations.
4. Managed Care Carveouts are services provided through FFS to managed care eligibles. These costs are moved from the FFS benchmark to the managed care cost. The carve-outs have been removed from their respective cost categories.
5. Managed care 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. Any significant mass adjustments were reallocated from the year of payment to the year(s) of service the payments are applicable to.
7. The eligibles and costs associated with managed care eligibles prior to the time of enrollment in a managed care plan have been removed from the FFS benchmark and added to managed care.
8. These payments made to providers by the State are based on FFS reimbursement for FFS eligibles and managed care reimbursement for managed care eligibles. Therefore, the existence of managed care 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 managed care and FFS, the total level of hospital days per eligible per month is reduced by managed care. However, reflection of utilization differences between managed care 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 managed care practices or the level of provider reimbursement. These costs have been reflected in the model but at equivalent levels for the benchmark and managed care 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 managed care program.
12. State costs for administrative services are included on this line and are allocated between managed care 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 managed care are fully reflected as a managed care expenditure as 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 managed care health plans. MC Delivery Payments are made for each member delivery event and include a component for Target Profit and Administration, as well.

14. The Managed Care Reimbursement Allowance (MRA) can no longer be assessed on the Medicaid managed care 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 managed care capitation payments.

Appendix B

MO HealthNet Division Presentation on Cost Avoidance Model

MO HealthNet Division

MO HealthNet Managed Care Cost Savings Analysis

Goal

"What would the total MO HealthNet Costs for eligibles enrolled in managed care be in the absence of managed care?"

Managed Care Counties

East Region: Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis, Warren, and Washington counties and St. Louis City

West Region: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, and Vernon counties

Central Region: Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline, and Shelby counties

All other counties are solely Fee For Service

Note: The Managed Care counties include recipients who receive carveout services paid from the Fee For Service appropriation.

Managed Care Like Eligibility Categories

- MAF – Adults and Children
- Medicaid for Pregnant Women
- Foster Care
- Child Welfare Services
- Refugee
- Children in State Custody
- Medicaid for Children
- MO HealthNet for Kids (SCHIP)

MO HealthNet Fee-For-Service Benchmark Expenditures

- Paid Claims Data
  - Less Managed Care Carveout Expenditures
  - Less Pharmacy Rebates
- Outlier Payments
- Quarterly and Enhanced GME Hospital Payments

Note: Based on Paid Date of Service
Source: Table 23, Institutional Reimbursement Hospital and Clinic Payouts.

MO HealthNet Fee-For-Service Benchmark Adjustments

- State Administrative Costs
- TPL Recoveries
- Fee-For-Service Mass Adjustments
- Removal of Prior Quarter Coverage/FFS Window
- Geographic Adjustment

Source: Indirect Costs file, Expenditure files, Prior Qtr Coverage/FFS Window Adhocs,

MO HealthNet Managed Care Expenditures

- Capitation Payments to MO HealthNet Health Plans
  - Medical Component
  - Administrative Component
  - Profit Component

- Delivery Payments to MO HealthNet Health Plans

- Managed Care Carveouts paid from the Fee For Service Appropriation

Note: Based on Paid Date of Service

Source: Capitation and Kick files, reinsurance files, carveout adhocs, Institutional Reimbursement Hospital and Clinic Payouts.

MO HealthNet Managed Care Expenditures (cont'd)

- Managed Care Federally Qualified Health Clinic (FQHC) and Rural Health Clinics (RHC) Interim Payments
- Managed Care Outlier Payments
- Managed Care Cost Settlement Hospital Payments
- Managed Care Quarterly and Enhanced GME Hospital Payments

Note: Based on Paid Date of Service

Source: Capitation and Kick files, reinsurance files, carveout adhocs, Institutional Reimbursement Hospital and Clinic Payouts.

MO HealthNet Managed Care Adjustments

- State Administrative Expenditures
- Managed Care Reimbursement Allowance
- Prior Quarter Coverage/FFS Window
- Mass Adjustments

Source: Indirect Costs file, Expenditure files, Prior Qtr Coverage/FFS Window Adhocs, Capitation Files

Per Member Per Month Comparison

- FFS Benchmark PMPM =
  Total FFS managed care like benchmark expenditures / Total FFS managed care like eligibles / 12 months

- MO HealthNet Managed Care PMPM =
  Total Managed Care Expenditures / Total Managed Care Eligibles / 12 months

- Savings = FFS Benchmark PMPM less MO HealthNet Managed Care PMPM * Total Managed Care eligibles

Appendix C

SFY 2009 Cost Avoidance Analysis

SFY 2009 Summary of FFS Benchmark and Managed Care PMPMs

Fee For Services Benchmark Expenditures

	Title XIX Expenditures	Title XIX PMPM	CHIP Expenditures	CHIP PMPM
Nursing Facilities	$ 151,264	$ 0.08	$ -	$ -
Inpatient	$ 203,450,499	$ 101.25	$ 5,735,455	$ 20.71
Add: Outlier Payments	$ 38,368	$ 0.02	$ 2,770	$ 0.01
GME payments	$ 10,651,858	$ 5.30	$ 933,491	$ 3.37
Enhanced GME payments	$ 10,571,994	$ 5.26	$ 926,492	$ 3.35
Less: Transplant Carve Outs	$ (1,645,236)	$ (0.82)	$ (200,996)	$ (0.73)
Total Inpatient	**$ 223,067,483**	**$ 111.01**	**$ 7,397,212**	**$ 26.72**
Outpatient	$ 132,188,081	$ 65.78	$ 10,230,042	$ 36.95
Dental Services	$ 8,222,875	$ 4.09	$ 1,384,657	$ 5.00
Less: Dental Carve Out	$ (1,056,619)	$ (0.53)	$ (2,340)	$ (0.01)
Total Dental	**$ 7,166,255**	**$ 3.57**	**$ 1,382,317**	**$ 4.99**
Pharmacy	$ 155,445,678	$ 77.36	$ 19,998,697	$ 72.23
Less: Pharmacy Rebates	$ (38,861,419)	$ (19.34)	$ (4,999,674)	$ (18.06)
Pharmacy Carve Outs	$ (28,256,183)	$ (14.06)	$ (3,848,103)	$ (13.90)
Protease Inhibitor Carve Outs	$ (621,463)	$ (0.31)	$ (3,228)	$ (0.01)
Total Pharmacy	**$ 87,706,612**	**$ 43.65**	**$ 11,147,692**	**$ 40.26**
Physician Related	$ 135,651,820	$ 67.51	$ 9,148,406	$ 33.04
Add: FQHC Cost Settlements	$ 292,070	$ 0.15	$ 21,086	$ 0.08
RHC Cost Settlements	$ 1,476,210	$ 0.73	$ 106,575	$ 0.38
Less: Optical Carve Out	$ (208,157)	$ (0.10)	$ (117)	$ (0.00)
Safe and Care Exams Carve Out	$ (62,108)	$ (0.03)	$ (2,473)	$ (0.01)
DOH Lab Carve Out	$ (21,358)	$ (0.01)	$ (322)	$ (0.00)
Environmental Lead Carve Out	$ (8,060)	$ (0.00)	$ (224)	$ (0.00)
Abortion	$ -	$ -	$ -	$ -
Total Physician	**$ 137,120,418**	**$ 68.24**	**$ 9,272,931**	**$ 33.49**
In-Home Services	$ 1,145,502	$ 0.57	$ 17,038	$ 0.06
Rehab and Specialty Services	$ 13,458,240	$ 6.70	$ 1,428,286	$ 5.16
Mental Health Services	$ 17,439,020	$ 8.68	$ 1,507,776	$ 5.45
State Institutions	$ 34,296,862	$ 17.07	$ 3,580,837	$ 12.93
Less: CPR Carve Out	$ (13,462,242)	$ (6.70)	$ (1,630,485)	$ (5.89)
CSTAR Carve Out	$ (8,601,816)	$ (4.28)	$ (690,954)	$ (2.50)
Targeted Case Management Carve Out	$ (9,850,899)	$ (4.90)	$ (1,096,686)	$ (3.96)
Total State Institutions	**$ 2,381,906**	**$ 1.19**	**$ 162,712**	**$ 0.59**
Less: MH COA 4 Carve Out (I/P, O/P, and Medical)	$ (49,207,268)	$ (24.49)	$ -	$ -
EPSDT Services	$ 86,446,333	$ 43.02	$ 8,329,553	$ 30.08
Less: Therapy Carve Outs	$ (3,167,927)	$ (1.58)	$ (392,186)	$ (1.42)
Less: EPSDT Targeted Case Management	$ (1,156,287)	$ (0.58)	$ 222	$ 0.00
Total EPSDT Services	**$ 82,122,118**	**$ 40.87**	**$ 7,937,589**	**$ 28.67**
TPL Recoveries	$ (32,153,825)	$ (16.00)	$ (2,321,349)	$ (8.38)

FFS Mass Adjustments	$ (9,529,532)	$ (4.74)	$ -	$ -
Prior Qtr Coverage/FFS Window	$ (52,009,203)	$ (25.88)	$ (1,400,238)	$ (5.06)
Geographic Adjustment	$ 26,991,161	$ 13.43	$ 2,245,101	$ 8.11
Administrative Services	$ 26,810,065	$ 13.34	$ 2,609,235	$ 9.42
FFS Grand Total Benchmark Expenditures	$ 614,848,297	$ 305.98	$ 51,616,345	$ 186.41
Average FFS Benchmark Eligibles		167,454		23,074
Annual FFS Benchmark Cost Per Eligible		$ 3,672		$ 2,237
FFS Benchmark PMPM		**$305.98**		**$186.41**

Managed Care Expenditures

	Title XIX Expenditures	Title XIX PMPM	CHIP Expenditures	CHIP PMPM
Managed Care Capitation Payments	$ 899,591,347	$ 204.78	$ 65,283,285	$ 141.30
Managed Care Delivery Payments	$ 78,923,118	$ 17.97	$ 168,638	$ 0.37
Health Plan Target Profit	$ 27,798,706	$ 6.33	$ 1,859,430	$ 4.02
Administrative Costs:				
Health Plan Admin	$ 105,635,084	$ 24.05	$ 7,065,833	$ 15.29
State Managed Care Oversight	$ 19,671,625	$ 4.48	$ 2,099,434	$ 4.54
Total Administrative Costs	**$ 125,306,709**	$ 28.52	**$ 9,165,266**	$ 19.84
Managed Care Reimbursement Allowance	$ (61,045,959)	$ (13.90)	$ (4,083,308)	$ (8.84)
Managed Care Reinsurance Payments	$ -	$ -	$ -	$ -
Managed Care Prior Quarter Coverage/FFS Window	$ 52,009,203	$ 11.84	$ 1,400,238	$ 3.03
Managed Care Mass Adjustments	$ (10,973,736)	$ (2.50)	$ -	$ -
Managed Care Carveouts	$ 116,169,336	$ 26.44	$ 7,868,112	$ 17.03
Managed Care EPSDT Targeted Case Management	$ 1,156,287	$ 0.26	$ (222)	$ (0.00)
Managed Care FQHC Interim Payments	$ 21,455,414	$ 4.88	$ 1,435,133	$ 3.11
Managed Care RHC Interim Payments	$ 6,198,631	$ 1.41	$ 414,621	$ 0.90
Managed Care FQHC Cost Settlements	$ 338,556	$ 0.08	$ 22,646	$ 0.05
Managed Care RHC Cost Settlements	$ 1,712,781	$ 0.39	$ 114,566	$ 0.25
Managed Care Outlier Payments	$ 63,079	$ 0.01	$ 4,219	$ 0.01
Managed Care GME Payments	$ 23,286,868	$ 5.30	$ 1,557,637	$ 3.37
Managed Care Enhanced GME Payments	$ 23,112,273	$ 5.26	$ 1,545,958	$ 3.35
	$ 1,305,102,612	$297.09	$ 86,756,221	$ 187.77
Average Managed Care Eligibles		366,084		38,502
Annual Mgd Care Cost Per Eligible		$ 3,565		$ 2,253
Managed Care PMPM		**$297.09**		**$187.77**
Managed Care Savings	**$ 39,065,851**	**$8.89**	**$ (628,380)**	**($1.36)**
Managed Care Savings %		**3%**		**-1%**

Total Savings	
$	38,437,471
	3%

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