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DIAMOND STATE HEALTH PLAN AND DIAMOND STATE HEALTH PLAN PLUS DATA BOOK

STATE OF DELAWARE
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

JANUARY 31, 2014

MARSH & McLENNAN COMPANIES

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1

Introduction

The purpose of this data book is to provide the State of Delaware's (State) Division of Medicaid and Medical Assistance (DMMA), and other interested parties, summarized historical data on the Medicaid and Children's Health Insurance Program (CHIP) populations eligible for the acute and/or long-term care segments of the State's managed care program. Delaware refers to the acute and long-term care segments of their capitated, risk-based managed care program as Diamond State Health Plan[1] (DSHP) and Diamond State Health Plan Plus (DSHP Plus), respectively.

This data book contains historical fee-for-service (FFS) data, as well as available historical managed care financial experience as reported by existing managed care organizations (MCOs). Additionally, this data book provides information on actuarial adjustments that have been made to the historical data or will be considered in the capitation rate development process. Mercer Government Human Services Consulting (Mercer) produced this data book with assistance from DMMA to support the re-procurement of DSHP and DSHP Plus with new MCO contracts anticipated to take effect on January 1, 2015.

The State's DSHP segment of the managed care program covers acute services for clients not meeting eligibility criteria for DSHP Plus. Beginning April 1, 2012, DSHP Plus expanded the existing managed care program to cover additional populations and long-term care services under full-risk, capitated managed care. With new managed care contracts expected to take effect on January 1, 2015, MCOs will be responsible to cover both the DSHP and DSHP Plus segments of the program under one contract.

In addition to DSHP and DSHP Plus, the State has administered a FFS-based managed care case-management program known as Diamond State Partners (DSP). The DSP program is expected to end June 30, 2014. DSP members eligible for DSHP will be enrolled in MCOs effective July 1, 2014.[2]

Aspects of the DSHP and DSHP Plus program will be described in more detail in subsequent sections of this data book.

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[1] Delaware also includes the State's Title XXI CHIP population in managed care under the same contract as the Title XIX Medicaid population as part of DSHP (i.e., acute care). Therefore, Title XXI and Title XIX individuals are collectively referred to as being part of DSHP in this data book unless a specific reference to CHIP was necessary. CHIP is sometimes referred to as the Delaware Healthy Children Program (DHCP).

[2] Based on current DSP enrollment, there are no DSP enrollees that will be enrolled in DSHP Plus.

The Centers for Medicare & Medicaid Services (CMS) will require DMMA/Mercer to certify that the Medicaid managed care capitation rates are actuarially sound as defined by CMS. This data book was prepared to help DMMA and other interested parties understand the basis for determining the capitation rates for the populations and services covered by DSHP and DSHP Plus. Please note the following items concerning this data book and the rate development process:

- This data book contains both historical FFS and MCO-reported experience.
- Demographic information was obtained from DMMA's eligibility determination system.
- FFS cost and utilization information in this data book was summarized from data obtained from the State.
- Historical MCO experience was summarized from MCO-reported financial statements submitted as part of DMMA's financial reporting requirements (FRRs).
- The vast majority of the data within this data book is from the State's traditional FFS program and MCO financial reports; however, there is a small amount of data derived from the State's DSP program, which is a FFS-based managed care program.
- The DSHP and DSHP Plus capitation rates will be developed using the historical data contained in this data book as well as other data that may become available throughout the rate development process. Please refer to Section 4 and 5 for more information on adjustments made to the data in this data book or adjustments that may be made to the data in the course of rate development.
- Additional supplemental information has been provided as available to support evaluation of proposed program changes or other aspects of the program (please refer to Section 6 for a list of proposed program changes known at this time).
- Please refer to Section 7 for a listing and description of the data exhibits presented in this data book.

In producing this data book, Mercer performed reasonability checks on the data provided by DMMA; however, Mercer did not independently audit the data nor audit the process used by DMMA to provide the data. In Mercer's opinion, the data provided was reasonable and appropriate for the intended purpose.

Please note: DMMA and Mercer continue to review MCO-reported encounter data for completeness and accuracy for use in financial-based analyses and program management. While DMMA and Mercer have chosen not to include historical managed care encounter data in this data book, DMMA places a high level of importance and value in the collection and submission of complete and accurate encounter data for program management and monitoring purposes. In the future, it is expected that encounter data will be used more extensively and could represent the base data for capitation rate development. As partners with the State, DMMA expects contracting MCOs to put forth the necessary efforts to submit complete and accurate encounter data for the State's use.

The user of this data book is cautioned against relying solely on the data contained herein. DMMA and Mercer provide no guarantee, either written or implied, that this data book is 100% accurate or error-free.

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DSHP Populations and Services

DSHP covers acute and behavioral health services for populations not eligible for DSHP Plus. Long-term services and supports are covered under the DSHP Plus segment of the program and will be discussed in Section 3 of this data book. The DSHP populations and services are described below.

DSHP Covered Populations

Individuals eligible for DSHP include the following population groups:

- Temporary assistance to needy families (TANF) adults and children.
- Social Security Income (SSI) adults and children.
- Title XXI CHIP children.
- Pregnant women.
- Uninsured adult population under 100% of poverty (this expansion was effective with Delaware's 1115 waiver in 1996).
- New adult expansion under the federal Affordable Care Act (ACA) up to 138% of poverty (effective January 2014).

Please note that individuals fully dual eligible for Medicaid and Medicare benefits (i.e., full dual eligibles) are not included in DSHP. Full dual eligibles, among other populations, were added to the MCO managed care program with the implementation of DSHP Plus on April 1, 2012.

The complete list of eligibility categories (called "aid categories") that are mandatorily enrolled in DSHP is shown in the following table.

Aid Category	Aid Category Description
01	Medicaid — GA, Non-Grant Regular, Non-Institutionalized
11	Medicaid — SSI Aged, Grant Regular, Non-Institutionalized
20	Medicaid — SSI Aged, 1619b
21	Medicaid — SSI Aged, Non-Grant Regular, Non-Institutionalized
2L	Medicaid — SSI Aged, Non-Grant Lawfully Admitted Aliens
31	Medicaid — SSI Blind, Grant Regular, Non-Institutionalized
41	Medicaid — SSI Blind, Non-Grant Regular, Non-Institutionalized
4L	Medicaid — SSI Blind, Non-Grant Lawfully Admitted Aliens
51	Medicaid — SSI Disabled, Grant Regular, Non-Institutionalized

Aid Category	Aid Category Description
60	Medicaid — SSI Disabled, 1619b
61	Medicaid — SSI Disabled, Non-Grant Regular, Non-Institutionalized
6L	Medicaid — SSI Disabled, Non-Grant Lawfully Admitted Aliens
71	Medicaid — AFDC or Foster Child Grant Regular, Non-Institutionalized
74	Medicaid — AFDC or Foster Child Grant AFDC-Related Foster Child
76	Medicaid — AFDC or Foster Child Grant Non-AFDC Related Foster Child
79	Medicaid — AFDC or Foster Child Grant Cuban, Vietnamese or Other Refugee
81	Medicaid — AFDC or Foster Child Non-Grant Regular, Non-Institutionalized
83	Medicaid — AFDC or Foster Child Non-Grant Percent Poverty (>AFDC)
89	Medicaid — AFDC or Foster Child Non-Grant Cuban, Vietnamese or Other Refugee
8L	Medicaid — AFDC or Foster Child Non-Grant Lawfully Admitted Aliens
8P	Medicaid — AFDC or Foster Child Non-Grant. Infants in private agencies for adoption
8S	Medicaid — AFDC or Foster Child Non-Grant Sanctioned Individuals
8T	Medicaid — AFDC or Foster Child Non-Grant Pregnant Teens
91	Medicaid — GA, Grant Regular, Non-Institutionalized
A1	Medicaid — IV-E Adoption Assistance Regular, Non-Institutionalized
B1	Medicaid — State Adoption Subsidy Regular, Non-Institutionalized
CB	Medicaid — Child, Under 19 Income 160% to 185% of Poverty Level
CC	Medicaid — Child, Under 19 Income 133% to 160% of Poverty Level
CD	Medicaid — Child, Under 19 Income 100% to 133% of Poverty Level
CE	Medicaid — Child, Under 19 Income AFDC Limit to 100% of Poverty Level
CF	Medicaid — Child, Under 19 Income 0 to AFDC Limit
CS	Medicaid — Poverty Infant Tobacco Funds, Income 185% to 200% of Poverty Level
GE	Adult Expansion Medicaid — Adult Income AFDC Limit to 100% of Poverty Level
GF	Adult Expansion Medicaid — Adult Income 0 to AFDC Limit
GG	Adult Expansion Medicaid — Adult GA Medicaid Adults
KI	CHIP — DHCP Level 4 (167% to 200%)
KJ	CHIP — DHCP Level 3 (151% to166%)
KM	CHIP — DHCP Level 2 (134% to 150%)
KQ	CHIP — DHCP Level 1 (up to 133%)
PB	Medicaid — Pregnant Female Income 160% to 185% of Poverty Level
PC	Medicaid — Pregnant Female Income 133% to 160% of Poverty Level
PD	Medicaid — Pregnant Female Income 100% to 133% of Poverty Level
PE	Medicaid — Pregnant Female Income AFDC Limit to 100% of Poverty level

Aid Category	Aid Category Description
PF	Medicaid — Pregnant Female Income 0 to AFDC Limit
PL	Medicaid — Pregnant Female Lawfully Admitted Aliens
PS	Medicaid — Poverty Pregnant Tobacco Funds, Income 185% to 200% of Poverty Level
PT	Medicaid — Poverty Related Pregnant Teen
X1	Childrens Medicaid MAGI Based
X2	Childrens Medicaid (CHIP Funded) MAGI-Based
X3	Pregnancy Medicaid MAGI-Based
X4	Adult Medicaid (Expanded Funding) MAGI-Based
X5	Adult Medicaid MAGI-Based
X6	Parent/Caretaker Medicaid MAGI-Based
X7	Former Foster Care Non-MAGI

DSHP Actuarial Rate Tier Configuration

The actuarial rate tiers for DSHP consolidate all of the aid categories listed in the previous table into different rate tiers for purposes of monthly capitation payment. Delaware also uses a maternity payment to compensate MCOs for the risk of a live birth outcome for MCO members. Medicare dual status also factors into the DSHP rate tier structure as full-benefit dual eligibles are mandatorily enrolled in DSHP Plus, which is addressed in Section 3 of this data book. The configuration of the DSHP rate tiers is shown below:

DSHP Rate Tier	Aid Categories	Gender	Age
TANF Newborns	71, 74, 76, 79, 81, 83, 89, 8L, 8P, 8S, 8T, 91, A1, B1, CB, CC, CD, CE, CF, CS, PB, PC, PD, PE, PF, PL, and X1	Male and Female	Under age 1 year
TANF Children	01, 71, 74, 76, 79, 81, 83, 89, 8L, 8P, 8S, 8T, 91, A1, B1, CB, CC, CD, CE, CF, CS, PB, PC, PD, PE, PF, PL, PS, PT, X1, X3 and X6	Male and Female	Age 1 through 17 years old
TANF Adults	71, 74, 76, 79, 81, 83, 89, 8L, 8P, 8S, 8T, A1, B1, CB, CC, CD, CE, CF, PB, PC, PD, PE, PF, PL, PS, PT, X3, X6, and X7	Male and Female	Age 18 years and older
Waiver Expanded (≤ 100% Federal Poverty Level [FPL])	01, 91, GE, GF, GG, and X4	Male and Female	All applicable ages
SSI	11, 20, 21, 2L, 31, 41, 4L, 51, 60, 61 and 6L	Male and Female	All applicable ages

DSHP Rate Tier	Aid Categories	Gender	Age
CHIP	KI, KJ, KM, KQ and X2. X2 is a new aid category code that will be used to designate CHIP kids who switched to Medicaid status per the ACA.	Male and Female	All applicable ages
ACA Expansion 19–49 Females (> 100–138% FPL)	X5	Female	Age 19 through 49 years old
ACA Expansion 19–49 Male (> 100–138% FPL)	X5	Male	Age 19 through 49 years old
ACA Expansion 50–64 (> 100–138% FPL)	X5	Male and Female	Age 50 through 64 years old
Maternity Care Payment	Any applicable aid category	Female	All applicable ages

All rate tiers, except the three ACA expansion tiers, are developed and paid separately for enrollees in each of Delaware's three counties: New Castle, Kent, and Sussex based on county of residence. The three ACA expansion rate tiers are developed and paid on a statewide level. This structure may be evaluated and modified in the future.

The maternity care payment is made for women delivering in all categories of aid and one payment is made per live birth delivery (C-section or vaginal), regardless of the number of births. The maternity payment is a lump-sum payment intended to reflect the risk of only the mother's claims 90 days prior to the delivery and the delivery event.

Excluded Populations

DSHP Plus includes additional populations that are not covered under DSHP. However, there are several distinct populations excluded from managed care altogether. Populations excluded from the managed care program include the following:

- Community-based individuals who meet ICF/MR level of care (under the DDDS/MR 1915c Waiver).
- Individuals residing in ICF/MRs (i.e., Stockley Center and Mary Campbell Center).
- Individuals who meet the Federal definition of an "inmate of a public institution," unless the individual is an inpatient in a hospital other than the State Department of Corrections (DOC) infirmary per the exception permitted under 42 CFR 435.1010.
- Aliens who are only eligible for Medicaid to treat an Emergency Medical Condition under Section 1903(v)(2) of the Social Security Act.
- Adults eligible for Delaware Medicaid who were residing outside of the State of Delaware in a nursing facility as of April 1, 2012 as long as they remain in an out-of-state facility.
- Individuals who choose to participate in PACE.

- Individuals receiving Medicare cost sharing only (i.e., Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries, Qualifying Individuals and Qualified and Disabled Working Individuals).
- Presumptively eligible pregnant women.
- Individuals in the Breast and Cervical Cancer Program for Uninsured Women.
- Individuals in the 30 Day Acute Care Hospital Program.
- Individuals eligible only for programs paid for by State general funds (e.g., Chronic Renal Disease Program, Delaware Prescription Assistance Program).

DSHP Covered Services

For individuals covered by DSHP, the MCOs will have responsibility for the coordination and provision of an array of acute and behavioral health services per the managed care contract. The MCOs have the ability to develop creative and innovative solutions to care for their members (i.e., provide other cost-effective services) as long as the contractually required Medicaid services are covered.

The following table provides a summary of the medical services DSHP members are eligible for and the MCOs will be contractually responsible to provide and effectively coordinate. Users of this data book seeking more information on DSHP services should refer to information concerning the DSHP benefit package in the MCO contract.

General Category of Service
Inpatient Hospital
Nursing Facility (limited number of days)
Institute for Mental Disease (IMD) Facilities
Family Planning Services
Outpatient Hospital and Other Clinics
Emergency Room
Physicians/Specialists
Mental Health and Substance Use Disorder Services[3]
Home Health Care
Hospice
Therapy Services
Durable Medical Equipment (DME) and Supplies
Lab and Radiology
Private Duty Nursing
Ambulance

[3] For certain adults participating in the State's PROMISE behavioral health program, the State will cover some behavioral health services via FFS.

General Category of Service
Pharmacy
School-Based Wellness Center Clinics

Services Excluded from or Limited in DSHP

The following services are either excluded from DSHP or the MCOs will have limited responsibility. Please refer to the MCO contract for more information on benefits provided by the State:

- Dental services for children, other than oral surgery, are excluded from DSHP.
- Day habilitation services for individuals with DD, provided under the Rehab Option.
- Prescribed pediatric extended care (PPEC) services for children with severe disabilities.
- Specialized services for nursing facility residents.
- Employment services and related supports provided through the Pathways program for eligible individuals.
- Non-emergency medical transportation.[4]
- Certain behavioral health/substance abuse services applicable to adults participating in the State's new PROMISE program.[5]

For the FFS wraparound services, the State will reimburse the billing provider directly. Although the MCOs are not responsible for directly furnishing wraparound services, the MCOs will be responsible for coordinating the overall delivery of care with both participating and non-participating providers and State personnel whenever one of its members requires Medicaid benefits provided by the State consistent with the requirements of the managed care contract.

[4] CHIP kids receive the same benefit package as Medicaid except non-emergency medical transportation is not a covered service under the State's CHIP Title XXI program.

[5] Refer to MCO contract for more details on the responsibilities of the MCO to coordinate with the PROMISE program.

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DSHP Plus Populations and Services

DSHP Plus covers additional populations and services not covered under DSHP.

DSHP Plus Covered Populations

The DSHP Plus covered populations are comprised of two main groups:

- Individuals who meet the State's medical and financial requirements for Medicaid institutional level-of-care; or
- Individuals who do not meet the State requirements for Medicaid institutional level-of-care, but satisfy other requirements for inclusion under DSHP Plus.

Within these two main population groups, individuals may or may not also have benefits through the separate federal Medicare program under Part A, B, or D. One of the objectives of DSHP Plus is to integrate Medicare and Medicaid services to achieve a better coordinated system of care. While DSHP Plus does not change or impact Medicare, it is a step in the direction of creating a more organized and simplified system of care for consumers. Accordingly, individuals who are dually entitled to and receive health care benefits through both Medicare and Medicaid are included in DSHP Plus. Because of their eligibility to obtain medical services through both Medicare and Medicaid, these individuals are commonly referred to as "full-benefit dual eligibles".[6] Conversely, individuals who do not have Medicare benefits are often referred to as "non-dual eligibles". For purposes of this data book and the resulting DSHP Plus capitation rates, an individual is considered a full-benefit dual eligible if the individual has Medicaid and any combination of Medicare coverage under Part A, B, or D.

Specific individuals who meet the State's Medicaid requirements for institutional level-of-care are included in DSHP Plus and were identified in the historical FFS data as either:

- A resident of a nursing facility (NF), including pediatric nursing facilities.
- A participant in either the State's Elderly & Physically Disabled (E&D) waiver or AIDS HCBS waiver.[7]

[6] Individuals with Medicare, who are not entitled to Medicaid's medical services benefits, may still obtain some limited assistance from Medicaid in paying Medicare's premiums, deductibles, and/or cost sharing. These individuals are commonly referred to as partial dual eligibles and are excluded from DSHP Plus.

[7] Under an 1115 waiver amendment, the State subsumed operating authority for the respective E&D and AIDS waiver programs under the 1115 waiver and; therefore, separate 1915(c) HCBS waiver authorities are no longer needed.

- Eligible under aid category D1-Limited Long-Term Care. Individuals with aid category D1 are NF residents, but are ineligible for Medicaid payment of the NF residential costs (e.g., room and board) due to a penalty period for asset transfers. After the penalty period is satisfied, the individual will transition to a different aid category as applicable. There were very few individuals under aid category D1 in the historical FFS data.

Prior to December 2010, the State operated three separate HCBS waivers serving the E&D: E&D, Assisted Living, and Acquired Brain Injury. In December 2010, the State received permission from CMS to consolidate these three HCBS waivers into one waiver, referred to as the E&D waiver. Throughout this data book, unless otherwise specified, any reference to the E&D waiver is a reference to these three HCBS waivers, collectively.

Individuals in DSHP Plus who do not meet the State's requirements for institutional level-of-care are often referred to as a "community well" group because these individuals do not receive the Medicaid-funded long-term services and supports (LTSS) that the E&D population receive. The term "community well" is only used to help in distinguishing the level-of-care population from the non-level-of-care population, and is not meant to imply that individuals who do not or have not yet satisfied the State's requirements for institutional level-of-care, are not in need of intensive Medicaid services and supports. Individuals who do not meet the State's institutional level-of-care need criteria and were not already enrolled in DSHP were part of the April 1, 2012 DSHP Plus implementation. These individuals were identified in the historical FFS data as one of the following:

- A full-benefit dual eligible who was not in a nursing home, E&D HCBS waiver, or AIDS HCBS waiver; or
- Eligible for Medicaid benefits under the Medicaid for Workers with Disabilities (MWD), regardless of dual eligibility status; or
- Individuals with aid category D1-Limited Long-Term Care regardless of dual eligibility status

A key financial difference between the institutional level-of-care need and community well populations is the relative impact Medicare has in paying for certain services. Medicare primarily covers only preventive and acute services (e.g., hospital, physician and pharmacy services), but Medicare provides very little (if any) coverage for long-term care services such as extended care in a NF, or the type of HCBS that were available under the State's E&D or AIDS waiver programs. Furthermore, for services that may be eligible for payment by both Medicare and Medicaid, Medicare pays first and then Medicaid pays the co-insurance and deductible; for Medicare Part B claims, Medicaid pays the difference between what Medicare paid and the Medicaid allowable amount, if greater than the Medicare allowed amount.[8] Therefore, the impact of Medicare in reducing the Medicaid expenditures is most pronounced in the community well population group, because this group does not receive the type of Medicaid-funded LTSS that would typically create a large average expenditure. Conversely,

[8] Medical services that are potentially subject to payment by both Medicare and Medicaid are commonly referred to as "cross-over" claims. The MCOs are responsible for cross-over claims in DSHP Plus.

the institutional level-of-care need population has a disproportionately higher share of LTSS paid for by Medicaid and, thus, a relatively high average cost.

The complete list of Medicaid aid categories that are mandatorily enrolled in DSHP Plus is shown in the following table. Note: nearly all of the non-institutionalized and non-HCBS waiver aid categories (e.g., 11, 51, 60, 61, and 71) are included in the DSHP program if the individual does not have Medicare coverage.[9] Full benefit duals with these aid categories are included as part of DSHP Plus.

Aid Category	Aid Category Description
01	Medicaid — GA, Non-Grant Regular, Non-Institutionalized
11	Medicaid — SSI Aged, Grant Regular, Non-Institutionalized
12	Medicaid — SSI Aged, Grant Institutionalized
17	Medicaid — SSI Aged, Grant Elderly/Disabled HCBS Waiver
1A	Medicaid — SSI Aged, Grant AIDS HCBS Waiver
1V	Medicaid — SSI Aged, Grant Assisted Living HCBS Waiver
20	Medicaid — SSI Aged, 1619B
21	Medicaid — SSI Aged, Non-Grant Regular, Non-Institutionalized
22	Medicaid — SSI Aged, Non-Grant Institutionalized
27	Medicaid — SSI Aged, Non-Grant Elderly/Disabled HCBS Waiver
28	Medicaid — SSI Aged, Non-Grant Institutionalized (>SSI)
2A	Medicaid — SSI Aged, Non-Grant AIDS HCBS Waiver
2L	Medicaid — SSI Aged, Non-Grant Lawfully Admitted Aliens
2V	Medicaid — SSI Aged, Non-Grant Assisted Living HCBS Waiver
31	Medicaid — SSI Blind, Grant Regular, Non-Institutionalized
32	Medicaid — SSI Blind, Grant Institutionalized
41	Medicaid — SSI Blind, Non-Grant Regular, Non-Institutionalized
42	Medicaid — SSI Blind, Non-Grant Institutionalized
48	Medicaid — SSI Blind, Non-Grant Institutionalized (>SSI)
4L	Medicaid — SSI Blind, Non-Grant Lawfully Admitted Aliens
51	Medicaid — SSI Disabled, Grant Regular, Non-Institutionalized
52	Medicaid — SSI Disabled, Grant Institutionalized
57	Medicaid — SSI Disabled, Grant Elderly/Disabled HCBS Waiver
5A	Medicaid — SSI Disabled, Grant AIDS HCBS Waiver
5V	Medicaid — SSI Disabled, Grant Assisted Living HCBS Waiver

[9] The J-series and D1 aid categories are excluded from DSHP, regardless of dual status.

Aid Category	Aid Category Description
60	Medicaid — SSI Disabled, 1619B
61	Medicaid — SSI Disabled, Non-Grant Regular, Non-Institutionalized
62	Medicaid — SSI Disabled, Non-Grant Institutionalized
67	Medicaid — SSI Disabled, Non-Grant Elderly/Disabled HCBS Waiver
68	Medicaid — SSI Disabled, Non-Grant Institutionalized (>SSI)
6A	Medicaid — SSI Disabled, Non-Grant AIDS HCBS Waiver
6L	Medicaid — SSI Disabled, Non-Grant Lawfully Admitted Aliens
6V	Medicaid — SSI Disabled, Non-Grant Assisted Living HCBS Waiver
71	Medicaid — AFDC Or Foster Child Grant Regular, Non-Institutionalized
74	Medicaid — AFDC Or Foster Child Grant AFDC-Related Foster Child
76	Medicaid — AFDC Or Foster Child Grant Non-AFDC Related Foster Child
79	Medicaid — AFDC Or Foster Child Grant Cuban, Vietnamese Or Other Refugee
81	Medicaid — AFDC Or Foster Child Non-Grant Regular, Non-Institutionalized
82	Medicaid — AFDC Or Foster Child Non-Grant Institutionalized
83	Medicaid — AFDC Or Foster Child Non-Grant Percent Poverty (>AFDC)
89	Medicaid — AFDC Or Foster Child Non-Grant Cuban, Vietnamese Or Other Refugee
8L	Medicaid — AFDC Or Foster Child Non-Grant Lawfully Admitted Aliens
8P	Medicaid — AFDC Or Foster Child Non-Grant Infants In Private Agencies For Adoption
8S	Medicaid — AFDC Or Foster Child Non-Grant Sanctioned Individuals
8T	Medicaid — AFDC Or Foster Child Non-Grant Pregnant Teens
91	Medicaid — GA, Grant Regular, Non-Institutionalized
9G	Medicaid — GA First Health
A1	Medicaid — IV-E Adoption Assistance Regular, Non-Institutionalized
B1	Medicaid — State Adoption Subsidy Regular, Non-Institutionalized
B2	Medicaid — State Adoption Subsidy, Institutionalized
CB	Medicaid — Child, Under 19 Income 160% To 185% Of Poverty Level
CC	Medicaid — Child, Under 19 Income 133% To 160% Of Poverty Level
CD	Medicaid — Child, Under 19 Income 100% To 133% Of Poverty Level
CE	Medicaid — Child, Under 19 Income AFDC Limit To 100% Of Poverty Level
CF	Medicaid — Child, Under 19 Income 0 To AFDC Limit
CS	Medicaid — Poverty Infant Tobacco Funds, Income 185% To 200% Of Poverty Level
D1	Medicaid — Limited Long Term Care Medicaid
J1	MWD Level 1 (Up To 100% FPL)
J2	MWD Level 2 (101–125% FPL)

Aid Category	Aid Category Description
J3	MWD Level 3 (126–150% FPL)
J4	MWD Level 4 (151–175% FPL)
J5	MWD Level 5 (176–200% FPL)
J6	MWD Level 6 (201–225% FPL)
J7	MWD Level 7 (226–250% FPL)
J8	MWD Level 8 (251–275% FPL)
PB	Medicaid — Pregnant Female Income 160% To 185% Of Poverty Level
PC	Medicaid — Pregnant Female Income 133% To 160% Of Poverty Level
PD	Medicaid — Pregnant Female Income 100% To 133% Of Poverty Level
PE	Medicaid — Pregnant Female Income AFDC Limit To 100% Of Poverty Level
PF	Medicaid — Pregnant Female Income 0 To AFDC Limit
PL	Medicaid — Pregnant Female Lawfully Admitted Aliens
PS	Medicaid — Poverty Pregnant Tobacco Funds, Income 185% To 200% Of Poverty Level
PT	Medicaid — Poverty Related Pregnant Teen
W1	Acquired Brain Injury HCBS Waiver Regular, Non-Institutionalized
W2	Acquired Brain Injury HCBS Waiver Institutionalized
X1	Childrens Medicaid MAGI Based
X2	Childrens Medicaid (CHIP Funded) MAGI-Based
X3	Pregnancy Medicaid MAGI-Based
X6	Parent/Caretaker Medicaid MAGI-Based
X7	Former Foster Care Non-MAGI

DSHP Plus Actuarial Rate Tier Configuration

The actuarial rate tiers for the DSHP Plus program consolidate all of the aid categories listed in the previous table into different rate tiers that the State uses for monthly capitation payment purposes. Medicare dual status also factors into the rate tier structure. The aid categories and dual status included in each respective DSHP Plus rate tier are shown below:

DSHP Plus Rate tier	Aid categories	Gender	Age	Dual Status
NF/HCBS Dual	12, 22, 28, 32, 42, 48, 52, 62, 68, 82, 1V, 2V, 5V, 6V, W1, W2, 1A, 2A, 5A, 6A, 17, 27, 57, and 67	Male and Female	All applicable ages	Dual: Any combination of Medicare Part A, B, or D.
NF/HCBS Non-Dual	12, 22, 28, 32, 42, 48, 52, 62, 68, 82, 1V, 2V, 5V, 6V, W1, W2, 1A, 2A, 5A, 6A, 17, 27, 57, and 67	Male and Female	All applicable ages	Non-Dual: Does not have any combination of Medicare Part A, B, or D.
Community Well	All other aid categories eligible for DSHP Plus	Male and Female	All applicable ages	Have coverage under Medicare Part A, B, or D, except for the J-series or D1 aid categories. J-series or D1 aid categories may or may not have Medicare coverage.

Excluded Populations

DSHP Plus includes additional populations that are not covered under DSHP. However, there are several distinct populations excluded from managed care altogether. As noted previously, populations excluded from the managed care program include the following:

- Community-based individuals who meet ICF/MR level of care (under the DDDS/MR 1915c Waiver).
- Individuals residing in ICF/MRs (i.e., Stockley Center and Mary Campbell Center).
- Individuals who meet the Federal definition of an “inmate of a public institution,” unless the individual is an inpatient in a hospital other than the State Department of Corrections (DOC) infirmary per the exception permitted under 42 CFR 435.1010.
- Aliens who are only eligible for Medicaid to treat an Emergency Medical Condition under Section 1903(v)(2) of the Social Security Act.
- Adults eligible for Delaware Medicaid who were residing outside of the State of Delaware in a nursing facility as of April 1, 2012 as long as they remain in an out-of-state facility.
- Individuals who choose to participate in PACE.
- Individuals receiving Medicare cost sharing only (i.e., Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries, Qualifying Individuals and Qualified and Disabled Working Individuals).
- Presumptively eligible pregnant women.
- Individuals in the Breast and Cervical Cancer Program for Uninsured Women.
- Individuals in the 30 Day Acute Care Hospital Program.
- Individuals eligible only for programs paid for by State general funds (e.g., Chronic Renal Disease Program, Delaware Prescription Assistance Program).

DSHP Plus Covered Services

For individuals covered by DSHP Plus, the MCOs will have responsibility for the coordination and provision of an array of Medicaid acute, behavioral health, and LTSS. This data book includes historical cost and utilization data on the Medicaid services that the MCOs are responsible for in DSHP Plus.

The following table lists the Medicaid services included in this data book. Users of this data book seeking more information on DSHP Plus services should refer to information concerning the DSHP Plus benefit package in the MCO contract. For DSHP Plus members, the MCOs will cover all the same acute/behavioral health services as in DSHP (i.e., the DSHP benefit package). Additionally, the MCOs will be responsible for the provision and effective coordination of Medicaid LTSS (i.e., the DSHP Plus LTC benefit package) for the DSHP Plus populations, respectively, per the requirements of the managed care contract. The MCOs have the ability to develop creative and innovative solutions to care for their members (i.e., provide other cost-effective services) as long as the contractually required Medicaid services are covered.

General Category of Service
DSHP benefit package
Additional Medicaid LTSS (for applicable populations)
Nursing Facility (beyond DSHP benefit package limit)
Home- and Community-Based Services
Transitional support services*
Adult day services
Assisted living
Case management
Cognitive services
Day habilitation services
Medical equipment and supplies
Personal care/homemaker services**
Personal emergency response systems**
Respite care services**
Support for participant direction (for personal care services)**
Home modifications***
Home-delivered meals***
Mental health services
Supplemental nutrition (HIV/AIDS-related)

* Transitional support services are a service that began with the implementation of DSHP Plus for individuals who transition from a nursing home to the community. No historical FFS experience data is available for this service. An adjustment will be made in the rate development process.

** Under the State's FFS program, these services were not available to assisted living residents because most of these services were already provided by assisted living staff.

*** Home modifications and home-delivered meals are new services that began with the implementation of DSHP Plus. No historical FFS experience data is available for this service.

Medicaid Services Excluded from or Limited in DSHP Plus

Consistent with DSHP, the following services are either excluded from DSHP Plus or the MCOs will have limited responsibility. Please refer to the MCO contract for more information on benefits provided by the State:

- Dental services for children, other than oral surgery, are excluded from DSHP.
- Day habilitation services for individuals with DD, provided under the Rehab Option.
- Prescribed pediatric extended care (PPEC) services for children with severe disabilities.
- Specialized services for nursing facility residents.
- Employment services and related supports provided through the Pathways program for eligible individuals.
- Non-emergency medical transportation.
- Certain behavioral health/substance abuse services applicable to adults participating in the State's new PROMISE program.

For the FFS wraparound services, the State will reimburse the billing provider directly. Although the MCOs are not responsible for directly furnishing wraparound services, the MCOs will be responsible for coordinating the overall delivery of care with both participating and non-participating providers and State personnel whenever one of its members requires Medicaid benefits provided by the State consistent with the requirements of the managed care contract.

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Adjustments Reflected in this Data Book

As noted previously, this data book contains a variety of data exhibits from different sources including:

- Financial report data from the existing Delaware MCOs.
- Historical FFS claims and eligibility data.
- Demographic data from the State's eligibility data.

Depending on the data source, the data exhibits referenced in Section 7 may or may not reflect adjustments for purposes of rate development. Adjustments made to the data exhibits in Section 7 are described below. For purposes of rate development, other adjustments may be made or considered as described in Section 5.

MCO Financial Summary Exhibits

The managed care experience data provided in Exhibits 1 through 4 have not been adjusted. The data is as-reported by the two existing MCOs pursuant to the State's financial reporting requirements. Data from both MCOs were combined for display purposes. Please note: The MCO-reported financials include incurred claim values based on incurred but not reported (IBNR) estimates as determined by the MCOs. IBNR calculations are typically based on some level of aggregated data rather than by detailed financial reporting cells. Negative expenses usually are the result of having to prorate IBNR adjustments for prior periods that were evaluated on an aggregated basis, to several financial reporting cells. As a result of this prorating process, a negative amount for particular service line for the current report may be shown. These situations, if applicable, are reflected in the summarized financial experience.

FFS Claims and Eligibility Exhibits

The following adjustments have been made to the historical FFS data contained in Exhibits 5a through 5g which are only applicable to DSHP Plus rate development.

- The State occasionally adjusts provider payments through the use of refunds. The historical FFS claims data contained a field that documented these refund amounts. Upon advice from DMMA, Mercer reduced the Medicaid paid amount by the respective refund amount to more accurately reflect the State's cost of providing services.
- Data associated with individuals and services not included in DSHP Plus were excluded (i.e., claims experience and member months).

- The total FFS paid dollars in the NF and institution and hospice categories of service have been "grossed up" by the applicable patient pay amount (i.e., patient liability). Most of these patient pay amounts are in the NF and institution category.
  - The State will deduct the member-specific patient pay amount from the gross DSHP Plus capitation rates applicable to the applicable institutional individuals at the time capitation payments are processed.
  - The amount of NF and institution and hospice patient pay that is included in the total paid dollars is shown on each data book exhibit, respectively.
  - As noted in Section 5, an adjustment will be made to add the historical value of the applicable patient pay amounts for E&D and AIDS HCBS waiver participants in the rate development process.
- Because the Carvel Center is now closed, historical claims dollars for the Carvel Center were adjusted to be consistent with the State-operated Delaware Hospital for the Chronically Ill.
- Certain institutional cross-over claims in the historical FFS data period were incorrectly paid by the State. Based on information provided by DMMA, adjustments were made to the FFS paid amount to reflect a more accurate Medicaid payment level.
- This data book summarizes claims according to the date of service and reflects payments and claims processed through December 1, 2012. Therefore, the data were not complete due to lag time in claims receipt and/or payment. Therefore, based on an analysis of the historical FFS data, the following monthly completion factors were developed. Both the dollars and units in each service group were adjusted using the following completion factors (applied by dividing the dollars and units by the respective completion factor).

Month of Service	Inpatient	Nursing Facility	Professional	Outpatient
January 2009	100.00%	100.00%	100.00%	100.00%
February 2009	100.00%	100.00%	100.00%	100.00%
March 2009	100.00%	100.00%	100.00%	100.00%
April 2009	100.00%	100.00%	100.00%	100.00%
May 2009	100.00%	100.00%	100.00%	100.00%
June 2009	100.00%	100.00%	100.00%	100.00%
July 2009	100.00%	100.00%	100.00%	100.00%
August 2009	100.00%	100.00%	100.00%	100.00%
September 2009	100.00%	100.00%	100.00%	100.00%
October 2009	100.00%	100.00%	100.00%	100.00%
November 2009	100.00%	100.00%	100.00%	100.00%
December 2009	99.45%	100.00%	100.00%	100.00%
January 2010	99.44%	100.00%	100.00%	100.00%
February 2010	99.44%	100.00%	100.00%	100.00%

Month of Service	Inpatient	Nursing Facility	Professional	Outpatient
March 2010	99.43%	100.00%	100.00%	100.00%
April 2010	99.35%	100.00%	100.00%	100.00%
May 2010	99.35%	99.99%	100.00%	100.00%
June 2010	99.34%	99.99%	100.00%	100.00%
July 2010	96.42%	99.99%	100.00%	100.00%
August 2010	96.36%	99.99%	100.00%	100.00%
September 2010	96.35%	99.99%	99.99%	100.00%
October 2010	96.34%	99.98%	99.99%	100.00%
November 2010	96.29%	99.98%	99.99%	99.97%
December 2010	96.14%	99.98%	99.98%	99.96%
January 2011	95.97%	99.98%	99.97%	99.95%
February 2011	95.89%	99.98%	99.96%	99.92%
March 2011	95.77%	99.98%	99.95%	99.90%
April 2011	95.68%	99.97%	99.94%	99.88%
May 2011	95.41%	99.97%	99.93%	99.85%
June 2011	95.29%	99.97%	99.90%	99.80%
July 2011	95.15%	99.95%	99.88%	99.71%
August 2011	94.86%	99.94%	99.84%	99.65%
September 2011	94.44%	99.92%	99.78%	99.61%
October 2011	93.20%	99.90%	99.72%	99.49%
November 2011	92.77%	99.88%	99.59%	99.36%
December 2011	92.09%	99.85%	99.42%	99.13%

Population/Demographic Data Exhibits

The data provided in Exhibits 6 and 7 have not been adjusted. These exhibits display various person counts and/or member months for the various populations eligible for and/or enrolled in DSHP or DSHP Plus.

School-Based Wellness Center Exhibit

The FFS data provided in Exhibit 8 provides historical FFS claims data for school-based wellness center services applicable to the populations eligible for DSHP or DSHP Plus. This FFS data has not been adjusted. Historical FFS claims data is limited on this service due to payment policy changes made by the State that render older months of service not representative of current risk or spending levels.

Pharmacy Exhibit

The FFS data provided in Exhibits 10a and 10b provides historical FFS pharmacy claims data applicable to the populations eligible for DSHP or DSHP Plus. The FFS data has not been adjusted. The State's FFS pharmacy rebates have not been deducted from this data; the FFS dollars are gross of the State's rebates.

Risk Adjustment Prevalence Exhibits

Exhibits 11a through 11c provide aggregate results from two recent runs of the State's risk-adjustment process for applicable DSHP populations. No adjustments have been made to these exhibits except to remove any MCO-specific information.

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Adjustments in the Capitation Rate Development Process

This section describes the adjustments that Mercer anticipates considering and making, as necessary, in the rate development process to ensure the final rate ranges are actuarially sound and reflect the State's policies for DSHP and DSHP Plus. Additionally, as applicable DMMA and Mercer intend to further adjust the final actuarially sound capitation rates to reflect MCO-specific risk.

DSHP Rate Development Adjustments

DSHP capitation rates for calendar year 2015 will be based on historical, Delaware managed care experience data (e.g., MCO financial data and/or encounter data) for the applicable populations and services. The following list of adjustments has not been reflected in this data book but will be considered in the rate development process for DSHP:

- Adjustment for adult behavioral health inpatient and outpatient services that exceeded the MCOs' coverage limit that was historically in place. Effective January 1, 2015, there will be no limit on the number of behavioral health inpatient and outpatient services covered by the MCOs for adults.
- Mercer will consider the potential impact of the State's new PROMISE program on the cost and/or utilization of services covered by the MCOs.
- Mercer will review MCO IBNR estimates included within the MCO-reported financial experience and may make adjustments to the data as deemed appropriate.
- Based on a review of MCO-reported financial experience by category of service, Mercer may shift expenses between service categories to improve reporting alignment between the MCOs and improve the data overall in total (budget neutral adjustment).
- Mercer will exclude maternity expenses from the DSHP non-maternity rate tiers in the MCO-reported financial experience and include them in the development of the DSHP maternity payment (budget neutral adjustment).
- MCO-reported financial experience will be adjusted to reflect the "net cost of reinsurance" (premiums less recoveries) reported within the financials to account for high cost claims.
- MCO-reported financial experience may be adjusted to account for funds MCOs collected from third party payers after the initial payment was recorded to reflect the ultimate financial responsibility of the MCOs.
- Expenses related to non-State Plan approved services, such as vision hardware for adults, will be removed from MCO-reported financial experience unless deemed to be a cost-effective in lieu of service expenditure.
- Mercer will develop prospective trend factors through a review of the historical data, input from DMMA, Mercer's knowledge of the Delaware marketplace, and Mercer's knowledge of health care trends in other states. The resulting trend factors will be annual factors that Mercer will use to project the base data to a future rating period. The number of months/years that the annual trend

factors will be applied will be equivalent to the months of movement measured between the midpoint of the base period and the midpoint of the rating period.

- Mercer may adjust MCO-reported financial experience to reflect historical and proposed program changes as deemed appropriate (please see Section 6 for a list of proposed program changes known at this time).
- After trend and program changes have been reflected, Mercer may apply relational modeling as necessary to shift funds between counties within certain rate tiers to mitigate rate volatility over time (budget neutral adjustment).
- Mercer may make adjustments to certain rate tiers to reflect the impact of latent demand on program enrollment and risk.
- Mercer may make adjustment to the MCO experience data for missed opportunities to effectively manage and coordinate member care (e.g., preventable hospitalizations, unnecessary emergency room use).
- An allowance for an MCO administrative/profit/risk contingency, non-medical expense load will be added to the projected managed care claims cost based on a percentage of premium.
- Adjustments for applicable health care taxes as needed consistent with federal and/or State policy and actuarial soundness requirements.

DSHP Plus Rate Development Adjustments

DSHP Plus capitation rates for calendar year 2015 will be based on historical, Delaware FFS data for the applicable populations and services. To the extent practical, DSHP Plus experience data from the MCOs will be considered/reviewed as part of the DSPH Plus rate development process. The following list of adjustments has not been reflected in this data book but will be considered in the rate development process for DSHP Plus:

- Adjustment for adult behavioral health inpatient and outpatient services that exceeded the MCOs' coverage limit that was historically in place. Effective January 1, 2015, there will be no limit on the number of behavioral health inpatient and outpatient services covered by the MCOs for adults.
- Mercer will consider the potential impact of the State's new PROMISE program on the cost and/or utilization of services covered by the MCOs.
- Historical HCBS patient pay amounts applicable to individuals in the E&D and AIDS waivers will be included in the rate development process.
- Applicable transitional expenditures pertaining to the State's MFP program that are not included in the historical MMIS-processed FFS claims.
- Anomalies may exist in the data; therefore, Mercer will consider multiple years of historical experience data. It is likely that the two most recent calendar years (i.e., 2011 and 2012) of FFS data will be consolidated to derive the base period of experience data, upon which subsequent adjustments and trend factors will be applied to develop prospective capitation rate ranges.
    - As noted, MCO financial and/or encounter data may be considered as supplemental data sources for purposes of DSHP Plus rate setting.

- Mercer may adjust the historical FFS base data for the following material program changes (please see Section 6 for a complete list of proposed program changes known at this time):
  - Those that occurred or were expected to occur after the base data period and have been approved by the State, such as home modifications and home-delivered meals.
  - Those that occurred partially through the base period data and, thus, may only be partially reflected in the consolidated base data.

- Mercer will develop prospective trend factors through a review of the historical data, input from DMMA, Mercer's knowledge of the Delaware marketplace, and Mercer's knowledge of health care trends in other states. The resulting trend factors will be annual factors that Mercer will use to project the base data to a future rating period. The number of months/years that the annual trend factors will be applied will be equivalent to the months of movement measured between the midpoint of the base period and the midpoint of the rating period.
- Mercer will make adjustments to each service category for each rate tier, as applicable. These adjustments reflect the expected changes that occur when a state transitions from a FFS environment to a more coordinated, managed care delivery system. Mercer will take into consideration the unique attributes of the populations covered under DSHP Plus and the MCO contractual requirements.
- An allowance for an MCO administrative/profit/risk contingency, non-medical expense load will be added to the projected managed care claims cost based on a percentage of premium.
- Adjustments for applicable health care taxes as needed consistent with federal and/or State policy and actuarial soundness requirements.

Actuarially Sound Rate Ranges and Risk Adjustment

At the conclusion of the rate development process, Mercer will provide the State an actuarially sound rate range for each DSHP and DSHP Plus rate tier. The State has the flexibility to use these rate ranges to contract with each MCO, as the State deems appropriate, so long as each final contracted MCO rate is within the range for the respective rate tier. In addition to the actuarially sound capitation rate ranges, DMMA and Mercer intend to further adjust the final actuarially sound capitation rates to reflect MCO-specific risk. An overview of each risk adjustment process to be used for DSHP and DSHP Plus is described below. Please refer to the MCO contract for more information on risk adjustment.

DSHP Risk-Adjustment Process

DMMA uses the CDPS+Rx model to further adjust the MCOs' DSHP base capitation rates. The CDPS+Rx model uses both diagnosis data on facility and professional records, in addition to pharmacy data, to classify individuals into disease conditions, along with member demographics (age and sex categories) to measure a population's anticipated health risk. For more information about the CDPS+Rx model see Appendix A. The health risk for each MCO is calculated at the consolidated risk-adjustment rating categories level of detail (maternity care payments and under age 1 newborn rates are not risk adjusted). NOTE: The ACA Expansion population does not have historical

experience available to use for risk adjustment purposes. Once the required ACA Expansion experience is available, DMMA intends to risk adjust this population.

Encounter data incurred over a 12-month period is used to classify recipients into CDPS+Rx disease conditions. Prior to utilizing the encounter data for risk adjustment purposes, the MCOs are given an opportunity to review the data for completeness and accuracy. This information is then combined with the anticipated cost associated with each of these CDPS+Rx model categories. The anticipated costs, referred to as cost weights, were developed using national data from 30+ Medicaid programs by the CDPS+Rx model developers (University of California, San Diego). The weights were adjusted to be consistent with DMMA's practice of paying for maternity services through a separate maternity care payment. A set of cost weights was provided for each of the three CDPS+Rx models: TANF Adults, TANF Children, and Disabled.

The combination of the CDPS+Rx categories and the appropriate cost weights produces a risk score for each recipient, referred to as an acuity factor. Acuity factors are only developed for recipients with at least six months of Medicaid eligibility within the 12 month study period (if newborns become subject to risk adjustment, this policy may be modified). The recipient-level risk scores will then be aggregated by statewide rate tiers and by MCOs. To ensure that the risk adjustment process does not increase or decrease the total capitation payments, the aggregated risk scores are adjusted for budget neutrality. The intent of this adjustment is to recalibrate the MCO risk scores to yield a population average of 1.000. DMMA intends to update the individual and MCO risk scores on a semi-annual basis.

DSHP Plus Selection Risk-Adjustment Process

Due to unique issues associated with the DSHP Plus populations (e.g., lack of Medicare claims data, nature of long-term needs/risk), DMMA does not use the CDPS+Rx risk adjustment process for the NF/HCBS and Community Well rate tiers. Instead, DMMA intends to use a process to adjust the DSHP Plus NF/HCBS capitation rate tiers for differences in actual selection risk related to institutionalized residents and HCBS waiver enrollees. The MCOs and the State will agree to accept the final payment rates that result from this selection risk adjustment methodology (SRAM) process including any retroactive adjustments without further rate negotiations, contract negotiations, or amendments. The SRAM is only applicable to the following DSHP Plus rate tiers, respectively:

- NF/HCBS Dual
- NF/HCBS Non-Dual

This provision is intended to be used for the CY 2015 rating period of the DSHP Plus program only and is similar to the process used when DSHP Plus was first implemented. At the discretion of the State, at some point in the future, this SRAM process may be replaced by a more sophisticated risk adjustment process developed specifically for long-term care populations or the State may consider developing capitation rate ranges that reflect MCO-specific member mix information when this information becomes available.

The State will ensure that the final risk-adjusted payment rates are budget neutral on a rate tier basis. In other words, the total cost to the State (i.e., federal and State funds combined) of the respective DSHP Plus managed care capitation payments under each rate tier must be the same before and after application of the SRAM.

The State's intended SRAM is described below:

1. The State will establish relative cost factors (RCFs) based on the respective per member per months (PMPMs) of the institutionalized and HCBS populations relative to the total DSHP Plus capitation rate, as determined by the State's actuary.

2. In the second step, the State will use the actuarially-derived RCFs to compute MCO-specific relative mix factors (RMFs). The RMFs will be based on a MCO-specific enrollment distribution of institutionalized and HCBS members in the applicable rate tiers as determined by the State.

3. In step three, the State will determine RMF-adjusted MCO capitation rates by multiplying the negotiated DSHP Plus managed care capitation rate by the applicable RMF.

4. In the fourth and final step, the State will ensure that the RMF-adjusted MCO rates are budget neutral. The State will compute the total cost of each rate tier using the negotiated rates and the RMF adjusted rates. If the results of the two calculations are not equal, the State will make a budget neutral adjustment (downward or upward) to compute the final payment rates.

The resulting SRAM DSHP Plus capitation payment rates will be paid prospectively to each respective MCO. In the event that MCO enrollment data is not fully available and the calculations have not been completed by the State for the initial or a subsequent SRAM rate adjustment prior to the time a capitation payment is due to the MCO, the State shall continue to pay the rates in effect and agreed to prior to the risk adjustment.

The State will only adjust the MCO capitation rates using this SRAM if one or more of the MCOs have a percentage of community-based HCBS members that differs by more than 1.0 percentage point from the statewide average percentage of community-based HCBS members assumed in the actuarial rate development process. The State may also consider other indicators of acuity in determining final DSHP Plus capitation rates with each MCO.

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Proposed Programmatic Changes

The following table includes information related to proposed programmatic changes that will be considered in the capitation rate development process for DSHP and DSHP Plus. This programmatic changes chart is subject to change as additional information becomes available.

No.	Program Change Issue with Description	Effective date	Major Population Group
1	**Mental health/substance abuse (MH/SA) parity:** Federal legislation requiring parity in MH/SA financial and treatment requirements.	TBD	DSHP & DSHP Plus
2	**School-based wellness center (SBWC) clinics:** SBWCs will be included as a benefit covered under managed care.	1/1/2015	DSHP
3	**Addition of home-delivered meals:** New service available with implementation of DSHP Plus. Limited to one meal per day, per person, based on medical necessity requirements.	4/1/2012	DSHP Plus
4	**Addition of home modifications:** New service available with implementation of DSHP Plus. Limit of up to $6,000 per project, $10,000 per benefit year, and $20,000 per lifetime; authorizations above this dollar limit can be made if MCO deems cost-effective.	4/1/2012	DSHP Plus
5	**Addition of community transition:** New service available with implementation of DSHP Plus. Limit of up to $2,500 to cover transition services for those moving from a NF to the community under the MFP program. MCO may authorize amounts above this limit.	4/1/2012	DSHP Plus
6	**HCBS provider fee increase:** Across the board 2.0% provider fee increase.	7/1/2011	DSHP Plus — all E&D and AIDS waiver services
10	**NH provider tax/Medicaid rate increase:** Impact of possible change to NH provider tax.	TBD	DSHP Plus — NH residents
11	**Medicaid ACA adult expansion — alternative benefit plan.**	1/1/2014, per ACA	DSHP — Medicaid adult ACA expansion rate tiers

No.	Program Change Issue with Description	Effective date	Major Population Group
12	**CHIP Title XXI kids switching to Medicaid Title XIX per ACA:** Effective January 2014, ACA expands Medicaid Title XIX income eligibility to 138% FPL for children. Some kids in the Title XXI CHIP program will "switch" to Title XIX Medicaid.	1/1/2014, per ACA	DSHP
13	**Patient Protection and ACA Sec 9010 annual fee on insurance companies:** Impact of health insurance providers' fee as implemented by the ACA.	1/1/2014, per ACA	TBD
14	**Outpatient pharmacy:** Add prescription drugs to the MCO benefit package: Outpatient drugs being carved-in to managed care.	1/1/2015	DSHP & DSHP Plus
15	**DSP program ending:** Managed care eligible enrollees in the DSP program will transition to DSHP.	7/1/2014	DSHP
16	**Behavioral health (BH) 1915(i)-like PROMISE program.**	7/1/2014	DSHP & DSHP Plus — Targeted adults age 18 and older meeting PROMISE eligibility
17	**BH inpatient and outpatient services:** limit on MCOs being removed.	1/1/2015	DSHP & DSHP Plus

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Exhibit Descriptions

The exhibits included in this data book provide historical data on the populations included in the DSHP and DSHP Plus segments of the Medicaid program. These exhibits show either managed care experience data or FFS data. The exhibits included within this data book, as well as a brief description of the information included, are as follows:

- Exhibit 1 — Calendar year (CY) 2010 summarized DSHP managed care financial experience. The data is as reported by the two existing MCOs pursuant to the State's financial reporting requirements. Data from both MCOs were combined for display purposes.
- Exhibit 2 — CY 2011 summarized DSHP managed care financial experience. The data is as reported by the two existing MCOs pursuant to the State's financial reporting requirements. Data from both MCOs were combined for display purposes.
- Exhibit 3 — CY 2012 summarized DSHP managed care financial experience. The data is as reported by the two existing MCOs pursuant to the State's financial reporting requirements. Data from both MCOs were combined for display purposes.
- Exhibit 4 — April 2012 through December 2012 summarized DSHP Plus managed care financial experience. The data is as reported by the two existing MCOs pursuant to the State's financial reporting requirements. Data from both MCOs were combined for display purposes.
- Exhibit 5 — CY 2009, 2010, and 2011 summarized DSHP Plus FFS cost and utilization information. As noted in Section 3, the DSHP Plus rate tier structure consists of three distinct tiers: NF/HCBS Duals, NF/HCBS Non-Duals and Community Well. However, for purposes of supporting this procurement, Mercer and DMMA decided that providing historical FFS cost and utilization information on the major sub-populations within the respective rate tiers would provide more useful information to the users of this data book as follows:

  - Exhibit 5a — Institutional dual eligible.
  - Exhibit 5b — Institutional non-dual eligible.
  - Exhibit 5c — E&D Waiver dual eligible.
  - Exhibit 5d — E&D Waiver non-dual eligible.
  - Exhibit 5e — AIDS Waiver dual eligible.
  - Exhibit 5f — AIDS Waiver non-dual eligible.
  - Exhibit 5g — Community Well duals & non-dual eligible combined.

- Exhibit 6 — Historical statewide DSHP Plus population mix by month.
- Exhibit 7 — Historical DSHP demographic information by county and by quarter.
- Exhibit 8 — Historical monthly FFS cost and utilization information for school-based wellness centers summarized by DSHP rate tier.
- Exhibit 9 — Historical monthly DSP member counts summarized by DSHP rate tier.
- Exhibit 10 — CY 2010, 2011, and 2012 summarized FFS pharmacy information by traditional and specialty drugs. A separate exhibit is provided for the following population groups, with rate tier level detail included within each one:

  - Exhibit 10a – DSHP
  - Exhibit 10b – DSHP Plus

- Exhibit 11 — Risk adjusted rates diagnostic category prevalence reports for the DSHP CY 2013a and 2013b time periods. The TANF Children, TANF Adult, and CHIP populations are evaluated using the TANF model and the SSI and Waiver Expanded (≤ 100% FPL) populations are evaluated using the Disabled population model. For more information on the risk assessment model used to develop this information and the diagnostic categories see Appendix A. A separate exhibit is provided for the following population groups:

  - Exhibit 11a – TANF Children and CHIP.
  - Exhibit 11b – TANF Adult
  - Exhibit 11c – SSI and Waiver Expanded (≤ 100% FPL).

Users of this data book are advised to review the information in Section 4 and 5 regarding adjustments made to the data within this data book, and adjustments that will be considered later in the actuarial rate development process, as well as the proposed program changes provided in Section 6.

Appendix A: CDPS+Rx Model Background

To measure the risk associated with each MCO, DMMA elected to implement the only model that was specifically designed for Medical Assistance populations. The Chronic Illness and Disability Payment System (CDPS) is a diagnostic classification system that Medicaid programs can use to make health-based capitated payments for Temporary Assistance for Needy Families (TANF) and Disabled Medicaid individuals. The CDPS model was designed by the University of California, San Diego (UCSD) in conjunction with clinical consultants.

In 2008, UCSD performed a comprehensive review of the existing CDPS model using updated data. While most of the framework remains the same, the model update released in November 2008 includes a reevaluation of model components and updates to several disease classifications. As part of this update, UCSD also created a diagnostic and pharmacy combined model which uses CDPS in conjunction with UCSD's pharmacy-based risk-assessment model, which is referred to as Medicaid Rx. Beginning in 2009, the combined CDPS and Medicaid Rx (CDPS+Rx) risk-assessment model has been used to adjust capitation payments for DSHP. This section outlines the major components of the CDPS+Rx model. More information regarding any of the UCSD models can be found at the UCSD website (http://cdps.ucsd.edu/).

Model Components

The CDPS+Rx model was designed using 2001–2002 data from 30+ Medicaid programs. The intent of the model was to include readily available demographic and disease characteristics that were valid and accurate estimators of current and future health care expenditures. As many services require the provision of diagnoses or a valid national drug code (NDC) in order to receive payment for services rendered, electronic claims information is a viable method of collecting diagnostic and drug data for risk-assessment purposes.

For diagnoses reporting, UCSD staff, along with their clinical consultants, reviewed the ICD-9[10] diagnoses manual to determine which diagnoses were ill-defined and inappropriate for risk assessment. Many diagnoses are indicative of symptoms rather than a specific disease condition which is likely to persist. For example, a diagnosis of chest pain can be indicative of many conditions and is most likely not a good estimator or predictor of health care expense. Once the ill-defined conditions were isolated, the remaining diagnoses were placed into 19 major categories. Some are representative of specific body systems (e.g., cardiovascular or pulmonary) and others fall into a group of illnesses that affect multiple systems (e.g., infectious disease or diabetes). For diagnosis-based conditions, these major categories are further delineated into subcategories based on their perceived medical intensity.

To determine which NDCs were appropriate to supplement the CDPS risk-assessment model for the identification of chronic conditions, UCSD staff and clinical consultants reviewed both the listing of NDCs and the 45 disease condition groupings within the Medicaid Rx model. The result of this review

[10] International Classification of Diseases, 9th Revision

is the Restricted Version of the Medicaid Rx model which includes 15 disease conditions. These Medicaid Rx conditions are linked to a specific subcategory within the CDPS model corresponding to the appropriate chronic disease condition and perceived medical intensity.

Table 1 provides a listing of the major categories, medical intensity subcategories/pharmacy categories, and sample conditions within each classification. The 15 categories within the Restricted Version of the Medicaid Rx model are identified by MRX and appear with the CDPS-linked subcategory.

Table 1 – The CDPS+Rx Categories with Sample Conditions

Disease category	Sample conditions
Cardiovascular	
Very high	Heart transplant status or artificial heart replacement
Medium and MRX Anti-Coagulants	Congestive heart failure, primary pulmonary hypertension or cardiomyopathy
Low	Heart valve transplant, atrial fibrillation or angina
Extra low and MRX Cardiac	Hypertension
Psychiatric	
High	Schizophrenia
Medium	Bipolar affective disorder or hallucinations
Medium low	Major depression or impulse control disorder
Low and MRX Depression/Psychosis/Bipolar	Other depression, obsessive-compulsive disorder or antisocial disorder
Skeletal and connective	
Medium	Aseptic necrosis of bone, anomalies of spine or kyphosis
Low	Ankylosis of joint, cyst of bone or traumatic amputation of arm/hand
Very low and MRX Inflammatory/Autoimmune	Kissing spine, claw toe, anomaly of the spleen or conjoined twins
Central nervous system	
High	Quadriplegia, Werdnig-Hoffmann disease or other motor neuron disease
Medium and MRX Multiple Sclerosis/Paralysis	Primary cerebellar degeneration, multiple sclerosis or Schilder's disease
Low; MRX Parkinson's/Tremor and MRX Seizure Disorders	Coma, Pick's disease or Parkinson's disease
Pulmonary	
Very high	Cystic fibrosis, lung transplant or tracheostomy complications
High	Respiratory arrest or selected pneumonias
Medium	Pulmonary collapse, acute respiratory failure or congenital cystic lung
Low and MRX Tuberculosis	Chronic bronchitis, asthma or mass in chest
Gastrointestinal	
High	Celiac disease or liver transplant status
Medium	Alcoholic fatty liver, chronic hepatitis or regional enteritis
Low	Ulcer of the esophagus, umbilical hernia or chronic pancreatitis

Disease category	Sample conditions
Diabetes	
Type 1	Type 1 diabetes
Type 2 and MRX Diabetes	Type 2 or unspecified diabetes
Skin	
High	Skin transplant status or chronic ulcer of skin
Low	Ulcer of lower limbs, except pressure ulcer
Very low	Cellulitis or burn
Renal	
Extra high	Renal dialysis status
Very high and MRX ESRD/Renal	Chronic kidney disease
Medium	Nephrotic syndrome or kidney transplant status
Low	Kidney infection, kidney stones or urinary incontinence
Substance abuse	
Low	Drug withdrawal, drug psychoses or cocaine dependence
Very low	Alcohol abuse, dependence or psychosis
Cancer	
Very high	Malignant neoplasm of pancreas or secondary malignant neoplasm of respiratory and digestive systems
High	Malignant neoplasm of stomach, trachea, bronchus, lung or brain
Medium and MRX Malignancies	Malignant neoplasm of colon, thymus, heart or Hodgkin's disease
Low	Malignant neoplasm of lip, tongue, breast or malignant melanoma of skin
Developmental disabilities	
Medium	Severe or profound mental retardation
Low	Mild/moderate mental retardation or Down syndrome
Genital	
Extra low	Uterine and pelvic inflammatory disease
Pregnancy	
Complete/Incomplete	Normal pregnancy, complications of pregnancy or multiple delivery
Metabolic	
High	Lipidoses or non-HIV immunity deficiencies
Medium	Cushing's syndrome, Kwashiorkor or other autoimmune disease
Very low	Other pituitary disorders or gout
Eye	
Low	Retinal detachment or cornea transplant status
Very low	Cataract, glaucoma or congenital eye anomaly
Cerebrovascular	
Low	Hemiplegia, hemiparesis or speech and language deficits

Disease category	Sample conditions
Infectious disease	
AIDS, high	AIDS[11], cryptococcosis or Kaposi's sarcoma
Infectious, high and MRX Infections, high	Pseudomonas, Whipple's disease or cytomegaloviral disease
HIV, medium; MRX Hepatitis and MRX HIV	Asymptomatic HIV[12] infection
Infectious, medium	Other septicemia, tularemia, brucellosis or rat-bite fever
Infectious, low	Toxic shock syndrome, acute poliomyelitis, herpes zoster or viral hepatitis
Hematological	
Extra high and MRX Hemophilia/von Willebrands	Congenital factor VIII and factor IX coagulation defects (hemophilia)
Very high	Hemoglobin-S sickle-cell disease
Medium	Aplastic anemia or splenomegaly
Low	Congenital factor XI deficiency, other hemorrhagic conditions or genetic anomalies of leukocytes

Prior to assessing the value associated with each of the above categories, a protocol was established as to how individuals could be classified into one of the above CDPS+Rx categories. The CDPS+Rx model was developed using 12 months of incurred diagnostic and pharmacy data to classify individuals into disease categories. This 12-month period is referred to as the study period. To reduce the effects of variations in data reporting, only a single diagnosis, regardless of position (i.e., primary, secondary, tertiary, etc.) or a single incidence of a drug, is necessary to establish a CDPS+Rx category. In the event that multiple conditions are identified within a major category, the individual is assigned to the subcategory with the highest intensity level. This protocol recognizes that individuals with multiple conditions in the same major category will most likely be treated simultaneously and not incur substantial additional cost. Although the CDPS+Rx model only incorporates the most serious disease intensity within each major category, it recognizes the increased medical cost when multiple systems are affected with chronic conditions. For example, an individual diagnosed with Antisocial Disorder (Psychiatric, low), Schizophrenia (Psychiatric, high), and Hypertension (Cardiovascular, extra low), would be classified into the Psychiatric, high and Cardiovascular, extra low categories.

The disease categories primarily represent chronic conditions that are likely to persist and correlate to additional medical expense. However, many acute conditions related to low-income populations are not included within the list above, such as ear infections. Recognizing that not all risk is explained through the chronic disease categories, the CDPS+Rx model incorporates additional demographic factors to estimate the medical resources not contained in one of the conditions listed in Table 1. There are 11 demographic classifications within this component of the CDPS+Rx model, which are listed below. For the demographic category determination, the exact age (not rounded) of each individual at the end of the study period is used:

[11] Acquired Immune Deficiency Syndrome

[12] Human Immunodeficiency Virus

- Under age 1
- Age 1 to 4
- Male age 5 to 14
- Female age 5 to 14
- Male age 15 to 24
- Female age 15 to 24
- Male age 25 to 44
- Female age 25 to 44
- Male age 45 to 64
- Female age 45 to 64
- Age 65 and over

Populations Evaluated

During the CDPS and CDPS+Rx model development, significant cost variation was measured among the TANF and Disabled populations. In order to maintain the cost variation and reflect that Medicaid programs typically have separate capitation rates for these two populations, separate models were developed for the TANF and Disabled populations.

In addition to recognizing the cost differences associated with the TANF and Disabled populations, UCSD explored the possibility of separate models for adults and children. For the TANF population, significant amounts of data were available to develop a TANF adult model and a TANF child model. Despite the variance in disease prevalence among adults and children, the Disabled population did not have sufficient membership to provide separate models for the adult and children populations. To reflect that certain conditions have additional costs when they are attributable to children, the CDPS+Rx Disabled model contains add-on values for children with certain disease conditions. These factors, referred to as child interaction factors, are incorporated in the risk assessment for any Disabled child. There are 10 classifications within this component of the Disabled CDPS+Rx model, which are listed below:

- Cardiovascular, very high
- Cardiovascular, medium
- Central nervous system, medium
- Pulmonary, very high
- Pulmonary, high
- Gastrointestinal, high
- Metabolic, high
- HIV, medium
- Infectious, medium
- Hematological, extra high

Relative Cost Weights

The CDPS+Rx categories provide a demographic and disease description of the Medicaid population studied. However, to best utilize the CDPS+Rx model to predict future expenditures, the relative cost associated with each CDPS+Rx model component needs to be known. Medical cost information is collected by individual and compared to their CDPS+Rx categories (disease, including any child interaction factors and demographic). Medical costs are then assigned to each CDPS+Rx category using a statistical analysis[13]. The estimated medical costs from the analysis are translated into a relative cost weight by comparing the costs attributable to each category to the average cost of the total population.

An additional consideration when developing relative cost weights is the relationship between incurred medical costs to the classified CDPS+Rx categories. There are two primary methods of correlating disease and cost data: the prospective method and the concurrent method. Under the prospective approach, disease conditions collected in one year are compared to the incurred medical costs in the subsequent year. Since this method utilizes first year diagnoses to “predict” the second year’s health costs, there is a lesser reliance on disease conditions and a greater reliance on demographic categories. Under the concurrent approach, disease conditions collected in one year are compared to the medical costs within the same year. Since the disease and cost information for the same time period are used in this method, there is a greater reliance on disease conditions and a lesser reliance on demographic categories.

The CDPS+Rx logic available on the UCSD web-site contains the relative costs weights associated with each category from the national data set used to develop the CDPS+Rx model. Since cost weights are used to estimate relative expenditures within a specific Medicaid program, the cost weights should reflect the expenditures associated with the program’s benefit package. As such, several versions of published cost weights are available based on different benefit packages and are provided separately for prospective and concurrent approaches.

The design of the CDPS+Rx model and the resulting relative cost weights assumes that the effects of diseases in different major categories are additive. To arrive at the estimated relative expenditure for an individual, the sum of the relative costs weights for each individual’s CDPS+Rx categories (disease, including any child interaction factors and demographic) is calculated. This relative expenditure value is known as a CDPS+Rx risk score, or an acuity factor.

With the release of Version 5.3 (and subsequent versions) of the CDPS+Rx model, the national cost weights that are published on the UCSD website were developed using 2003 through 2007 data from 30+ Medicaid programs.

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[13] A standardized statistical multiple regression analysis was used.

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