



One Financial Plaza  
501 North Broadway  
Suite 550  
St. Louis, MO 63102-2121  
USA

Tel +1 314 231 3031  
Fax +1 314 231 0249

milliman.com

July 18, 2008

Iowa Department of Human Services  
Bureau of Managed Care and Clinical Services  
Attention: Cynthia Tracy  
100 Army Post Road  
Des Moines, IA 50315

**Re: Iowa Plan Capitation Rate Setting – SFY 2009 Rates**

Dear Ms. Tracy:

Enclosed are the final Iowa Plan ranges of actuarially sound capitation rates for SFY 2009. The rate ranges are actuarially sound by rate cell, as required by CMS. The rates were developed using encounter data provided by Magellan, the community reinvestment expenditures file, and other program information. The rates comply with CMS requirements.

The rates have been based on SFY 2006 data adjusted for program changes and trended forward for utilization and costs. A review of the financial status of Magellan, a common practice in Medicaid rate setting, was also completed.

In order to be consistent with CMS requirements, the actual capitation rate in each rate cell cannot be higher than the upper bound or lower than the lower bound shown in the report. Using the midpoint of the projected rate range, the rates would represent an approximate 0.9% decrease from the midpoint of the SFY 2008 range of rates on an aggregate basis using SFY 2006 enrollment as the weights. The lower end of the range would represent a 7.0% decrease while the upper end would represent a 5.2% increase.

This letter is being provided to Iowa DHS. It is our understanding that this report will be distributed to CMS and potentially to any interested MCO. Any distribution of this report must be in its entirety, including any appendices.

If you have any questions, please let us know.

Sincerely,

A handwritten signature in black ink, appearing to read 'Timothy F. Harris', written over a white background.

Timothy F. Harris, FSA, MAAA  
Principal & Consulting Actuary

**STATE OF IOWA  
IOWA PLAN - MH/SA CAPITATION RATES  
MEDICAID PROGRAM  
STATE FISCAL YEAR 2009**

*Prepared for:*  
**IOWA DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MEDICAL SERVICES**

*Prepared By:*

Milliman, Inc.

Timothy F. Harris, FSA, MAAA  
Bruce M. Bordeaux  
Jeffrey S. French  
Carol E. Hughey, MBA

July 14, 2008

**TABLE OF CONTENTS**

	<b><u>Page</u></b>
I. Introduction.....	1
II. Actuarial Certification .....	2
III. Overview of Rate Setting Methodology .....	3
IV. Summary of Results .....	5
V. Description of Rate Calculations .....	8

Appendix A - SFY 2006 Historical Experience – Aggregate Data

Appendix B – SFY 2006 Historical Experience – Cost Model

Appendix C – Adjustments for Community Reinvestment

Appendix D – Adjustments Other Than Community Reinvestment

Appendix E – Adjustments to Experience and Range of Rates

Appendix F – Summary of Rate Ranges

**I. INTRODUCTION**

Milliman, Inc. (Milliman) was retained by the Iowa Department of Human Services (DHS) to calculate a range of actuarially sound capitation rates for the Iowa Plan for Behavioral Health (Iowa Plan) for SFY 2009. This report presents the results of the calculations and describes the rate setting methodology.

This report is being provided to the Iowa DHS. It is our understanding that this report will be distributed to the Centers for Medicare and Medicaid Services (CMS) and potentially to any interested Managed Care Organization (MCO). It should not be distributed to any other party without our prior written consent. Any distribution of this report must be in its entirety, including any appendices.

The values in this report were developed on behalf of the State of Iowa for use in negotiations with carrier(s) interested in participating in the Iowa Plan program and may not be appropriate for any other purpose. We do not intend to benefit, and assume no liability to, any third party who receives this report.

Milliman has relied on the following data sources as provided by Iowa DHS:

- Prepaid Inpatient Health Plan (PIHP) claims data – SFY 2005 - SFY 2007
- Iowa Medicaid eligibility data – SFY 2005- SFY 2007
- Various Iowa Medicaid program documents
- PIHP financial information
- Additional information including cost estimates relating to program changes from the State and the PIHP provided in conference calls and emails

The values presented are based on a series of historical data and projections. Actual results may differ from the projected values. Although the data was reviewed for reasonableness, Milliman has not audited the data. If the information provided to Milliman was inaccurate or incomplete, this report may need to be revised.

The rates in this report are estimates but not predictions. While we believe the rates to be reasonable, they may not be appropriate for any particular contractor. Before contracting with the State, the contractor should review its own experience and revenue requirements with an actuary or other professional competent in finance and modeling.

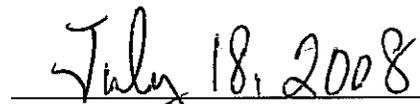
**II. ACTUARIAL CERTIFICATION**

In calculating the rates found in this report, we have followed generally accepted actuarial principles and practices. We believe that the capitation rates developed in this report are appropriate for the populations to be covered and the services to be furnished under the contract.

The actuary certifying these rates meets the qualification standards of the American Academy of Actuaries and follows the standards of practice established by the Actuarial Standards Board. We have relied on historical data, background information, and cost estimates provided to us by the State, the fiscal agent, and the PIHP. We have reviewed the data for reasonableness but have not audited the data. We believe, and certify, that these rates were developed using a methodology that is consistent with the regulation in 438.6 (c) and with the rate checklist released by CMS.

These rates were developed on behalf of the State of Iowa to demonstrate compliance with CMS requirements. We do not certify that these rates are appropriate for any particular MCO. The MCO is advised to conduct its own analysis of experience and revenue requirements before agreeing to contract with the State.

  
\_\_\_\_\_  
Timothy F Harris, FSA, MAAA

  
\_\_\_\_\_  
Date

### **III. OVERVIEW OF RATE SETTING METHODOLOGY**

This section describes, in general, the methodology used to calculate the range of actuarially sound Iowa Plan capitation rates. The results of the calculations are shown in Section IV. A more detailed discussion of the calculations is included in Section V.

The primary data source for the SFY 2009 Iowa Plan rate setting was the Iowa Plan encounter data from SFY 2006 (July 1, 2005 through June 30, 2006). The claims data includes information regarding both the utilization of healthcare services and the cost of those services.

An actuarial model was developed using the SFY 2006 utilization and cost data as the base data in the model. Total eligible months for SFY 2006 were calculated from Iowa Medicaid eligibility data and incorporated into the model to develop utilization per 1,000 eligibles statistics. The equivalent data from SFY 2005 and SFY 2007 was used to estimate the utilization trend rate. A similar trend rate was calculated for average costs.

All utilization and average cost data were summarized into service categories (using the benefit field code) by category of aid, age group, and gender. On May 28, 2008, we were provided with a new B(3) list that was used to determine which services were B(3) and which were Non B(3). The new B(3) list resulted in a change in the base year allocation of services to B(3) and Non B(3) but not to the overall base year costs.

Categories of aid include the following:

- Family Medicaid Assistance Program (FMAP) and FMAP-related
- Supplemental Security Income (SSI) and SSI-related
- Dual Eligibles under age 65
- Foster Care

To calculate the rates, the baseline data was adjusted for the following:

- Claims incurred but not yet paid;
- PIHP administrative expense;
- Utilization and cost trending;
- Community reinvestment;
- Program changes; and
- Managed care.

Consideration was given to other potential adjustments such as copayments and financial experience but these other adjustments were determined to be unnecessary.

To calculate the range of actuarially sound rates for SFY 2009, upper and lower points were determined by using varying degrees of healthcare management (DOHM) for psychiatric and substance abuse services in a Medicaid population.

DOHM is a concept used by Milliman to quantify the expected utilization and average charge of a population based on the extent to which its care is being managed. A 0% DOHM would

indicate a loosely or unmanaged plan while a 100% DOHM would indicate a very well managed plan. A high DOHM would result from the efficient and effective use of multiple cost management programs (pre-admission testing, large case management, concurrent review, etc.) but would also be influenced by such factors as the geographic distribution of the population. There is much judgment involved in determining the appropriate DOHM. The final range of actuarially sound capitation rates reflects this judgment.

The impact of varying degrees of DOHM was based on the Milliman Health Cost Guidelines (HCGs). The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research, and judgment. They provide a flexible but consistent basis for the determination of claim costs and premium rates for a wide variety of health benefit plans. The underlying utilization and charge level assumptions can be characterized as typical of a large group of relatively benefit conscious individuals covered under a comprehensive state Medicaid medical plan. The base assumptions are typically adjusted for age, gender, area, benefit design, etc.

#### IV. SUMMARY OF RESULTS

The calculations used to develop the SFY 2009 capitations are summarized, in aggregate, below.

SFY 2006 paid claims (Non-Community Reinvestment)	\$70,087,938
Adjustments (IBNR, PIHP Administration Costs, Utilization and Cost Trending, Community Reinvestment, Copays, Managed Care, Program Changes, etc)	\$34,421,658
Total SFY 2009 capitations at SFY 2006 enrollment levels (midpoint)	\$104,509,596

The following tables show the midpoints of the SFY 2009 Iowa Plan Medicaid PMPM Capitation Rate Ranges, by rate cell, for services required under the Iowa Plan contract. To allow for separate monitoring of B(3) services, capitation rates for both State Plan services and for B(3) services are included in Table 1-B and Table 1-C, respectively. B(3) costs were based on the B(3) procedure codes provided by the PIHP on May 28, 2008.

Overall, the midpoint of the SFY 2009 actuarially sound range of rates will result in an estimated 0.9% decrease from the midpoint of the SFY 2008 range of rates, while the lower bound of the range would represent a 7.0% decrease and the upper bound would represent a 5.2% increase.

Appendix F provides rates (State Plan, B(3), and Total) for the upper and lower bounds of the actuarially sound range of rates. The lower bound of the range was calculated using a 55% DOHM while the higher bound was calculated using a 35% DOHM. The midpoint of the rate ranges use the current level of management inherent in the encounter data, which is assumed to be 45% for the purposes of calculating the range of rates.

<b>TABLE 1-A IOWA MEDICAID SFY 2009 IOWA PLAN CAPITATION RATE MIDPOINT</b>		
<b>CATEGORY/AGE RANGE</b>	<b>FEMALE</b>	<b>MALE</b>
<b>FMAP 0 – 17</b>	\$8.65	\$10.50
<b>FMAP 18 – 64</b>	32.32	22.42
<b>SSI 0 – 17</b>	31.27	43.87
<b>SSI 18 – 64</b>	105.65	96.90
<b>Dual Eligibles 0 – 64</b>	58.29	64.07
<b>Foster Care 0 – 9</b>	33.86	53.73
<b>Foster Care 10 – 22</b>	145.45	150.57

**TABLE 1-B**  
**IOWA MEDICAID SFY 2009**  
**IOWA PLAN CAPITATION RATE – STATE PLAN SERVICES**  
**MIDPOINT**

CATEGORY/AGE RANGE	FEMALE	MALE
FMAP 0 – 17	\$8.24	\$9.98
FMAP 18 – 64	22.20	19.21
SSI 0 – 17	30.68	42.95
SSI 18 – 64	90.28	84.00
Dual Eligibles 0 – 64	37.08	43.05
Foster Care 0 – 9	33.21	47.58
Foster Care 10 – 22	126.63	134.04

**TABLE 1-C**  
**IOWA MEDICAID SFY 2009**  
**IOWA PLAN CAPITATION RATE – B(3) SERVICES**  
**MIDPOINT**

CATEGORY/AGE RANGE	FEMALE	MALE
FMAP 0 – 17	\$0.41	\$0.52
FMAP 18 – 64	10.12	3.21
SSI 0 – 17	0.59	0.92
SSI 18 – 64	15.37	12.90
Dual Eligibles 0 – 64	21.21	21.02
Foster Care 0 – 9	0.65	6.15
Foster Care 10 – 22	18.82	16.53

The following table compares the expected aggregate capitations using the assumed midpoint of the SFY 2008 rates and the assumed SFY 2009 rates at the SFY 2006 level of enrollment. The composite PMPM rates were calculated using SFY 2006 member months as weights.

<b>TABLE 2 AGGREGATE RESULTS</b>			
	Composite PMPM Rates	SFY 2006 Member Months	Projected Expenditures (Annualized)
SFY 2008 Rates (midpoint)	\$31.27	3,372,228	\$105,465,093
SFY 2009 Rates (midpoint)	\$30.99	3,372,228	\$104,509,596
Increase/Decrease			-0.9%

## V. DESCRIPTION OF RATE CALCULATIONS

The following section describes the steps used to calculate the SFY 2009 Iowa Plan capitation rates.

### 1. Calculate Eligible Months

For the rate setting, eligibility data provided by Iowa DHS was used to determine the total number of months of eligibility for Medicaid recipients meeting the eligibility requirements of the Iowa Plan program. The eligibility data from DHS contained information on all Medicaid recipients for each month of SFY 2005 - SFY 2007. A Medicaid recipient was considered eligible for the Iowa Plan program by month if the recipient was an active enrollee and had a valid alternate delivery indicator. The following table shows the categories of eligibility included in the study along with the appropriate alternate delivery indicator(s).

<b>TABLE 3 IOWA MEDICAID IOWA PLAN ALTERNATE DELIVERY INDICATORS INCLUDED IN EACH RATE CELL</b>	
<b>Category</b>	<b>Alternate Delivery Indicators</b>
FMAP 0 – 17	A, C, E, G
FMAP 18 – 64	B, D, F, H
SSI 0 – 17	J, L, N, Q
SSI 18 – 64	K, M, P, R
DUAL ELIGIBLES 0 – 64	S, T
FOSTER CARE 0 – 9	W
FOSTER CARE 10 – 22	V*, X

\* The age group for code V is 0 – 22; however, the only individuals with this code were in the 10 – 22 category.

Iowa Plan also restricts eligibility to individuals not in the following categories:

- A person who is eligible for Medicaid as a result of spending down excess income (medically needy with a cash spend-down).
- A person living in the Woodward State Hospital-School or the Glenwood State Hospital-School.
- Those whose Medicaid benefit package is limited such as Qualified Medicare Beneficiaries (QMB), Presumptive Eligibles, illegal aliens and others not entitled to the full range of mental health and substance abuse treatment.
- Persons age 65 and older.

Based on discussions with the State and the PIHP, the use of Table 3 above to determine eligibility is presumed to exclude these individuals.

Once calculated, eligible months were summarized by category of aid, age group, and gender. Appendix A summarizes the eligibles by rate cell groupings.

## **2. Calculate Base Historical Encounter Claims**

Iowa Plan SFY 2006 encounter data excluding denied claims was provided by the PIHP for Mental Health/Behavioral Health claims paid through October 7, 2006. Claims for services included in the Iowa Plan program were extracted from this encounter data using the following criteria:

- a. Claims with a beginning date of service between (and including) July 1, 2005 and June 30, 2006.
- b. Claims without a Community Reinvestment code (the cost for Community Reinvestment is included as an adjustment).
- c. Claims where the claimant was determined to be eligible after cross-referencing with the eligibility file. This step removed approximately 0.2% of claim dollars from the base period. Due to mass adjustments that are not tied to individuals, some of these claims were excluded in this step (and the following two steps.) However, this issue was considered immaterial to SFY 2006 as the mass adjustments mainly affected claims incurred in SFY 2005 and SFY 2007. Adjustments to the trend calculations are described below.
- d. Claims for diagnosis codes 290.00 - 309.99 and 311.00 through 314.99. This step removed an additional 0.3% of claim dollars from the base period.
- e. The following codes had additional age restrictions:
  - PMIC – T2048: 17 and under
  - Assertive Community Treatment – H0040: Over 18
  - Community Support Services – H0037: Over 18
  - Intensive Psychiatric Rehab – H2017: Over 18
  - School Based Specialist – H0036: 17 and Under
  - Targeted Case Management – T2022: Over 18
  - Drop-in Center/Clubhouse – H2031: Over 18
  - Co-occurring Disorder – T2023: Over 18
  - CAFAS functioning scale – H0002: 17 and Under
  - PASARR – T2011: Over 18

This step removed an additional 0.1% of claim dollars from the base period.

- f. The Iowa Plan encounter data fell into the service categories shown in Table 4 below. Claims with blank service categories were not removed because both the State and the PIHP are confident that the charge data is accurate and complete. Similarly, claims with procedure codes outside of the range of specified codes were also not removed.

**TABLE 4**  
**IOWA PLAN APPROVED SERVICES**

23 Hour Observation	Level III.1 – Halfway House – SA
ACT/PACT	Level III.5/III.3 – Primary Extended – SA
Clozapine Labs	Level III.7 – Med Monitored Res. – SA
Community Support Services	Level IV – Inpatient – SA
Day Treatment	Mobile Crisis
Emergency Transportation	Non-Emergency Transportation
Home Based Care	Outpatient
Home Psych Nursing	Partial Hospitalization
Inpatient – MH	PMIC
Intensive Outpatient	Residential
Intensive Psych Rehab	Respite
Level I – Outpatient – SA	Subacute
Level II – Intensive Outpatient – SA	Targeted Case Management

The split between B(3) and non-B(3) services was determined using a list of B(3) procedure codes provided by the State and the PIHP on May 28, 2008.

Some mass adjustments were made to the claims as well. These did not have a large impact on the SFY 2006 experience but did significantly affect the SFY 2005 and SFY 2007 experience.

### 3. Develop Cost Model

An actuarial cost model is a tool that allows historical utilization and reimbursement to be interpreted on a per member basis for specific service categories. The development of the cost model used for the Iowa Plan rate calculation is described in this section.

#### Service Categories

The service categories found in the encounter data were used as the major categories into which the encounter data was grouped.

#### Eligible Months

Eligible months represent the total number of months of exposure of the population during the time period. Each beneficiary contributes one member month for each full month of eligibility in the program. Eligible months are calculated for each category of aid, age group, and gender. The tabulated eligible months are shown in Appendix A.

**Utilization Rates per 1,000**

Utilization rates per 1,000 represent the annual (or annualized) number of encounters per 1,000 eligible (exposed) members. The definition of utilization varies by general service category definition.

The calculation of utilization rates per 1,000 is based on the following formula that is used for all service categories:

$$\text{Utilization Rates per 1,000} = \frac{\text{Claim Counts} \times 12 \times 1,000}{\text{Member Months}}$$

**Net Reimbursed Charges**

Net reimbursed charges were based on the “AmtPd” field of the encounter data.

The total reimbursed amount is net of TPL payments. The TPL payments will be collected by the PIHPs. There are no recipient copayments.

**Per Member Per Month**

The per member per month (PMPM) value is calculated using the following formula:

$$\text{PMPM} = \frac{\text{Annual Utilization per 1,000} \times \text{Average NET Reimb. Charges}}{12 \times 1,000}$$

Base year utilization rates, charge data and PMPMs are shown in Appendix B.

**Rating Categories**

The encounter data and eligibility were categorized into rating categories based on the age group, gender and category of aid. These rate cell divisions were created to group individuals with similar expected cost and utilization characteristics together. Because there is a single PIHP contractor, rates for different regions within the state were not created.

The following age/category of aid groups were used for male and female eligibles:

- FMAP 0 through 17 years
- FMAP 18 through 64 years
- SSI 0 through 17 years
- SSI 18 through 64 years
- Dual Eligibles 0 through 64 years
- Foster Care 0 through 9 years
- Foster Care 10 through 22 years

Appendix A contains a summary of the baseline data (SFY 2006) used in the cost model.

**4. Calculate Capitation Rate**

To calculate the capitation rate, the following adjustments were made to the base claims data. All of the adjustments made to the SFY 2006 data are summarized in Appendix E.

**a) Population Biased Selection**

Due to the large number of rate cells, differences in the age and gender mix of the population are taken into account in the enrollment process. Enrollment is mandatory for those eligibility categories identified. No additional adjustment is needed.

**b) Dual Eligibles**

Dual eligibles less than 65 years of age are included in the managed care plan. A separate rate for this population has been calculated.

**c) Spenddown**

Medically Needy individuals with spenddown are not eligible for the managed care program. Therefore, these claims and the associated eligibles have been excluded from the data. No further adjustment is necessary.

**d) Benefit Differences/Program Changes**

Iowa Plan has had numerous program changes since the SFY 2006 base year. Estimates were used to account for these changes in the SFY 2007 (October 1, 2006 – June 30, 2007) and SFY 2008 (July 1, 2007 – June 30, 2008) capitation rate setting. When available, actual expenditures have replaced the estimates used in the prior rate settings. The following table provides a description of each program change and the method undertaken to adjust the rates for the change.

**TABLE 5**  
**IOWA PLAN CHANGES**

Item	Change	Description and Method
1	New Community Reinvestment Services and ACT service were approved (effective 1/06). Note: ACT was to become State Plan service as of July 1, 2007.	The new community reinvestment services were Self-Directed Care, Co-Occurring Disorders, and Child Health Specialty Clinics. A cost impact (\$1,053,995) was originally estimated by the PIHP and the State. Actual expenditures for these new services were \$283,662 in SFY 2007 and \$242,330 in SFY 2008. These actual amounts were added to the trend-adjusted historical costs for community reinvestment services. The costs were allocated to the rate cells according to the SFY 2006 paid amounts for each cell. Note – in the June 25, 2007 report, Council Bluffs ACT was included in this adjustment. As of SFY 2008, ACT was to become a State Plan service. Therefore the Council Bluffs ACT amount (actual paid was \$404,296 in SFY 2007) has been included as a State Plan adjustment. An additional \$53,333 has been added as a State Plan adjustment to account for a payment made to U of I in SFY07.
2	Provider increases (3/06).	A 3% provider cost increase was provided in March 2006 that was not yet fully reflected in the encounter data. An average charge trend of 3% was assumed for this time period.
3	Expansion of diagnostic services (9/06).	The PIHP expanded diagnostic services to provide assessments for persons who requested remedial services (although the remedial services themselves are not covered). An annual cost impact (\$1,161,384) was determined using actual experience and allocated to the rate cells based on the distribution of amounts paid in SFY 2006 for CPT code 90801 – Psychiatric diagnostic interview examination.
4	“LPHAs” involvement in family meetings (11/06).	Related to 3 above, licensed practitioners of the healing arts (LPHAs) who perform these diagnostic services will be involved in family meetings for some of the children. An annual cost impact (\$64,456) was determined using actual experience and allocated to the child rate cells based on the amounts paid for CPT code 90899 – Unlisted psychiatric service or procedure.

5	Change in Foster Care age limit (7/06).	A new coverage group was added to provide coverage to Foster Care children up to age 22 who would otherwise have aged out of the system at 18. Upon review of the experience, costs for foster care children generally increase by age through ages 16-17. Discussion with the PIHP and the State indicated that these new children are expected to have costs similar to the 16-17 year olds. Foster Care children aged 16-17 years old appear to have costs that are greater than the average Foster Care rate for children aged 10-22 years old. According to the State, there are approximately 92 of these children as of November 2006 and it appears to be increasing by 15 children per month. This information was used to estimate that the Foster Care age 10-22 rates should be adjusted 0.9% to account for an increase in the expected number of these higher than average cost individuals.
6	Legislated payment increases to CMHCs, psychiatrists, and mental health hospitalizations (10/06).	Payments to CMHCs, psychiatrists, and hospital costs for mental health hospitalizations are to be made at 100% of cost. Actual annual cost impacts were provided by the PIHP. After accounting for trend, the amounts were \$243,844 for psychiatrists, and \$5,255,080 for inpatient hospitalizations. Actual amounts for CMHCs are not available. An estimate of \$3,710,579 has been made. The increases for CMHCs and psychiatrists were allocated to the rate cells based on amounts paid with a provider type of CMHC and Physician, M.D., respectively. The increases for hospitalizations were allocated to the rate cells based on the sum of amounts paid with a service type of either Inpatient – MH or Level IV – Inpatient – SA.
7	New Service for SFY 2009 was T2023 Webcam Coordination Fee.	An estimate of \$2,000 per month was provided by the PIHP. This amount has been included in the SFY 2009 rates.

e) Administrative Cost Allowance

The PIHP contract includes a 13.8% of premium administrative cost allowance. The adjustment factor applied to claims of 116.01% is calculated as  $1/(1-0.138)$ . This adjustment is shown on Appendix E.

f) Special Populations

No adjustment is made as the population has not significantly changed since the base year. The large number of rate cells mitigates the effect of utilization differences within the population.

g) Eligibility Adjustments

It is our understanding that the eligibility data provided to us already reflects all retrospective eligibility as well as any other adjustments necessary for the member months to parallel the appropriate time period.

h) DSH/GME/IME

Medical education payments and disproportionate share hospital payments have been excluded from the encounter data.

i) Third Party Liability

Because the cost field in the encounter data is net of TPL, no adjustment is necessary. The PIHP is responsible for collecting the TPL payments. The PIHP requires an Explanation of Benefits prior to payment. Should the PIHP receive a TPL payment after their payment, the data is readjusted to reflect the PIHP's cost.

j) Copayments, Coinsurance and Deductibles

The managed care program does not have any cost-sharing so none would be included in the encounter data. No adjustment is made.

k) FQHC and RHC Reimbursement

This is not applicable. No adjustment is necessary.

l) Utilization Adjustment and Cost Trending/Inflation

Trend adjustments were made to the base data to account for changes in price and utilization patterns including intensity, mix of service and technology. Trend adjustments for adjusting the base data from SFY 2006 to the rating period were made based on experience, historical and projected trends as calculated by Milliman's internal data sources, and information provided by the State.

Linear regression on the monthly encounter data for SFY 2005 – SFY 2006 was performed to determine the historical annual utilization trend rates of 0.7%. This calculation was done before any claims were removed due to eligibility, diagnosis, or age restrictions because the mass adjustments would be flagged as ineligible due to the fact that they are not tied to an individual. This issue is immaterial to the SFY 2006 experience but is material to the SFY 2005 experience because there were many more mass adjustments made to the SFY 2005 experience. The figure above includes an adjustment to account for changes in the population distribution among the rate cells between SFY 2005 and SFY 2006. A similar comparison was done for SFY 2006 and SFY 2007 but

was not used directly due to the level of program changes that took place throughout the year.

Only State Plan services were used in these calculations. The trend rate for B(3) services was limited to the trend for State Plan services plus Wraparounds because the calculated rate would have been higher. This State Plan plus Wraparounds trend is greater than the State Plan services only trend rate for a portion of the trending period (see Appendix E).

Based on information provided by the State, an additional 3% was added to the trend factor to account for legislated price increases between SFY 2006 and the October 1, 2006 – June 30, 2007 rating period. Based on information provided by the State, no legislated price increases were implemented for SFY 2008 and 1% for SFY 2009. This was comparable to the average cost trend calculated from the encounter data and other sources.

The resulting trends used in the actuarial model are shown in Appendix E.

m) Post-Eligibility Treatment of Income

This does not affect Iowa’s managed care program. No adjustment has been made.

n) Claims Completion Factor

A claim completion factor of 1.017 was derived from a claim triangulation matrix (run-off method) developed for claims incurred prior to the end of SFY 2006 and paid after October 2006.

o) Other Adjustments

i) Payments and recoupments outside the MMIS system

There have not been any significant payments or recoupments made outside the MMIS system for Non Community Reinvestment Services. Therefore, no adjustment has been made for these services. Community Reinvestment Services are entered into the encounter data as \$1. An adjustment is made to reflect actual costs (see Community Reinvestment adjustment).

ii) Certified match

This does not affect Iowa’s managed care program. No adjustment has been made.

iii) Pharmacy rebates

Pharmaceutical drugs are not included in the managed care plan. Therefore, no adjustment has been made.

iv) Investment income

No adjustment is made.

v) Managed care adjustment

This adjustment was made to the base year data to reflect the effect of healthcare management. The managed care adjustments are based on information in the Guidelines.

We have set the range of actuarially sound capitation rates using three sets of managed care adjustments. The rates at the lower end of the range assume a higher DOHM (55%). The rates at the higher end of the range assume a lower DOHM (35%). The midpoint of the rate range uses the current level of management inherent in the encounter data, which we assume to be 45%.

vi) Financial experience adjustment

Medicaid revenues and expenses as stated in the year-end 2004, 2005, 2006, and 2007 financial statement as well as the quarterly 2007 statements for the Iowa Medicaid PIHP were reviewed. The Medicaid business appears to be moderately profitable. No adjustment is necessary.

vii) PCCM case-management fee deduction

Since there is no PCCM program, no adjustment is necessary.

p) Reinsurance

The PIHP is a limited service organization (LSO) in the state of Iowa. The LSO status is monitored and reviewed by the Iowa Department of Commerce, Division of Insurance. Iowa Administrative Rules require LSOs to maintain an insolvency plan. According to the plan, the LSO must maintain significant positive equity. The solvency requirements are included in the PIHP contract with the State.

q) Community Reinvestment

An adjustment was made to account for the amount of the Community Reinvestment Fund expenses. After removing community reinvestment claims from the encounter data, an adjustment was made in Appendix C to allow for the actual dollars spent in SFY 2006. An adjustment was also made for newly approved community reinvestment services (see Table 5). Note, the ACT CR services were moved to State Plan as of July 1, 2007.

Therefore, the ACT CR costs have been included in the State Plan rate calculation.

r) Smoothing

The SFY 2006 encounter data was reviewed to determine if any large claims by a single individual were distorting the experience. No unexpectedly large claims were found in the SFY 2006 data. Some large claims were found in the SFY 2005 data, although these are attributed to the mass adjustments referred to above.

**Appendix A**  
**SFY 2006 Historical Experience – Aggregate Data**

Appendix B  
SFY 2006 Historical Experience – Cost Model

Appendix C  
Adjustments for Community Reinvestment

**Appendix D**  
**Adjustments Other Than Community Reinvestment**

**Appendix E**  
**Adjustments to Experience and Range of Rates**

Appendix F  
Summary of Rate Ranges