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November 29, 2016

Ms. Tara Smith Clark
Executive Administrator
Mississippi Office of the Governor, Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

Re: SFY 2017 MississippiCAN CCO Rate Calculation and Certification

Dear Tara:

The Mississippi Division of Medicaid (DOM) has retained Milliman to develop actuarially sound capitation rates for July 1, 2016 – June 30, 2017 (SFY 2017) for Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for Medicaid beneficiaries. This report documents capitation rates for all populations enrolled in MississippiCAN.

Capitation rates may need to be adjusted for future changes to pharmacy reimbursement methodology or preferred drug lists occurring during the SFY 2017 contract period.

Rates will continue to be retroactively adjusted for the Health Insurer Fee. In addition, final capitation rates will be recertified after actual membership is known for SFY 2017 to determine the final MHAP add-on for SFY 2017 capitation rates.

❖ ❖ ❖ ❖ ❖

Please call me or Jill Bruckert at 262-784-2250 if you have questions. We look forward to discussing the report with you and the CCOs.

Sincerely,

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

MCC/vrr

Attachments

State of Mississippi
Division of Medicaid
July 1, 2016 – June 30, 2017
MississippiCAN Capitation Rate Development

Prepared for:
The State of Mississippi
Division of Medicaid

Prepared by:
Milliman, Inc.

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APPENDICES

I. SUMMARY AND DISCUSSION OF RESULTS

This report documents the development of July 1, 2016 – June 30, 2017 (SFY 2017) Coordinated Care Organization (CCO) capitation rates for Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for targeted Medicaid beneficiaries.

The Mississippi Division of Medicaid (DOM) retained Milliman to calculate, document, and certify to its capitation rate development. We developed the proposed capitation rates using the methodology described in this report. Our role is to certify that the SFY 2017 capitation rates are actuarially sound and comply with Centers for Medicare and Medicaid Services (CMS) regulations. DOM and the CCOs have the option to contract at these proposed rates. Our Actuarial Certification is included in Appendix F.

This report is structured as follows. Information pertaining to all rate cells is included in the body of the report. Information specific to different populations in MississippiCAN is included in Appendices A and B.

- Section II provides a short background of the MississippiCAN program.
- Section III documents the SFY 2017 rate cell definitions.
- Section IV explains the data sources used to develop capitation rates.
- Appendix A documents capitation rate development items specific to the Adult and Newborn rate cells. These capitation rates are developed from a combination of CCO financial reporting, encounter data, and fee-for-service (FFS) data for services and / or populations not covered by MississippiCAN during the base year.
- Appendix B documents capitation rate development items specific to the medical assistance (MA) Children and Quasi-CHIP rate cells. The MA Children capitation rates are developed using FFS data with adjustments applied to reflect projected costs in a managed care environment. The Quasi-CHIP capitation rates are developed from CCO financial reporting of experience for the population while enrolled in CHIP with adjustments to reflect projected costs under MississippiCAN.
- Appendix C includes supporting documentation of assumptions and future expenditures for all MississippiCAN populations.
- Appendices D and E provide responses to the CMS rate setting checklist and CMS managed care rate setting guide for all rate cells.
- Appendix F contains an Actuarial Certification for all MississippiCAN rate cells.
- Appendix G documents our reliance on DOM for data and other assumptions in the development of the capitation rates.

SFY 2017 CAPITATION RATES AND ACTUARIAL CERTIFICATION

Table 1 includes per member per month (PMPM) capitation rates effective for SFY 2017 varying by region and rate cell.

Each CCO will be paid based on the distribution of members they have in each rate cell. In addition, CCO capitation payments will vary based on their members' county of residence. We have assigned each county to one of the following regions: North, Central, or South. Regional capitation rates, including the Mississippi Hospital Access Program (MHAP) add-on are shown in Table 1.

Table 1 MississippiCAN Capitation Rates Including MHAP Per Member Per Month (PMPM) Effective July 1, 2016 to June 30, 2017			
Rate Cell	**North**	**Central**	**South**
Non-Newborn SSI / Disabled	$1,051.07	$1,159.72	$1,141.27
Foster Care	$440.98	$480.47	$473.76
Breast and Cervical Cancer	$3,335.83	$3,703.50	$3,641.07
SSI / Disabled Newborn	$6,839.96	$7,604.89	$7,475.00
MA Adult	$517.29	$565.43	$557.26
Pregnant Women	$614.98	$674.19	$664.13
Non-SSI Newborns 0 - 2 Months	$1,446.78	$1,600.29	$1,574.23
Non-SSI Newborns 3 - 12 Months	$347.80	$376.72	$371.81
Delivery Kick Payment	$4,828.79	$5,376.23	$5,283.26
MA Children	$270.97	$279.59	$277.20
Q-CHIP children	$282.30	$291.47	$288.93

** Flat MHAP add-on of $92.67, including associated premium tax, across all non-delivery rate cells.*

The capitation rates for the Non-Newborn SSI / Disabled, MA Adult and MA Children rate cells will be adjusted for each CCO using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx). The CDPS + Rx risk adjuster will be used to adjust for the acuity differences between the enrolled populations of each CCO and will be budget-neutral to DOM. The CDPS + Rx demographic and disease category weights are specific to the services covered by MississippiCAN and calculated using Mississippi FFS and encounter data.

Our Actuarial Certification of the SFY 2017 MississippiCAN capitation rates is included as Appendix F. It should be emphasized that capitation rates are a projection of future costs based on a set of starting data and assumptions. Actual costs will be dependent on each contracted CCO's situation and experience.

CAPITATION RATE CHANGE SUMMARY

Overall, SFY 2017 MississippiCAN capitation rates are 4.25% higher than the SFY 2016 capitation rates effective December 2015, which include the increase for the inclusion of inpatient services and newborn enrollment changes. This rate change excludes the MHAP add-on. The MHAP add-on, including the impact of the 3% premium tax, in SFY 2016 was $165.98 PMPM and is $92.67 PMPM in SFY 2017. Note that the projected annual payments are the same for both years, but in the SFY 2016 rates MHAP payments were spread across only seven months instead of a full year. Table 2 shows a summary of the main drivers of the rate changes across all MississippiCAN capitation rates. All compositing is based upon the membership distribution of rate cells in CY 2014.

Table 2 MississippiCAN Capitation Rates Summary of SFY 2017 Rate Change by Component	
SFY 2016 Composite Capitation Rate (Effective Dec 2015)	**$352.24**
CY 2014 Actual to Expected Difference	0.966
Restated Trend	1.038
Restated Inpatient CCO Savings	1.013
Restated SFY 2016 Rate	**1.016**
SFY 2016 to SFY 2017 Trend	1.065
Update to TPL Assumption	1.001
Implementation of Federal Upper Limit	0.957
Non-Benefit Assumption Change	1.006
SFY 2017 Rate Change*	**1.0425**

**Rates exclude MHAP and will be adjusted retrospectively for HIF.*

- Updating the base period costs from CY 2013 to CY 2014, trend and inpatient savings assumptions from CY 2014 to SFY 2016 increases the projection of SFY 2016 costs by 1.6% from cost included in the SFY 2016 capitation rates. Overall rate changes are largely driven by the top three rate cells by membership which experienced the following changes as a combination of projected CY 2014 costs to actual CY 2014 costs and revisions to trends and inpatient savings assumptions to SFY 2016.
  - Non-Newborn SSI / Disabled – increase of 7.1%
  - MA Adults – increase of 1.8%
  - MA Children – decrease of 4.4%
- Composite utilization and unit cost trends from SFY 2016 to SFY 2017 increase costs 6.5%.
- The third party liability recovery percentage was updated from 1.00% in SFY 2016 to 0.90% for SFY 2017, resulting in an increase in costs of 0.05%.
- Establishment of Federal Upper Limits (FULs) for certain prescription drugs is expected to reduce pharmacy costs by 16%, which has a -4.3% impact on total rates.
- Non-benefit expense assumption updates result in a 0.6% increase to capitation rates.

CAPITATION RATE CHANGE BY RATE CELL

Rate increases vary by capitation rate cell as shown in Table 3, which compares SFY 2017 capitation rates to SFY 2016 capitation rates including inpatient services and the newborn enrollment change effective December 2015. MHAP is excluded from these rate changes. Notable rate changes include commentary below Table 3.

Table 3
MississippiCAN Capitation Rates
Summary of Statewide SFY 2017 Rate Change*

Rate Cell	SFY 2016** to SFY 2017
Non-Newborn SSI / Disabled	10.35%
Foster Care	17.27%
Breast and Cervical Cancer	22.24%
SSI / Disabled Newborn	23.18%
MA Adult	5.66%
Pregnant Women	11.59%
Non-SSI Newborns 0 – 2 Months	-6.13%
Non-SSI Newborns 3 – 12 Months	8.40%
Delivery Kick Payment	6.03%
MA Children	-3.44%
Q-CHIP Children	-7.46%
All Rates Cells	**4.25%**

** Rate changes exclude impact of MHAP and HIF.*
*** SFY 2016 capitation rates from December 2015 to June 2016 including IP.*

- Non-Newborn SSI / Disabled: Capitation rates increased 10.35%. This increase is largely driven by an uptick in inpatient and pharmacy costs, separate from the impact of moving to a uniform PDL on January 1, 2015. Pharmacy unit cost trend was updated to 10.50% annually, supported by historical data and projected industry knowledge of future cost changes. In the SFY 2016 rates a pharmacy unit cost trend of 5.00% was used for this population. Increasing the pharmacy unit cost trend increases capitation rates approximately 4.25%.

- Foster Care: Capitation rates for this small population increased 17.27%. CY 2014 experience is 4.67% higher than where CY 2014 would have been projected to be using the SFY 2016 capitation rate assumptions.

- Breast and Cervical Cancer: Capitation rates for this small population increased 22.24%. CY 2014 experience is 11.89% higher than where CY 2014 would have been projected to be using the SFY 2016 capitation rate assumptions.

- SSI / Disabled Newborns: Capitation rates for this small population increased 23.18%. CY 2014 experience is 10.37% higher than where CY 2014 would have been projected to be using the SFY 2016 capitation rate assumptions. This increase is driven by higher than expected inpatient costs for the first few months of life when newborns were previously enrolled in FFS.

- Non-SSI Newborns 0 – 2 Months: Capitation rates decreased 6.13%. CY 2014 experience is 16.48% lower than where CY 2014 would have been projected to be using the SFY 2016 capitation rate assumptions. This decrease is driven by lower than expected inpatient costs for the first few months of life when newborns were previously enrolled in FFS.

DATA RELIANCE AND IMPORTANT CAVEATS

We used CCO encounter data and CCO financial reporting for January 2011 to June 2016, FFS cost and eligibility data for January 2012 to October 2015, and historical and projected reimbursement information, TPL recoveries, fee schedules, and other information from DOM, CCOs, and CMS to calculate the MississippiCAN capitation rates shown in this report. If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Our report is intended for the internal use of DOM to develop SFY 2017 MississippiCAN capitation rates. It may not be appropriate for other purposes. We anticipate the report will be shared with contracted CCOs and other interested parties. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. It should only be distributed and reviewed in its entirety. These capitation rates may not be appropriate for all CCOs. Any CCO considering participating in MississippiCAN should consider their unique circumstances before deciding to contract under these rates.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Michael Cook is an Actuary for Milliman, a member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of his knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The terms of Milliman's contract with DOM effective June 1, 2015 apply to this report and its use.

II. MISSISSIPPICAN BACKGROUND

MississippiCAN, a Coordinated Care Program for Mississippi Medicaid beneficiaries, was designed to address the following goals:

- Improve access to needed medical services – This goal will be accomplished by connecting the targeted beneficiaries with a medical home, increasing access to providers, and improving beneficiaries' use of primary and preventive care services.

- Improve quality of care – This goal will be accomplished by providing systems and supportive services, including disease state management, and other programs that will allow beneficiaries to take increased responsibility for their health care.

- Improve efficiencies and cost effectiveness – This goal will be accomplished by contracting with CCOs on a capitated basis to provide services through an efficient, cost effective system of care.

TARGET POPULATION

MississippiCAN was implemented in all 82 counties in the State of Mississippi for all eligible beneficiaries beginning January 1, 2011 for targeted, high cost Medicaid beneficiaries defined by these COEs:

- COE001 – SSI via SDX
- COE019 – Disabled children at home
- COE025 – Working Disabled
- COE026 – DHS CWS Foster Care
- COE027 – Breast-Cervical

On December 1, 2012 the eligible population of MississippiCAN was expanded to include all Foster Care children, Non-SSI Newborns 0 - 12 months, MA Adults, and Pregnant Women as defined by the following categories of eligibility and age requirements:

- COE003 – DHS-IV-E-Medicaid
- COE075 – Parents / Caretakers of minor children
- COE085 – Medical Assistance – Intact Family – Ages 19+
- COE088 – Pregnant Women, 185% FPL – Ages 8+
- Non-SSI Newborns – Ages 0 – 12 months
  - COE003 – DHS IV-E Medicaid
  - COE026 – DHS Foster Care
  - COE071 – Newborn age 0 – 1 with income at or below 185% FPL
  - COE085 – Medical Assistance for Intact Family – Ages 1 – 19
  - COE087 – Kids 0 – 6, 133% FPL
  - COE088 – Pregnant Women, 185% FPL
  - COE091 – Children under 19 under 100%

Effective December 1, 2012 all MississippiCAN populations were mandatory enrolled except SSI children, disabled children at home, Foster Care children, and members of the Choctaw Indian tribe.

Between December 2014 and July 2015 the eligible population of MississippiCAN was expanded again to include MississippiCAN Children as defined by the following categories of eligibility, age, and income requirements:

- COE072 – Children age 1 – 5 with income at or below 133% FPL
- COE073 – Children age 6 – 19 with income at or below 100% FPL
- COE074 – Children age 6 – 19 with income between 100% and 133% FPL who would have qualified for CHIP under pre-ACA rules
- COE085 – Medical Assistance for Intact Family – Ages 1 – 19
- COE087 – Children age 1 - 5 under 133%
- COE091 – Children under 19 under 100%

In COE074, children previously eligible for CHIP with income eligibility between 100% and 133% FPL are now covered by MississippiCAN and referred to as "Quasi-CHIP" children. Effective January 1, 2014, these children became Medicaid eligible rather than CHIP eligible due to income eligibility outlined in the Affordable Care Act. These children were moved into MississippiCAN effective December 1, 2014.

The MississippiCAN Children covered under the above COEs previously covered in the Medicaid program are called "MA Children." DOM phased in enrollment from FFS into MississippiCAN by July 2015, with the majority of children transitioned between May 2015 and July 2015.

Effective December 1, 2015, in conjunction with the movement of inpatient services into MississippiCAN, enrollment procedures were changed to enroll newborns in MississippiCAN on the day of their birth. Previously newborns were not enrolled until on average their second month of life due to a delay in assigning a Medicaid identification number and the enrollment process to enroll them in a CCO.

COVERED SERVICES

When MississippiCAN was first established in January 2011 three key services were initially excluded from the program. Over time each has been moved from being covered by FFS to MississippiCAN as follows:

- Behavioral health services – Rolled into MississippiCAN effective December 1, 2012
- Non-emergent transportation services – Rolled into MississippiCAN effective July 1, 2014
- Inpatient services – Rolled into MississippiCAN effective December 1, 2015

MississippiCAN continues to exclude costs for inpatient residential psychiatric stays, though members are not disenrolled from MississippiCAN. This allows for more effective discharge planning and post-discharge coordination of care. DOM monitors CCO efforts for delivery and coordination of care for children at high risk of placement into a residential psychiatric setting in order to ensure the best possible care for these children.

CCOs did not provide services not covered under MississippiCAN "in lieu of" covered services.

ENROLLMENT PERIOD

All beneficiaries will have the ability to choose the CCO of their choice. Enrolled beneficiaries will have an open enrollment period during the 90 days following their initial enrollment in a CCO during which they can enroll in a different CCO "without cause" and an open enrollment period from October to December of each year. During this time period, beneficiaries may choose to change their CCO.

Various "for cause" reasons for disenrollment at other times will incorporate federal requirements, such as: providers that do not (for religious or moral reasons) offer needed services; not all related services are available in the plan's network; or the plan lacks providers experienced in dealing with the enrollee's health care needs.

Eligibility criteria for MississippiCAN are the same as the eligibility criteria for Mississippi Medicaid.

The CCOs do not have the ability to directly market to the targeted beneficiaries. DOM provides information about choice of CCOs and enrolls the beneficiaries into their chosen CCO. The Medicaid Fiscal Agent provides some specific services of an enrollment broker to accomplish these tasks.

III. SFY 2017 RATE CELL DEFINITIONS

This section of our report outlines the rate cell definitions to be used for SFY 2017 for the populations addressed in this report. These definitions are summarized in Table 4 below.

Table 4
Mississippi Division of Medicaid
Rate Cell Definitions

Rate Cell	Age Requirement	Category of Eligibility (COE)*
Children		
SSI / Disabled Newborns	Ages 0 – 12 months (13 month duration)	01, 19
Non-SSI Newborns – age 0 – 2 months	Ages 0 – 2 months (3 month duration)	03, 26, 71, 85, 87, 88, 91
Non-SSI Newborns – age 3 – 12 months	Ages 3 – 12 months (10 month duration)	03, 26, 71, 85, 87, 88, 91
MA Children	Ages 1 – 19	72, 73, 85, 87, 91
Quasi-CHIP	Ages 1 – 19	74
Pregnant Women		
Pregnant Women	Ages 8 – 64	88
Delivery Kick Payment**	Ages 1+	75, 85, 88
Other Populations		
MA Adults	Ages 19+	75, 85
Non-Newborn SSI / Disabled	Ages 1+	01, 19, 25
Foster Care	Ages 1+	03, 26
Breast and Cervical Cancer	N/A	27

* *DOM updated COE codes effective January 1, 2014 to reflect new MAGI eligibility standards. COE codes 71, 72, 73, 74, and 75 are new codes and COE codes 85, 87 and 91 will be phased out. In addition, COE 88 changed from Pregnant Women and Infants to only Pregnant Women, with Infants covered under COE 71.*

***Delivery kick payment is only available for individuals in the MA Adult or Pregnant Women rate cells.*

After examining membership and claim experience, capitation rate cells for SFY 2017 were kept consistent with the SFY 2016 capitation rate cells.

All rate cell eligibility excludes the following individuals:

- Retroactive membership
- Dual eligible
- Institutionalized beneficiaries in a long-term care facility
- Individuals in the following waiver programs: SED, WAL, WED, WMR, WTB, or the Mississippi Youth Programs Around the Clock (MYPAC)
- Individuals diagnosed with Hemophilia or Von Willebrand disease

GEOGRAPHIC REGIONS

DOM uses regional payments to better reflect enrollment for CCOs that enroll a disproportionate number of members from higher-cost or lower-cost regions of the state. DOM uses the three regions of North, Central, and South based on the county where a beneficiary lives. Table 5 displays the counties included in each region.

Table 5
Mississippi Division of Medicaid
Geographic Regions by County

North Region	Central Region	South Region
Alcorn	Calhoun	Adams
Attala	Chickasaw	Amite
Benton	Choctaw	Covington
Bolivar	Claiborne	Forrest
Carroll	Clarke	Franklin
Coahoma	Clay	George
DeSoto	Copiah	Greene
Grenada	Hinds	Hancock
Holmes	Issaquena	Harrison
Humphreys	Jasper	Jackson
Itawamba	Kemper	Jefferson
Lafayette	Lauderdale	Jefferson Davis
Lee	Leake	Jones
LeFlore	Lowndes	Lamar
Marshall	Madison	Lawrence
Montgomery	Monroe	Lincoln
Panola	Neshoba	Marion
Pontotoc	Newton	Pearl River
Prentiss	Noxubee	Perry
Quitman	Okitbbeha	Pike
Sunflower	Rankin	Stone
Tallahatchie	Scott	Walthall
Tate	Sharkey	Wayne
Tippah	Simpson	Wilkinson
Tishomingo	Smith	
Tunica	Warren	
Union	Webster	
Washington	Winston	
Yalobusha	Yazoo	

To determine a beneficiary's county, we used the following approach:

a. County code included on a beneficiary's enrollment record in a given month.

b. Absent (a), we mapped zip codes in the enrollment file to counties. In cases where a zip code is present in more than one county, we assumed that a zip code maps to a given county if:

   i. The zip code shows up most frequently for a given county in the enrollment file (assuming a minimum of five occurrences).

   ii. Census information indicating the portion of a zip code's population that resides in each county. County is assigned to a zip code based on the county that includes the largest portion of a zip code's population.

   iii. If a beneficiary could not be assigned to a region, we excluded their eligibility and claim experience from the base data. This accounts for less than 0.5% of all current MississippiCAN eligible members.

IV. DATA SOURCES

MEDICAID ELIGIBILITY

DOM's MMIS vendor provided detailed Medicaid FFS claim and eligibility data for CY 2014 to form the base period data for rate development. Before analyzing claims, we pared down the eligibility data to groups that are eligible to enroll in MississippiCAN as defined in Section III of our report.

In order to isolate data only for this group, we applied various filters as described in the rest of this section of our report.

If the population was enrolled in MississippiCAN at the time of the data, we relied upon the 'CAN' lckn_cd for each eligibility span to include individuals enrolled in MississippiCAN in CY 2014 and did not apply most of the additional filters described below, assuming that MMIS-calculated enrollment criteria in CY 2014 is consistent with SFY 2017. In addition, this removes voluntary populations, which has been stable in recent experience, from the base data used to develop capitation rates. However, adjustments were still made for the removal of retroactive eligibility periods and records we were not able to map to a geographic area.

Removal of Retroactive Eligibility Periods

Beneficiary enrollment in the FFS program can occur retroactively. When some individuals apply and qualify for Medicaid coverage, DOM reimburses claims which occurred during the retroactive qualification period prior to their application. DOM backdates the eligibility of the individual to accommodate the retroactive coverage.

There is also a lag between the first date of eligibility and the date of enrollment in a CCO because Medicaid eligibility begins on the first day of the month in which the application was received. Once a Medicaid beneficiary signs up for a CCO, they will be enrolled on the first day of the subsequent month. The retroactive enrollment period is not covered by the CCO, so we removed retroactive eligibility included in the data provided to us using the following criteria:

- Eligibility months prior to the date that a beneficiary was added to the Medicaid enrollment file were removed. For example, if a beneficiary is active 1/15/14 but they were added to the enrollment file 2/1/14, we only included data on or after 2/1/14 to exclude any retroactivity that may have occurred.

Excluded Eligibility Categories

Not all Medicaid beneficiaries are eligible to enroll in the MississippiCAN program. In addition to limiting membership to the COEs described earlier, several other filters were applied to the enrollment data for FFS enrollees to remove Medicare eligible beneficiaries, institutionalized beneficiaries, and beneficiaries participating in other waiver programs. Both the exposure and claims for the following populations are excluded from the data used to set capitation rates.

Medicare Enrollment Spans

In addition to the COE exclusions that identify Medicare eligibles (i.e., COE Codes 031, 051, 054, and 057), we also removed any enrollees that were known to have been eligible for Medicare. Specifically, we used the date fields provided in the eligibility files to isolate the timeframes when enrollees were eligible for Medicare. If a beneficiary was Medicare eligible any time during a given month, the exposure and claims for that member month were removed for purposes of the capitation rate development.

Medicare Crossover Claims

Per DOM staff, Medicare claims with a claim type field of "A, B, or U" indicate that Medicare is making payments on a claim. We used this as another way to identify Medicare eligible beneficiaries. If a Medicare claim was incurred in a month, then all claim and enrollment records from the month were excluded from the capitation rate development.

Institutionalized Population

In addition to the COEs that identify institutionalized beneficiaries (i.e., COE Codes 005, and 010), we also removed institutionalized beneficiaries based on LTC codes in the eligibility files indicating dates that a person was institutionalized. Additionally, any individuals receiving services for category of service (COS) 26 – Inpatient Residential Psych were also removed from the data. If a beneficiary was institutionalized any time during a given month, the member months and any corresponding claims were removed for purposes of rate setting.

Waiver Program Exclusions

In addition to the COEs that identify various waiver programs (i.e., COE Codes 046 – 049, 057, 062 – 067), we also removed waiver beneficiaries based on information from the eligibility files indicating dates that a person was in a waiver program. Per DOM staff, a beneficiary is enrolled in waiver program if their lock in code (data field "lckn_cd") equals SED, WAL, WED, WIL, WMR, or WTB. When this occurred, we removed their eligibility record for each month of such occurrence. Any individuals receiving services for the Mississippi Youth Programs Around the Clock (MYPAC) (COS 57) were also removed from the base data.

Hemophilia / Von Willebrand Disease Carve-Out

Members that would otherwise be eligible for MississippiCAN, but have been diagnosed with hemophilia or Von Willebrand disease were excluded from the program effective December 1, 2012, and services for these individuals are covered by the Medicaid FFS system. Exposure and claims for 710 member months totaling $2.8 million in claims for CY 2014 have been removed from the FFS data used to calculate the capitation rate for MA Children. A diagnosis of hemophilia or Von Willebrand disease was assigned to a member based upon ICD9 and NDC mappings consistent with the MississippiCAN specific risk adjustment weights developed by us. A list of the hemophilia related ICD9 and NDC codes can be found in Appendix C1.

Geographic Area

If a beneficiary could not be assigned to a region, we excluded them from the base data. This accounts for less than 0.50% of all current MississippiCAN eligible members. See Section III of this report for additional information on the assignment of a geographic region.

FFS DATA

FFS claims are included in the data provided by DOM's MMIS vendor. These claims include any populations and / or services not included in MississippiCAN and are utilized primarily for the following in the development of capitation rates.

- MA Children historical experience
- Newborn experience from the day of their birth until they were enrolled in a CCO
- Inpatient services

We reviewed the FFS data for reasonability for several considerations, including the following, and verified it was consistent with monthly DOM cost reporting.

We reviewed the FFS data for several considerations, including:

- Monthly claim counts per member
- Monthly payments per member
- Average cost per unit
- Monthly units and payments by COS
- Monthly units and payments by rate cell

ENCOUNTER DATA

Encounter claims are included in the data provided by DOM's MMIS vendor. This data represents the actual amounts paid to the provider, so no repricing was done as part of the development of capitation rates. A claim processed by a CCO and submitted to DOM can be identified in the data using the following definition. Please note that the field names may vary from those provided in the encounter data submission from the CCOs.

- The 6th character of claim_id is '5' and cl_type is 'R', or
- The 6th character of claim_id is '0' and cl_type is not 'R'.

Only encounter claims for members flagged as a MississippiCAN enrollee in the eligibility data were included in the base data. Encounter claims which failed to be mapped to a MississippiCAN enrollee were removed; this affected about 0.7% of all encounter claims in the data.

We reviewed the encounter data for several considerations, including:

- Monthly encounter counts per member (including and excluding $0 payments)
- Monthly payments per member
- Average cost per unit
- Monthly units and payments by COS
- Monthly units and payments by rate cell
- Quarterly units and payments relative to financials by COS
- Frequency of diagnosis completion by COS and against FFS

Overall, the paid amounts in the encounters reconcile well to the paid amounts shown in the CCO financial reporting for the Adult and Newborn populations. Differences between encounter data paid amounts and financial reporting are primarily driven by two issues.

1) The encounter data lacks a definitive field to indicate duplication of claim submissions. We attempt to de-duplicate the encounter data, but there are likely some non-final claims still reflected in the final data set. This tends to increase encounter paid amounts.

2) Encounter submissions are incomplete due to difficulties in DOM system edits, provider IDs, and other issues. This tends to decrease encounter paid amounts.

We also applied corresponding adjustments to the encounter data for any considerations outlined in the Financial Reporting Section of this report, when those adjustments are also applicable to the encounter data. Those applicable adjustments include excluding pharmacy benefit managed expenses from medical costs and excluding the value of expanded benefits.

Because of differences in rate cell reporting between encounters and financial reporting, we are applying high level adjustments to CCO claim experience by category of service for the incorporation of encounter data. Overall, encounter paid amounts are estimated to be 0.81% lower than the financial paid amounts including paid claims, Incurred But Not Reported (IBNR) estimates, and subcapitated amounts. Please see Appendix A for additional details behind the development of this difference.

FINANCIAL REPORTING DATA

For base data development, each CCO submitted a financial report tied to their organization's audited CY 2014 financial statements for MississippiCAN and for CHIP / Quasi-CHIP, if applicable. This report included CY 2014 earned premium, claim experience with run out through June 2015, best estimate IBNR claim amounts, subcapitated arrangements, administrative expenses, and membership. The reported membership was close in total to the MMIS enrollment, so in general we utilized the reported membership for rate development. The one exception was to reallocate newborn membership between the SSI / Disabled Newborn, Non-SSI Newborns 0 – 2 months, and Non-SSI Newborns 3 – 12 months newborn rate cells. In total, the membership was consistent with the enrollment summarized from MMIS; however, it did not follow the same allocation across rate cells.

We worked with each CCO to validate that this report was filled out consistently with the category of service and non-medical definitions used in the capitation rate development. Adjustments were made to the original submissions to help align these definitions as well as allocating costs between populations.

Additionally, each CCO submitted a financial report containing CY 2015 and emerging experience from January through June 2016. We reviewed these templates alongside our projected SFY 2017 rates, and used this to further inform our trend factor development.

Financial Reporting Adjustments

Non-Benefit Expenses

Costs that are included in the non-benefit expense load for MississippiCAN rates were removed from the medical portion of the financial reporting.

- Medical management costs: We moved $3.3 million from the medical portion of the financial reporting data to non-benefit expenses for these services, as reported by the CCOs.

- Pharmacy Benefit Manager Expenses: We moved $11.3 million from the medical portion of the financial reporting data to non-benefit expenses for these services, as reported by the CCOs.

Expanded Benefits

The value of expanded benefits offered to plan members that are not state plan covered benefits were excluded from rate development. These benefits include services such as revised limits on physician visits or prescriptions, member incentive programs, enhanced vision benefits, and other services provided to members. The costs of expanded benefits, other than eliminating the twelve visit annual physician limit were identified in CCO financial reporting and equivalent to approximately 0.25% of total reported medical costs. These costs were removed from the financial reporting to develop MississippiCAN capitation rates.

The most significant expanded benefit is the coverage of physician office visits beyond the twelve visit annual maximum in effect for FFS Medicaid. The value of these services was not estimated by the CCOs but rather developed using the following methodology.

- The physician office visit limit does not apply to emergency department visits or inpatient hospital consults. This benefit differential is only applicable for MA Adults and SSI adults, since pregnant women and newborns are eligible to receive all medically-necessary services under FFS. In order to estimate the value of this supplemental benefit, we examined the percentage of costs we identified as exceeding twelve visits in the calendar year 2014 base period encounter data relative to the last calendar year covered under FFS. Since managed care for MA Adults began on December 1, 2012, we extrapolated December 2012 visits under FFS from previous months in 2012 in order to compare to the base period data. Table 6 illustrates the results of the analyses, with approximately 0.4% – 0.5% of total medical costs identified as expanded benefits and removed from rate development.

Table 6
Mississippi Division of Medicaid
Estimated Expanded Physician Office Visit Costs

Rate Cell	% of Physician Costs Under MSCAN	% of Physician Costs Under FFS	% Difference	Difference as % of Total Costs
Non-Newborn SSI / Disabled	12.27%	3.32%	8.94%	0.40%
MA Adult	8.36%	2.95%	5.41%	0.48%

Subcapitated Claims

Each CCO contracted with providers to subcapitate various services, differing by CCO, including behavioral health services, vision, non-emergency transportation, and radiology in CY 2014. Subcapitated services for non-emergency transportation did not become a covered service until July 1, 2014. We excluded these services from base period data, since we make a separate adjustment for this new benefit later in the rate development process.

Subcapitated costs were identified separately in the financial data by each CCO. Additional information was provided for subcapitated vendors that were related parties to the CCO. If applicable, adjustments were made to reflect market level margins for these related parties. In addition, subcapitated costs were reduced by 8.25% to remove margin and variable expense loads that are later included in the development of capitation rates.

Financial Reporting Reallocations

The following adjustments were made to the financial reporting submitted by the CCOs. No costs were added or subtracted in these adjustments.

Subcapitated Claims by Category of Service

All subcapitated claim amounts were included as 'other services' on the financial reporting. These claims were allocated to the applicable category of service as follows:

1) Behavioral health services – For each rate cell, subcapitated behavioral service amounts were allocated based on the relationships in the MMIS encounter data between physician and outpatient services

2) Vision services – Physician services

3) Radiology – Physician Services

Newborn Rate cells

In total, the membership and costs for the three newborn rate cells; SSI / Disabled Newborns, Non-SSI Newborns 0 – 2 months, and Non-SSI Newborns 3 – 12 months, was consistent with the enrollment and costs from the MMIS system, however, the reported amounts in the financials were not consistent by rate cell. Therefore, we reallocated these costs and enrollment between the three rate cells using the relationships in the MMIS encounter data.

Delivery Kick Payment

Delivery costs are reported by the CCOs with the mother in their applicable rate cell; Pregnant Women, or the MA Adult rate cell. We utilized encounter data relationships to allocate delivery costs from each of these rate cells into the Delivery Kick Payment. The delivery costs for a mother's delivery were identified by the existence of one or more of the following ICD9 procedure codes or CPT procedure codes within an inpatient stay.

ICD-9 Procedure Codes

- 7220 - 7229, 7230 - 7239, 7250 - 7254, 7270 - 7279, 7300 - 7309, 7320 - 7322, 7350 - 7359, 7390 - 7399, 7492 - 7499, 7490, 720, 721, 724, 726, 728, 729, 731, 733, 734, 736, 738, 740, 741, 742, 743, or 744

CPT Procedure Codes

- 59400 - 59414, 59510 - 59515, 59618 - 59622, 59610 ,59612, 59614, 01958, 01960, 01967, 01961, or 01968

Quasi-CHIP

Financial reporting for the Quasi-CHIP population was included with CHIP financial reporting submitted by the CCO administering the program in CY 2014 for dates of service from January 2014 to November 2014. On December 1, 2014 the population transitioned into MississippiCAN. The CCO relied upon DOM provided member identifiers for the Quasi-CHIP population to separate their experience from the remainder of the CHIP population. Detailed encounter data is not available for this population to perform a reconciliation. Therefore, we performed reasonability tests on the cost metrics between the Quasi-CHIP population and the remaining CHIP population between CY 2013 and January through November 2014. We also performed similar validations and outreach to the CCO as we did for the broader MississippiCAN financial reporting.

APPENDIX A

Capitation Rate Methodology – Adults and Newborns

APPENDIX A
CAPITATION RATE METHODOLOGY – ADULTS AND NEWBORNS

This section of our report describes the development of the SFY 2017 MississippiCAN capitation rates for populations that had MississippiCAN experience in CY 2014, the base period used to develop SFY 2017 capitation rates. This includes the following rate cells:

- Non-Newborn SSI / Disabled
- Foster Care
- Breast and Cervical Cancer
- SSI / Disabled Newborn
- MA Adult
- Pregnant Women
- Non-SSI Newborns 0 - 2 Months
- Non-SSI Newborns 3 - 12 Months
- Delivery Kick Payment

METHODOLOGY OVERVIEW

The methodology used to calculate the capitation rates can be outlined in the following steps:

1. Summarize encounter data for CY 2014 MississippiCAN enrollees described in Section IV of the main report.

2. Summarize financial reporting data for CY 2014 MississippiCAN enrollees described in Section IV of the main report.

3. Summarize FFS costs for CY 2014 MississippiCAN enrollees for inpatient services described in Section IV of the main report.

4. Combine financial reporting data, encounter data, and FFS data.

5. Apply trend and any program or reimbursement changes from CY 2014 adjusted experience to SFY 2017, adjust for enhanced PCP payment under ACA for 2014 and continued in 2015, and add provision for non-emergency transportation coverage.

6. Provide an allowance for CCO non-benefit expenses.

7. Adjust for geographic region.

8. Adjust for CCO specific risk scores (if applicable).

9. Add MHAP Payments.

Each of the above steps is described in detail below.

Step 1: Summarize Encounter Data for CY 2014 MississippiCAN Enrollees

In this step, the estimated encounter data expenditures by rate cell and category of service for both CCOs is combined to show the CY 2014 claim experience for MississippiCAN enrollees. The total program encounter cost relativity versus financial reporting is developed in Exhibit A1. Note that, because of inconsistencies in rate cell level reporting definitions, we are using financial reporting to generate high level encounter data costs by broad category of service. In total encounter data is 0.81% lower than financial data. Table 1 displays the relationship of encounter data to financial reporting by broad category of service. Throughout capitation rate development, the detailed encounter data relationships have been used for various budget neutral analyses.

APPENDIX A
CAPITATION RATE METHODOLOGY – ADULTS AND NEWBORNS

Table 1
Mississippi Division of Medicaid
Statewide FFS CY 2014 MississippiCAN Enrollment and Costs
Relationship of Encounter Data and Financial Reporting

	Financial Reporting - Paid	Encounter Data*	Subcapitated and IBNR Claims**	% Difference
Outpatient	$160,154,945	$165,035,365	$6,070,008	2.94%
Physician	$231,221,210	$232,043,346	$65,067,587	0.28%
Prescription Drugs***	$211,930,611	$211,930,611	$0	0.00%
Dental	$11,562,085	$10,465,344	$124,618	-9.38%
Other	$41,277,502	$30,745,758	$7,184,908	-21.73%
Total Claims	**$656,146,353**	**$650,220,424**	**$78,447,121**	**-0.81%**

** With paid run-out through June 30, 2015 to match financial reporting.*
*** Subcapitated and IBNR claims added to both financial reporting and encounter data.*
**** Prescription drug encounter data paid amounts limited to amounts reported in financial data due to known issues related to duplicate encounters.*

Step 2: Summarize Financial Reporting Data for CY 2014 MississippiCAN Enrollees

In this step, the financial reporting for both CCOs, including any adjustments, is combined to show the CY 2014 claim experience for MississippiCAN enrollees at a broad category of service level. The following adjustments are then applied to the blended data.

IBNR Adjustment

The adjustment for Incurred but Not Reported (IBNR) claims uses the best estimate IBNR claims provided by each of the CCOs in their financial reporting. We validated the reasonability of these estimates relative to claim payment patterns observed for FFS populations.

The following high level reasonability checks were performed on the reported IBNR amounts from each CCO:

1) Data, including IBNR estimates, was reported on a quarterly basis by each CCO. We reviewed the reported IBNR by quarter to determine that there was a reasonable pattern throughout the year (i.e., IBNR amounts held for Q1 2014 were significantly lower than Q4 2014).

2) IBNR estimates between the two CCOs were reviewed to validate that they were approximately the same on a percentage of total claims.

3) Using encounter data submitted by the plans, independent estimates of IBNR were calculated using the Milliman CREW® model, which employs the classical chain-ladder approach by building claim lag triangles by category of service. For the most recent months, we gave weight to trended historical PMPMs in addition to the completion factor-developed approach. We reviewed all historical payment patterns and results for outliers and adjusted when appropriate. These independent estimates were compared to the estimates provided by the CCOs are were within a reasonable range.

4) Based on our experience with other Medicaid managed care organizations in other states the IBNR estimates are reasonable for similar periods of claim run-out.

This adjustment is shown in Exhibit A2 in column (c).

Subcapitated Claims

Each CCO contracted with providers to subcapitate various services, differing by CCO, including behavioral health services, vision, non-emergency transportation, and radiology in CY 2014. Subcapitated services for non-emergency transportation were excluded as they did not become a covered service until July 1, 2014 and, therefore, only half a year of experience is included in the financial data reporting. A separate PMPM add-on is included for these services in Step 5.

Subcapitated costs were identified separately in the financial data by each CCO. Additional information was provided for subcapitated vendors that were related parties to the CCO. If applicable, adjustments were made to reflect market level margins for these related parties. In addition, subcapitated costs were reduced by 8.25% to remove margin and variable expense loads that are later included in the costs in Step 6.

Subcapitated costs are summarized in Exhibit A2 in column (e).

Final PMPM Base Period Costs

Total base period PMPM costs excluding expanded benefits by rate cell are shown in Exhibit A2 column (f).

Step 3: Summarize FFS Inpatient Costs for CY 2014 MississippiCAN Enrollees

In this step we summarize inpatient costs from FFS data and apply adjustment factors to reflect differences between the base period Medicaid FFS inpatient data and the MississippiCAN program. Each adjustment factor is explained in detail below.

Claims and eligible member months were summarized from the FFS data for CY 2014 for inpatient services. The resulting Allowed Costs (net paid amount plus beneficiary copays) by rate cell are shown in Table 2.

Table 2
Mississippi Division of Medicaid
Statewide FFS CY 2014 MississippiCAN Enrollment and Costs
Hospital Inpatient Costs

Rate Cell	Member Months / Deliveries	Allowed Costs	PMPM / Per Delivery
Non-Newborn SSI / Disabled	763,250	$147,232,991	$192.90
Foster Care	49,122	$3,016,307	$61.40
Breast and Cervical Cancer	1,447	$273,469	$188.99
SSI / Disabled Newborn	5,470	$6,588,499	$1,204.48
MA Adult	582,128	$31,221,282	$53.63
Pregnant Women	136,265	$11,485,774	$84.29
Non-SSI Newborns 0 - 2 Months	27,087	$2,313,553	$85.41
Non-SSI Newborns 3 - 12	256,298	$9,637,863	$37.60
Delivery Kick Payment	21,359	$72,222,968	$3,381.38
All Rates Cells	**1,821,067**	**$283,992,706**	**$155.95**

Note this step excludes the consideration of newborn experience from FFS prior to enrollment in MississippiCAN, which moved into capitation effective December 2015. That adjustment is implemented in Step 5.

IBNR Adjustment

The adjustment for Incurred But Not Reported (IBNR) claims uses completion factors that we developed based on DOM's historical claims payment patterns.

We used the Milliman CREW® model, which employs the classical chain-ladder approach by building claim lag triangles by category of service, to develop the inpatient IBNR adjustments. For the most recent months we gave weight to trended historical PMPMs in addition to the completion factor-developed approach. We reviewed all historical payment patterns and results for outliers and adjusted when appropriate.

We calculated these adjustments by region in aggregate across all rate cells for inpatient services. We do not have reason to believe the speed of inpatient service payment varies based on the category of eligibility of a member. Performing these calculations at a rate cell level would generate variable, and likely non-credible, results for smaller rate cells.

Such adjustments are required since we received data with claim payments through June 2015.

This adjustment is shown in Exhibit A2 in column (c).

Third Party Liability Recoveries

DOM provided us with a summary of the aggregate third party liability (TPL) recoveries that are not reflected in the claims data. We summarized paid claims data by state fiscal year (SFY) for all Medicaid fee-for-service programs to develop a TPL adjustment factor which averaged 0.90% of all Medicaid claim expenditures for SFY 2010 through SFY 2015. We assume that the CCOs will be at least as aggressive in capturing TPL recoveries as occurs in FFS, since they retain financial incentive to do so. Therefore, we used a downward adjustment of 0.90% to inpatient allowed costs in our capitation rate calculation.

This adjustment is shown in Exhibit A2 in column (d).

Final PMPM Base Period Costs

Resulting PMPM costs by rate cell are shown in Exhibit A2 column (f).

Step 4: Combine Financial Reporting, Encounter Data, and FFS Inpatient Data

Encounter data and financial reporting data was blended together using the percentage of encounter data shown in Table 3. Applying weight to encounter data overall reduces the blended data by 0.24% compared to solely using financial reporting data for the development of capitation rates.

Table 3
Mississippi Division of Medicaid
Statewide FFS CY 2014 MississippiCAN Enrollment and Costs
Relationship of Encounter Data and Financial Reporting

	% Difference	Encounter Data Weight	% Difference Applied
Outpatient	2.94%	20%	0.59%
Physician	0.28%	20%	0.06%
Prescription Drugs	0.00%	50%	0.00%
Dental	-9.38%	50%	-4.69%
Other	-21.73%	20%	-4.35%
Total Claims	**-0.81%**	**30%**	**-0.24%**

APPENDIX A
CAPITATION RATE METHODOLOGY – ADULTS AND NEWBORNS

After combining together the data sources by the percentages shown in Table 3 and column (b) of Exhibit A3 by broad category of services, the following CY 2014 PMPMs were calculated by rate cell.

Table 4
Mississippi Division of Medicaid
MississippiCAN Statewide CY 2014 PMPM Costs

Rate Cell	Non-IP PMPM	IP PMPM	Total PMPM
Non-Newborn SSI / Disabled	$559.00	$192.06	$751.06
Foster Care	$203.74	$61.13	$264.87
Breast and Cervical Cancer	$2,413.10	$188.16	$2,601.26
SSI / Disabled Newborn	$1,907.70	$1,199.19	$3,106.88
MA Adult	$279.43	$53.40	$332.83
Pregnant Women	$337.69	$83.92	$421.61
Non-SSI Newborns 0 - 2 Months	$241.65	$85.04	$326.69
Non-SSI Newborns 3 - 12 Months	$161.39	$37.44	$198.83
Delivery Kick Payment	$1,362.81	$3,366.53	$4,729.33
All Rates Cells	**$403.05**	**$155.26**	**$558.31**

Step 5: Trend CY 2014 Adjusted Experience to SFY 2017

Table 5 shows the annual utilization and unit cost trends applied to the CY 2014 adjusted experience data in order to put it on a SFY 2017 basis. The CY 2014 experience is trended from the base period midpoint, July 1, 2014, to the midpoint of January 1, 2016. The hospital inpatient, hospital outpatient, physician, and dental Medicaid FFS fee schedules are updated on July 1st of each year, as described in detail later in this section. For this rate development iteration, we assume no change to the dental fee schedule for SFY 2017. DOM does not mandate provider reimbursement levels other than to require reimbursement be at least as great as FFS. We assume that CCO reimbursement levels will move in tandem with changes to FFS reimbursement.

Table 5
Mississippi Division of Medicaid
CY 2014 to SFY 2017 Utilization and Unit Cost Trends

	Annualized Utilization Trend			Annualized Unit Cost Trend		
COS	**SSI***	**MA****	**Delivery**	**SSI***	**MA****	**Delivery**
Hospital Inpatient	3.00%	3.50%	1.00%	0.28%	0.28%	0.28%
Hospital Outpatient	5.00%	5.00%	1.00%	1.91%	1.91%	1.91%
Physician	5.00%	5.00%	1.00%	0.70%	0.70%	0.70%
Prescription Drugs	4.00%	4.50%	1.00%	10.50%	11.00%	11.00%
Dental	2.00%	2.00%	1.00%	3.54%	3.87%	3.87%
Other	5.50%	5.50%	1.00%	0.70%	0.70%	0.70%

** SSI includes the following rate cells: Non-Newborn SSI / Disabled, Foster Care, Breast and Cervical Cancer, and SSI / Disabled Newborn.*

*** MA includes the following rate cells: MA Adults, Pregnant Women, and Non-SSI Newborns 0 - 2 months, Non-SSI Newborns 3 - 12 months.*

The rest of this section outlines the methodology used to develop these trend values.

Utilization Trend

Utilization trend reflects expected changes in:

- Demand for medical services
- Intensity or mix of medical services
- Provider practice patterns
- Provider coding changes

We reviewed multiple data sources to determine utilization trends for use in the SFY 2017 rate development.

- Historical trends by major service categories
- Q1 CY 2015 to Q2 2016 claim experience as reported by CCOs in detailed financial reporting
  - In particular, it appears that new 2016 enrollees may be accessing services more quickly upon enrollment that in previous years, rather than taking a year or more to establish provider relationships
- Experience from similar Medicaid programs in other states

The adjustment resulting from these utilization trends is shown in Exhibit A4 in column (b).

Hospital Inpatient Unit Cost Trend

DOM reimburses hospital inpatient claims using an APR-DRG methodology based upon the 3M Medicaid grouper, with updates to the fee schedule implemented July 1st of each year. The APR-DRG update on July 1, 2016 will be a budget neutral update.

Table 6
Mississippi Division of Medicaid
Inpatient Unit Cost Increase

Effective Date	Rate Increase
7/1/2014	1.00%
7/1/2015	0.00%
7/1/2016	0.20%

The Table 5 inpatient services unit cost trend of 0.28% is a blend of the values from Table 6. Column (c) in Exhibit A4 includes this adjustment for the inpatient hospital services line.

Hospital Outpatient Unit Cost Trend

DOM updates the hospital outpatient fee schedule July 1st of each year consistent with the Medicare APC Jackson, Mississippi conversion factor update. Historical and projected increases are shown in Table 7 below. The July 1, 2015 increase also accounts for the implementation of Outpatient APC Phase II changes, estimated by DOM to have a 4.00% impact.

Table 7
Mississippi Division of Medicaid
Outpatient Unit Cost Increase

Effective Date	Rate Increase
7/1/2014	2.72%
7/1/2015	4.00%
7/1/2016	-0.53%

The Table 5 outpatient services unit cost trend of 1.91% is a blend of the values from Table 7. Column (c) in Exhibit A4 includes this adjustment for the outpatient hospital services line.

Physician and Other Unit Cost Trend

DOM changes most of these fee schedules July 1st of each year with the most recent Mississippi Medicare fee change. Historical and projected changes to Medicare's fee schedules, which generally form the basis for FFS reimbursement, are shown in Table 8 below. Cost for "other services," such as laboratory, radiology, and durable medical equipment is a small portion of total costs, and we use physician cost trend increases as a reasonable assumption for the reimbursement trend for these other services.

Table 8
Mississippi Division of Medicaid
Physician and Other Services
Unit Cost Increase

Effective Date	Rate Increase
7/1/2014	1.50%
7/1/2015	0.25%
7/1/2016	0.75%

The Table 5 physician and other services charge trend of 0.70% are a blend of the values from Table 8.

The per-encounter FQHC and RHC reimbursement is included in the MississippiCAN capitation rates to provide a steadier cash flow to the RHCs and FQHCs that serve the MississippiCAN population. The CCOs are expected to reimburse FQHCs and RHCs at DOM's per-encounter rates. DOM will monitor the utilization of services at FQHCs and RHCs under MississippiCAN to ensure services are not diverted from FQHCs and RHCs to other providers.

Column (c) in Exhibit A4 includes the adjustment to trend CY 2014 adjusted experience to a SFY 2017 basis.

Dental Unit Cost Trend

Effective July 1, 2014, DOM implemented increases to FFS fee schedules. In order to approximate the annual charge trend for rate development, we first identified the most utilized dental codes from the SSI and MA populations CY 2013 encounter data experience. Then, we examined the historical DOM dental fee schedules and summarized the rates from the prior SFY 2014 and SFY 2015 fee schedules of the most utilized dental codes. We compared the rates between these two fee schedules to arrive at an approximate 14.93% one-time charge increase for the SSI population and 16.92% for the MA population.

For this rate development iteration, we assume no change to the dental fee schedule for SFY 2017.

Historical and projected increases are shown in Table 9 below.

Table 9
Mississippi Division of Medicaid
Dental Unit Cost Increase

Effective Date	SSI	MA
7/1/2014	14.93%	16.92%
7/1/2015	2.00%	2.00%
7/1/2016	0.00%	0.00%

** SSI includes the following rate cells: Non-Newborn SSI / Disabled, Foster Care, Breast and Cervical Cancer, and SSI / Disabled Newborn.*
*** MA includes the following rate cells: MA Adults, Pregnant Women, and Non-SSI Newborns 0 - 2 months, Non-SSI Newborns 3 - 12 months.*

The Table 5 unit cost trends of 3.54% and 3.87% are a blend of the values from Table 9. Column (c) in Exhibit A4 includes this adjustment for the dental services line.

Prescription Drug Unit Cost Trend

We analyzed 2012 to 2015 pharmacy experience for the eligible population and developed utilization and cost summaries by brand, generic, and specialty drug types for the 25 top therapeutic classes for non-specialty prescriptions and the 5 top therapeutic classes for specially prescriptions. We developed cost projections for CY 2014 to SFY 2017, using those summaries, giving consideration for script utilization per 1,000 increases and average script cost increases for brand, generic, and specialty drugs. Considerations were made when reviewing prescription drug experience after the movement of MA Children into MississippiCAN beginning in May 2015 in order to only reflect true drug trend and not any managed care savings achieved.

For the preliminary rates we have not modeled the impact of brand patent expiries and resulting shifts in utilization to generic alternatives. Once future updates to the PDL are established we will reevaluate the potential impact of cost and utilization shifts.

As a result of this analysis, we applied an annualized unit cost increase of 10.0% for the SSI population and 11.0% for the MA population to CY 2014 experience for drug services. These assumptions also give consideration to Q1 and Q2 2016 claim experience reported on CCO financial reporting.

The prescription drug unit cost trend was increased by 0.5% to 10.5% for the SSI population to reflect anticipated cost increases for individuals ages 12 and older with cystic fibrosis due to the release of Orkambi in 2015. No additional costs are anticipated for the MA population. The increase to drug trend was developed by identifying individuals ages 12 and over in these rate cells with cystic fibrosis based upon utilized prescription drugs and diagnosis codes in December 2015. Of these members 40% were assumed to utilize Orkambi in SFY 2017 at an annual cost of $259,000. This additional program cost increases drug spend approximately 1.00% which was translated into an additional 0.5% trend over 30 months.

Column (c) in Exhibit A4 includes the cost adjustment for the drug services.

Coordinated Care Savings Assumptions

Adults and newborns have been enrolled in MississippiCAN for several years, though inpatient services only started being covered under capitation effective December 2015. In the first two years of the program, the Inpatient Savings Guarantee Program demonstrated that CCOs achieved inpatient savings of approximately 15% for individuals enrolled in MississippiCAN. Examination of Q1 and Q2 2016 financial reporting indicates little or no additional savings being achieved with the services covered under capitation. For these reasons, we are not assuming any additional coordinated care savings for rate development for these populations.

Evaluation and Management Adjustment

The Affordable Care Act (ACA) amended sections 1902(a) (13), 1902(jj), 1905(dd), and 1932(f) of the Social Security Act required that payment to eligible primary care physicians (PCP) for certain primary care services from January 2013 through December 2014 be made at Medicare rates in effect during those years (but not less than the applicable rate using the 2009 Medicare conversion factor). DOM extended these rates through June 30, 2015, after which they will be paid at 100% of Medicare, which is still an enhancement from the non-eligible physician services being reimbursed at 90% of Medicare. Therefore, an adjustment was made to reflect the reimbursement difference between the CY 2014 base period data and the SFY 2017 projection period. The CY 2014 base period data reflects the enhanced rate of approximately 106% of Medicare versus the SFY 2017 reimbursement at 100% of Medicare.

To the extent that these services (or their successors) are covered under MississippiCAN, the following primary care services are eligible for the enhanced payment:

- Evaluation and Management (E&M) Current Procedural Terminology (CPT) Codes 99201 through 99499

- Vaccine administration Codes 90460 – 90461, 90465, and 90471 – 90474. The final rule also updates the interim regional maximum fees for vaccine administration provided under the Vaccines for Children (VFC) program

Eligible physicians must self-attest that they meet the following qualifications.

1) Specialty designation of family medicine, general internal medicine, and pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association, and

2) One of the following:

   i. Board certified in an eligible specialty or subspecialty, **OR**
   ii. 60% of the Medicaid claims for the prior year were for the services covered by the regulation.

The following criteria were used to determine the portion of the SFY 2017 capitation rates represented by primary care providers and procedure codes eligible for the enhanced reimbursement.

The following provider specialties are eligible for the enhanced reimbursement:

- Provider Specialty Code 000 – General Practitioner
- Provider Specialty Code 001 – Pediatrician
- Provider Specialty Code 012 – Internist
- Provider Specialty Code 031 – Family Practice

All specialty fields for a provider within the data received from DOM's Medicaid Management Information Systems (MMIS) vendor were reviewed; and if any specialty field was flagged as one of the these four specialties, the provider was included as being eligible for the enhanced reimbursement.

Eligible services include the following:

- Vaccine Administration Codes: 90460, 90461, 90465 , 90471, 90472, 90473, 90474
- Evaluation and Management Codes: 99201 – 99499

Per the Final Rule, services provided in Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), state health clinics, and nursing homes were excluded. Mississippi state health clinics are reimbursed on an encounter basis and nursing homes are reimbursed on a per diem basis, making them ineligible for the enhanced primary care payment. DOM believes that all physician extenders will be eligible for enhanced payment levels, though the current payment differential of 10% will be maintained.

APPENDIX A
CAPITATION RATE METHODOLOGY – ADULTS AND NEWBORNS

To develop the final medical component of the revised capitation rates, the portion of the rates associated with PCP services eligible for enhanced reimbursement was adjusted from the CY 2014 reimbursement level to 100% of Medicare.

This adjustment is shown in Exhibit A4 in column (e).

Pharmacy Reimbursement Changes

There are a number of changes that will be implemented to pharmacy reimbursement in MississippiCAN as a result of the Covered Outpatient Drug final rule (CMS-2345-FC) (81 FR 5170) published by CMS on February 1, 2016.

1) As part of the Affordable Care Act, Federal Upper Limits (FULs) are imposed on generic drug pricing. DOM implemented this change on April 11, 2016.

2) By April 1, 2017 DOM must finalize changes to reimbursement methodology to move to an actual acquisition cost plus professional dispensing fee to be established by DOM.

3) As a result of the implementation of the FULs and change in reimbursement methodology DOM is evaluating changes to the preferred drug list (PDL), with implementation phased in starting as early as January 1, 2017.

These rates also continue to use the same PDL adjustment as SFY 2016 capitation rates which reflects the impact of moving to a uniform PDL on January 1, 2015 and revisions to the PDL implemented on July 1, 2015. Once the PDL is revised for the Covered Outpatient Drug rule, we will review the impact and, if material, make adjustments to SFY 2017 capitation rates.

To determine the impact of the establishment of FULs, we reviewed March 2016 pharmacy claims in conjunction with the March FULs. We repriced prescriptions whose ingredient cost exceeded the FUL and determined the percentage impact on the total cost, including dispensing fee, for that prescription. Prescriptions subject to usual and customary pricing or to "Dispense as Written" instructions were not repriced as part of the analysis. Our estimate of the impact for the FUL on total drug costs is 16.00%. This impact did not vary significantly across regions or rate cells, except for rate cells with very low utilization of pharmacy services (e.g. 0 – 2 month newborns and delivery kick payment). Following is an example of our calculation for a particular NDC:

> In March 2016 pharmacy encounter claims, the most common amount paid for a fill of six units of NDC 59762306001 (azithromycin) is $24.04. Of this paid amount, $4.91 is allocated to dispensing fees based upon the standard DOM dispensing fees. The remaining $19.13 is the ingredient cost, which corresponds to an approximate ingredient cost per pill of $3.19. On the March 2016 FUL list, the maximum allowable ingredient cost per pill for this NDC is $0.50055. Therefore, the ingredient cost for this script using FUL pricing is approximately $3.00 (= 6 x $0.50055) and the total paid amount is $7.91 (= $3.00 + $4.91). For this particular NDC and fill size, this results in a 67% decrease in the paid amount.

In addition to this analysis, CCOs performed their own script-level analyses of the FUL impact using slightly different data sets and analyses resulting in impacts from 15.50% to 17.50%. We reviewed the methodology underlying these analyses and followed up with CCOs with any necessary questions or clarifications.

As a result of the various studies, we incorporated a flat 16.00% savings assumption to pharmacy costs for the FUL impact across all rates cells, excluding delivery kick payments.

The combined adjustment due to changes in pharmacy reimbursement is shown in Exhibit A4 in column (f).

Newborn Enrollment Adjustment

Beginning on December 1, 2015 all newborns are enrolled in MississippiCAN the first day of life rather than the prior average lag of approximately two months. FFS experience was used to summarize newborn experience from their first day of life until enrollment in MississippiCAN. This experience is used to apply a population adjustment for the SSI / Disabled Newborn, Non-SSI Newborns 0 - 2 Months, and Non-SSI Newborns 3 - 12 Months rate cells. The FFS experience was adjusted for anticipated CCO savings (shown in Table 11 of this report) and TPL recoveries. Based on data provided by DOM we observed that TPL recoveries have historically averaged approximately 0.90% of all Medicaid claim expenditures and, therefore, a 0.90% downward adjustment to allowed costs was applied. More information about the TPL adjustment is provided in Step 3 of this appendix. The FFS allowed costs (net paid amount plus beneficiary copays) underlying the newborn enrollment adjustment are shown by rate cell in Table 10.

Table 10
Mississippi Division of Medicaid
Statewide FFS CY 2014 MississippiCAN Enrollment and Costs
Expanded Newborn Enrollment

	SSI / Disabled Newborn	Non-SSI Newborns 0 - 2 Months	Non-SSI Newborns 3 - 12 Months
Member Months	970	34,456	6,216
Inpatient	$15,709,332	$46,989,251	$469,267
Outpatient	$137,844	$1,099,069	$304,596
Physician	$3,629,342	$12,852,875	$2,579,241
Prescription Drugs	$178,628	$265,562	$158,094
Dental	$289	$13,997	$3,980
Other	$223,013	$426,110	$77,940
Total Claims	**$19,878,448**	**$61,646,864**	**$3,593,118**
Total Claims PMPM	**$20,493.25**	**$1,789.15**	**$578.04**

Savings assumptions applied to FFS non-inpatient services for data used to develop the population adjustment for the newborn enrollment changes effective December 1, 2015 are shown in Table 11. These assumptions are applied to the FFS data shown in Table 10 to adjust the data to a post managed care environment prior to calculating the newborn enrollment adjustment.

Table 11
Mississippi Division of Medicaid
Non-IP Savings Targets for Newborn Expanded Enrollment

Service Category	CCO Savings Targets
Outpatient Hospital	15%
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Benefits	-10%
Physician – Non-EPSDT	10%
Prescription Drugs	10%
Dental	0%
Other	15%

This adjustment is shown in Exhibit A4 in column (g).

Non-Emergency Transportation

Effective July 1, 2014 CCOs became responsible for providing non-emergency transportation (NET) services for MississippiCAN members. The NET vendor providing services to FFS members prior to that time did not submit encounter data of sufficient completeness and quality to use in developing a MississippiCAN rate adjustment for this service. Therefore, we solicited utilization and cost per trip information from the CCOs for July to December 2014 experience. The cost per trip was then trended forward at 3% per year (CPI unit cost growth plus modest 1% utilization increases) and grossed up to include a load of 20% for NET broker administrative expenses and margin, consistent with values we have observed in other NET Medicaid programs. The resulting PMPMs of $13.62 for the SSI population and $1.51 for the MA population are shown in column (h) of Exhibit A4.

Step 6: Provide an Allowance for CCO Non-Benefit Expenses

Administrative Expenses, Premium Tax, and Targeted Margin

The administrative allowance included in the capitation rate is intended to cover administrative costs, including the following:

- Case management
- Utilization management
- Claim processing and other IT functions
- Customer service
- Provider contracting and credentialing
- TPL and program integrity
- Member grievances and appeals
- Financial and other program reporting
- Local overhead costs
- Corporate overhead and business functions (e.g., legal, executive, human resources)

The non-benefit expense allowance for the SFY 2017 capitation rate is comprised of a flat PMPM for fixed administrative costs and a percentage of revenue for variable administrative costs. We also included explicit adjustments of 2% of revenue for target underwriting margin and 3% for the Mississippi premium tax, for a total variable non-benefit expense allowance of 11.25% as reflected in Exhibit A5. Table 12 displays the allowance included in the Adults and Newborns rates for non-benefit expenses.

Table 12
Mississippi Division of Medicaid
SFY 2017 MississippiCAN Non-Benefit Expenses

	SSI Population		MA Population		Delivery Kick Payment	
	% of Revenue	PMPM	% of Revenue	PMPM	% of Revenue	Per Delivery
Fixed Costs[1]	0.48%	**$4.92**	1.10%	**$4.92**	0.00%	**$0.00**
Variable Costs[2]	**6.25%**	$64.48	**6.25%**	$28.05	**0.00%**	$0.00
Premium Tax[2]	**3.00%**	$30.95	**3.00%**	$13.47	**3.00%**	$154.93
Margin[2]	**2.00%**	$20.63	**2.00%**	$8.98	**2.00%**	$103.29
Total	11.73%	$120.98	12.35%	$55.42	5.00%	$258.22

[1] Included in the rate as a flat PMPM, equivalent % of revenue shown.
[2] Included in the rate as a % of Revenue, equivalent PMPM is shown.

Since the same two CCOs administer both CHIP and MississippiCAN, we coordinated the administrative expense development across the two programs. We developed the administration allowance based on an analysis of the actual CY 2014 CHIP and MississippiCAN CCO administrative expenses. The actual CY 2014 reported administrative costs, excluding taxes and fees, were compared to national benchmarks

released by the Sherlock Company and in Milliman's annual analysis of administrative costs for Medicaid managed care plans. Adjustments were made as necessary to reduce actual program experience to align with these benchmarks.

We estimated a split of fixed versus variable expenses across all populations. Projected variable expenses, as a percentage of non-kick payment revenue, were kept consistent with adjusted CY 2014 administrative expenses. Similar to last year, we gave consideration to the impact of significantly increased CCO enrollment over which to spread fixed costs between CY 2014 and SFY 2017 due to the roll-in of MA Children in CY 2015, resulting in a lower total fixed administrative allowance on a PMPM basis. An illustration of the development of the administrative cost assumptions in included in Appendix C2.

Health Insurer Fee

DOM will process the capitation rate adjustments for the ACA Health Insurer Excise Fee (HIF) outside of the monthly capitation rate payment system in the form of one annual payment to CCOs for the actual health insurer fee amount (allocated across CCO lines of business by revenue) and the associated income tax impact related to the HIF. We will calculate adjusted capitation rates after the Internal Revenue Service fee notices are distributed to the CCOs and these fee notices are provided to DOM. The annual capitation rate adjustment will be allocated to each managed care contract period effective in 2016, proportional to the revenue associated with each contract. Bill H.R.2029 signed into law on December 18, 2015 put a moratorium on 2017 HIF. Based on the current law, no HIF payments shall be made in calendar year 2017.

The capitation rate adjustment will include consideration for the marginal federal and state corporate tax income rates, as well as the Mississippi premium tax. Using the following assumptions:

- A = Marginal Federal Income Tax % = 35%, subject to CCO verification of actual liability
- B = Marginal State Income Tax % = 0% (Mississippi tax code allows income tax to be offset by premium tax payments)
- C = State Premium Tax % = 3%

The total capitation rate adjustment to CCOs would be based on the following formula:

*Total Capitation Adjustment = HIF / (1 – A – B *(1 – A)) * 1 / (1 – C) = 1.586 * HIF*

Step 7: Adjust for Geographic Region

CCO capitation payments will vary based on their members' county of residence. We assigned each county to one of the following regions (as defined in Section III): North, Central, or South. Table 13 shows the geographic area factor adjustments that are applied based on a beneficiary's region.

Table 13
Mississippi Division of Medicaid
Area Factors

Region	Area Factors
North	0.935
Central	1.041
South	1.023

We developed the geographic area factors on a budget-neutral basis by blending projected claims PMPM across rate cells weighted upon the statewide rate cell distribution for each region and reviewing the relative difference in PMPM cost for each region. Exhibit A6 includes the resulting capitation rates for each region using these area factors.

Step 8: Adjust for CCO Specific Risk Score (if Applicable)

The capitation rates for the Non-Newborn SSI / Disabled and MA Adult rate cell will be further adjusted for each CCO using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx). Costs for the Breast and Cervical Cancer, Foster Care, and Pregnant Women populations are less variable, since they tend to utilized similar services across each population. In addition, some of the population sizes are too small from which to develop custom weights specific to the covered services and MississippiCAN reimbursement levels. Therefore, we do not risk adjust these populations. Since the risk adjustment is prospective, there is no historical diagnosis information from which to develop a risk score for Newborns.

The CDPS + Rx risk adjuster will be used to adjust for the acuity differences between the enrolled populations of each CCO. Risk adjustment will be budget-neutral to DOM. This risk sharing mechanism is developed in accordance with generally accepted actuarial principles and practices.

To establish these risk scores, the CDPS + Rx risk adjuster will be run with risk weights consistent with services covered in MississippiCAN for the given time period. These risk weights are calculated using Mississippi FFS and encounter data for the Non-Newborn SSI / Disabled and MA Adult populations. In addition, a beneficiary must have at least six months of eligibility in the data year to be scored. If a beneficiary does not have enough data, they will receive a score equal to the average of those beneficiaries with scores in each cohort (i.e., the CCO-specific average). We will monitor the percentage of CCO enrollees who are not scored and adjust the methodology if necessary.

A CCO's capitation rate will be determined based upon the following formula:

CCO Capitation Rate = Base Capitation Rate x CCO Normalized Risk Factor

The base capitation rates are found in column (d) in Appendices D1 and D2.

The CCO normalized risk factor will equal the average risk factor across all beneficiaries that a CCO enrolls divided by the average risk factor for the rate cell's population. Regional risk scores will be normalized to ensure the risk adjustment process is revenue neutral across both CCOs.

Risk Adjustment for SFY 2017

Risk adjustment for SFY 2017 capitation payments will be based on CY 2016 or SFY 2016 FFS and encounter diagnosis data.

Each CCO's adjusted risk factor will be prospectively set using April 2016 as a proxy for the enrollment for July 1, 2016 to December 31, 2016 and October 2016 as a proxy for the enrollment from January 1, 2017 to June 30, 2017.

The schedule for risk score data sources and calculations is found in Table 14.

Table 14
CCO Capitation Rate Risk Adjustment Schedule
SFY 2017 Capitation Payments

Rate Cell	Capitation Payments	Diagnosis Source Data	Enrollment Source
Non-Newborn SSI / Disabled and MA Adult	July 2016 to December 2016	CY 2015 FFS and Encounters	April 2016
Non-Newborn SSI / Disabled and MA Adult	January 2017 to June 2017	SFY 2016 FFS and Encounters	October 2016

Step 9: Add MHAP Payments

Concurrent with the inclusion of inpatient hospital services in MississippiCAN capitation rates effective December 1, 2015, the Mississippi Hospital Access Program (MHAP) was established. This program helps to ensure sufficient access to inpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates. MHAP is funded through a broad-based hospital assessment.

The enhanced hospital reimbursement will be $533,110,956 annually, which will be paid by the MississippiCAN CCOs to individual hospitals. The MississippiCAN non-delivery capitation rates include an $89.89 PMPM allowance for the MHAP liability along with its associated premium tax liability of $2.78 PMPM (see Exhibit A6) which does not vary by region, rate cell, or risk score. On a PMPM basis, this is a significant decrease from the MHAP PMPM included in the December 2015 to June 2016 MississippiCAN capitation rates. While the total annual amount funded through this program is unchanged from SFY 2016, the payments are spread across a full year rather than seven months.

Monthly MHAP payments based on the projected membership and estimated PMPM will be made to the CCOs until the $533 million threshold has been reached. Due to actual versus projected MississippiCAN membership this estimated PMPM may result in an overpayment or underpayment of MHAP in SFY 2017 if no adjustments are made. If membership is higher than expected payments will be capped at the $533 million funding amount. If membership is lower than expected, the final payments will be grossed up to meet the $533 million funding amount.

Exhibits A1 – A6

Adults and Newborns Capitation Rate Development

A1	**CY 2014 Encounter Experience Data (Magnolia and United)**
A2	**CY 2014 Financial Reporting Data (Magnolia and United)**
A3	**CY 2014 Blended Encounter, FFS, and Financial Reporting Data**
A4	**PMPM Medical and Pharmacy Cost Estimates Projected to July 1, 2016 – June 30, 2017**
A5	**Non-Claim Expense for Rates Excluding Inpatient Services**
A6	**July 1, 2016 – June 30, 2017 Capitation Rates**

Exhibit A1 Mississippi Division of Medicaid July 2016 - June 2017 MississippiCAN Capitation Rate Development Base Encounter Data (Magnolia, United) - CY 2014 Adjustment	
Financial Reporting Paid (excluding subcapited claims and IBNR):	$656,146,353
Encounter Data Paid (excluding subcapitated providers):	$650,220,424
Encounter Data Paid Relative to Financial Reporting:	-0.90%
Subcapitation and IBNR from Financial Reporting:	$78,447,121
Encounter Data Impact Over Combined Paid, IBNR and Subcapitated Costs:	-0.81%

Notes

1. Costs reflect CY 2014 dates of service.

2. Adjustment is made across all rate cells due to inconsistencies in reporting across data sources.

3. Adjustment is made by categories of service.

4. Costs reflect all Milliman deduping exercises and attempts at reconciliation with CCO expectations as of the date of this report.

Exhibit A2
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
MississippiCAN Financial Reporting Data - CY 2014

Region: Statewide
Rate Cell: Non-Newborn SSI / Disabled
MississippiCAN CY 2014 Member Months: 758,434

	a	b	c	d	e	f = (b * c * d) + e
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Subcapitation Arrangements PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$147,232,991	$192.90	1.0046	0.9910	$0.00	$192.06
Outpatient Hospital Services	$87,889,208	$115.88	1.0101	1.0000	$4.78	$121.84
Physician Services	$88,273,624	$116.39	1.0101	1.0000	$66.94	$184.50
Drug Services	$154,133,601	$203.23	1.0000	1.0000	$0.00	$203.23
Dental Services	$6,072,052	$8.01	1.0129	1.0000	$0.00	$8.11
Other Services	$26,471,912	$34.90	1.0158	1.0000	$7.30	$42.75
Total	**$510,073,388**	**$671.31**			**$79.02**	**$752.48**

**** Member Months as reported in the financial exhibits based upon CY 2014 rate cell definitions (Non-Newborn SSI / Disabled).***
**** Inpatient hospital services line reflects FFS claims from 763,250 member months.***

Region: Statewide
Rate Cell: Foster Care
MississippiCAN CY 2014 Member Months: 49,701

	a	b	c	d	e	f = (b * c * d) + e
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Subcapitation Arrangements PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$3,016,307	$61.40	1.0046	0.9910	$0.00	$61.13
Outpatient Hospital Services	$1,149,841	$23.14	1.0222	1.0000	$8.39	$32.04
Physician Services	$2,039,044	$41.03	1.0122	1.0000	$34.21	$75.73
Drug Services	$3,064,744	$61.66	1.0000	1.0000	$0.00	$61.66
Dental Services	$877,954	$17.66	1.0112	1.0000	$0.00	$17.86
Other Services	$516,116	$10.38	1.0152	1.0000	$7.28	$17.82
Total	**$10,664,005**	**$215.28**			**$49.88**	**$266.26**

**** Member Months as reported in the financial exhibits based upon CY 2014 rate cell definitions (Foster Care).***
**** Inpatient hospital services line reflects FFS claims from 49,122 member months.***

Region: Statewide
Rate Cell: Breast and Cervical Cancer
MississippiCAN CY 2014 Member Months: 1,570

	a	b	c	d	e	f = (b * c * d) + e
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Subcapitation Arrangements PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$273,469	$188.99	1.0046	0.9910	$0.00	$188.16
Outpatient Hospital Services	$1,723,437	$1,097.73	1.0046	1.0000	$0.00	$1,102.78
Physician Services	$1,233,884	$785.91	1.0063	1.0000	$181.17	$972.03
Drug Services	$390,729	$248.87	1.0000	1.0000	$0.00	$248.87
Dental Services	$30,272	$19.28	1.0293	1.0000	$0.00	$19.85
Other Services	$75,415	$48.03	1.0305	1.0000	$16.87	$66.37
Total	**$3,727,207**	**$2,388.82**			**$198.04**	**$2,598.06**

**** Member Months as reported in the financial exhibits based upon CY 2014 rate cell definitions (Breast and Cervical Cancer).***
**** Inpatient hospital services line reflects FFS claims from 1,447 member months.***

Exhibit A2
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
MississippiCAN Financial Reporting Data - CY 2014

Region: Statewide
Rate Cell: SSI / Disabled Newborn
MississippiCAN CY 2014 Member Months: 5,524

	a	b	c	d	e	f = (b * c * d) + e
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Subcapitation Arrangements PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$6,588,499	$1,204.48	1.0046	0.9910	$0.00	$1,199.19
Outpatient Hospital Services	$974,765	$176.46	1.0153	1.0000	$45.30	$224.46
Physician Services	$4,799,324	$868.82	1.0299	1.0000	$22.75	$917.51
Drug Services	$3,140,084	$568.45	1.0000	1.0000	$0.00	$568.45
Dental Services	$397	$0.07	1.0031	1.0000	$0.00	$0.07
Other Services	$1,058,536	$191.63	1.0182	1.0000	$9.14	$204.26
Total	**$16,561,605**	**$3,009.90**			**$77.19**	**$3,113.94**

**** Member Months as reported in the financial exhibits based upon CY 2014 rate cell definitions (SSI / Disabled Newborn).***
**** Inpatient hospital services line reflects FFS claims from 5,470 member months.***

Region: Statewide
Rate Cell: MA Adult
MississippiCAN CY 2014 Member Months: 590,706

	a	b	c	d	e	f = (b * c * d) + e
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Subcapitation Arrangements PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$31,221,282	$53.63	1.0046	0.9910	$0.00	$53.40
Outpatient Hospital Services	$47,447,656	$80.32	1.0110	1.0000	$0.09	$81.30
Physician Services	$54,950,962	$93.03	1.0127	1.0000	$10.01	$104.22
Drug Services	$43,069,526	$72.91	1.0000	1.0000	$0.00	$72.91
Dental Services	$4,291,334	$7.26	1.0081	1.0000	$0.00	$7.32
Other Services	$7,889,596	$13.36	1.0124	1.0000	$0.58	$14.10
Total	**$188,870,356**	**$320.52**			**$10.68**	**$333.25**

**** Member Months as reported in the financial exhibits based upon CY 2014 rate cell definitions (MA Adult).***
**** Inpatient hospital services line reflects FFS claims from 582,128 member months.***

Region: Statewide
Rate Cell: Pregnant Women
MississippiCAN CY 2014 Member Months: 137,220

	a	b	c	d	e	f = (b * c * d) + e
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Subcapitation Arrangements PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$11,485,774	$84.29	1.0046	0.9910	$0.00	$83.92
Outpatient Hospital Services	$10,507,305	$76.57	1.0175	1.0000	$0.22	$78.13
Physician Services	$26,277,141	$191.50	1.0076	1.0000	$14.78	$207.73
Drug Services	$4,430,730	$32.29	1.0000	1.0000	$0.00	$32.29
Dental Services	$260,567	$1.90	1.0030	1.0000	$0.00	$1.90
Other Services	$2,299,413	$16.76	1.0159	1.0000	$0.91	$17.93
Total	**$55,260,930**	**$403.30**			**$15.91**	**$421.91**

**** Member Months as reported in the financial exhibits based upon CY 2014 rate cell definitions (Pregnant Women).***
**** Inpatient hospital services line reflects FFS claims from 136,265 member months.***

Exhibit A2
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
MississippiCAN Financial Reporting Data - CY 2014

Region: Statewide
Rate Cell: Non-SSI Newborns 0-2 Months
MississippiCAN CY 2014 Member Months: 27,354

	a	b	c	d	e	f = (b * c * d) + e
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Subcapitation Arrangements PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$2,313,553	$85.41	1.0046	0.9910	$0.00	$85.04
Outpatient Hospital Services	$916,054	$33.49	1.0153	1.0000	$0.93	$34.93
Physician Services	$4,521,540	$165.30	1.0299	1.0000	$7.24	$177.47
Drug Services	$486,273	$17.78	1.0000	1.0000	$0.00	$17.78
Dental Services	$635	$0.02	1.0031	1.0000	$0.00	$0.02
Other Services	$295,204	$10.79	1.0182	1.0000	$0.66	$11.65
Total	**$8,533,260**	**$312.79**			**$8.84**	**$326.89**

**** Member Months as reported in the financial exhibits based upon CY 2014 rate cell definitions (Non-SSI Newborns 0-2 Months).***
**** Inpatient hospital services line reflects FFS claims from 27,087 member months.***

Region: Statewide
Rate Cell: Non-SSI Newborns 3-12 Months
MississippiCAN CY 2014 Member Months: 258,827

	a	b	c	d	e	f = (b * c * d) + e
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Subcapitation Arrangements PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$9,637,863	$37.60	1.0046	0.9910	$0.00	$37.44
Outpatient Hospital Services	$9,337,330	$36.08	1.0153	1.0000	$0.45	$37.08
Physician Services	$22,326,442	$86.26	1.0299	1.0000	$3.12	$91.96
Drug Services	$6,754,762	$26.10	1.0000	1.0000	$0.00	$26.10
Dental Services	$27,526	$0.11	1.0031	1.0000	$0.00	$0.11
Other Services	$1,474,073	$5.70	1.0182	1.0000	$0.36	$6.16
Total	**$49,557,997**	**$191.84**			**$3.93**	**$198.84**

**** Member Months as reported in the financial exhibits based upon CY 2014 rate cell definitions (Non-SSI Newborns 3-12 Months).***
**** Inpatient hospital services line reflects FFS claims from 256,298 member months.***

Region: Statewide
Rate Cell: Delivery Kick Payment
CY 2013 Delivery Count: 21,359

	a	b	c	d	e	f = (b * c * d) + e
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Subcapitation Arrangements PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$72,222,968	$3,381.38	1.0046	0.9910	$0.00	$3,366.53
Outpatient Hospital Services	$209,348	$9.80	1.0155	1.0000	$0.00	$9.95
Physician Services	$26,799,250	$1,254.71	1.0084	1.0000	$0.00	$1,265.19
Drug Services	$691,615	$32.38	1.0000	1.0000	$0.00	$32.38
Dental Services	$1,347	$0.06	1.0038	1.0000	$0.00	$0.06
Other Services	$1,197,235	$56.05	1.0157	1.0000	$0.00	$56.93
Total	**$101,121,764**	**$4,734.39**			**$0.00**	**$4,731.05**

**** Delivery count based upon CY 2014 rate cell definitions (Delivery Kick Payment).***
**** Inpatient hospital services line reflects FFS claims from 21,359 deliveries.***

Exhibit A3
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
MississippiCAN Blended Costs - CY 2014

Region: Statewide
Rate Cell: Non-Newborn SSI / Disabled

	a	b	c	d	e = a * b + c * d
Category of Service	**CY 2014 Adjusted PMPM Cost - Encounters**	**% Encounter**	**CY 2014 Adjusted PMPM Cost - Financials / IP FFS***	**% Financials**	**Blended CY 2014 PMPM Cost**
Inpatient Hospital Services	$192.06	0%	$192.06	100%	$192.06
Outpatient Hospital Services	$125.42	20%	$121.84	80%	$122.55
Physician Services	$185.01	20%	$184.50	80%	$184.60
Drug Services	$203.23	50%	$203.23	50%	$203.23
Dental Services	$7.35	50%	$8.11	50%	$7.73
Other Services	$33.46	20%	$42.75	80%	$40.89
Total	**$746.52**		**$752.48**		**$751.06**

**** Inpatient hospital services line reflects FFS claims from 763,250 member months.***

Region: Statewide
Rate Cell: Foster Care

	a	b	c	d	e = a * b + c * d
Category of Service	**CY 2014 Adjusted PMPM Cost - Encounters**	**% Encounter**	**CY 2014 Adjusted PMPM Cost - Financials / IP FFS***	**% Financials**	**Blended CY 2014 PMPM Cost**
Inpatient Hospital Services	$61.13	0%	$61.13	100%	$61.13
Outpatient Hospital Services	$32.98	20%	$32.04	80%	$32.23
Physician Services	$75.94	20%	$75.73	80%	$75.77
Drug Services	$61.66	50%	$61.66	50%	$61.66
Dental Services	$16.19	50%	$17.86	50%	$17.02
Other Services	$13.95	20%	$17.82	80%	$17.05
Total	**$261.86**		**$266.26**		**$264.87**

**** Inpatient hospital services line reflects FFS claims from 49,122 member months.***

Region: Statewide
Rate Cell: Breast and Cervical Cancer

	a	b	c	d	e = a * b + c * d
Category of Service	**CY 2014 Adjusted PMPM Cost - Encounters**	**% Encounter**	**CY 2014 Adjusted PMPM Cost - Financials / IP FFS***	**% Financials**	**Blended CY 2014 PMPM Cost**
Inpatient Hospital Services	$188.16	0%	$188.16	100%	$188.16
Outpatient Hospital Services	$1,135.16	20%	$1,102.78	80%	$1,109.26
Physician Services	$974.73	20%	$972.03	80%	$972.57
Drug Services	$248.87	50%	$248.87	50%	$248.87
Dental Services	$17.98	50%	$19.85	50%	$18.91
Other Services	$51.95	20%	$66.37	80%	$63.49
Total	**$2,616.85**		**$2,598.06**		**$2,601.26**

**** Inpatient hospital services line reflects FFS claims from 1,447 member months.***

Exhibit A3
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
MississippiCAN Blended Costs - CY 2014

Region: Statewide
Rate Cell: SSI / Disabled Newborn

	a	b	c	d	e = a * b + c * d
Category of Service	**CY 2014 Adjusted PMPM Cost - Encounters**	**% Encounter**	**CY 2014 Adjusted PMPM Cost - Financials / IP FFS***	**% Financials**	**Blended CY 2014 PMPM Cost**
Inpatient Hospital Services	$1,199.19	0%	$1,199.19	100%	$1,199.19
Outpatient Hospital Services	$231.05	20%	$224.46	80%	$225.78
Physician Services	$920.06	20%	$917.51	80%	$918.02
Drug Services	$568.45	50%	$568.45	50%	$568.45
Dental Services	$0.07	50%	$0.07	50%	$0.07
Other Services	$159.87	20%	$204.26	80%	$195.38
Total	**$3,078.68**		**$3,113.94**		**$3,106.88**

**** Inpatient hospital services line reflects FFS claims from 5,470 member months.***

Region: Statewide
Rate Cell: MA Adult

	a	b	c	d	e = a * b + c * d
Category of Service	**CY 2014 Adjusted PMPM Cost - Encounters**	**% Encounter**	**CY 2014 Adjusted PMPM Cost - Financials / IP FFS***	**% Financials**	**Blended CY 2014 PMPM Cost**
Inpatient Hospital Services	$53.40	0%	$53.40	100%	$53.40
Outpatient Hospital Services	$83.69	20%	$81.30	80%	$81.78
Physician Services	$104.51	20%	$104.22	80%	$104.28
Drug Services	$72.91	50%	$72.91	50%	$72.91
Dental Services	$6.64	50%	$7.32	50%	$6.98
Other Services	$11.03	20%	$14.10	80%	$13.49
Total	**$332.18**		**$333.25**		**$332.83**

**** Inpatient hospital services line reflects FFS claims from 582,128 member months.***

Region: Statewide
Rate Cell: Pregnant Women

	a	b	c	d	e = a * b + c * d
Category of Service	**CY 2014 Adjusted PMPM Cost - Encounters**	**% Encounter**	**CY 2014 Adjusted PMPM Cost - Financials / IP FFS***	**% Financials**	**Blended CY 2014 PMPM Cost**
Inpatient Hospital Services	$83.92	0%	$83.92	100%	$83.92
Outpatient Hospital Services	$80.42	20%	$78.13	80%	$78.59
Physician Services	$208.31	20%	$207.73	80%	$207.85
Drug Services	$32.29	50%	$32.29	50%	$32.29
Dental Services	$1.73	50%	$1.90	50%	$1.82
Other Services	$14.03	20%	$17.93	80%	$17.15
Total	**$420.70**		**$421.91**		**$421.61**

**** Inpatient hospital services line reflects FFS claims from 136,265 member months.***

Exhibit A3
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
MississippiCAN Blended Costs - CY 2014

Region: Statewide
Rate Cell: Non-SSI Newborns 0-2 Months

	a	b	c	d	e = a * b + c * d
Category of Service	**CY 2014 Adjusted PMPM Cost - Encounters**	**% Encounter**	**CY 2014 Adjusted PMPM Cost - Financials / IP FFS***	**% Financials**	**Blended CY 2014 PMPM Cost**
Inpatient Hospital Services	$85.04	0%	$85.04	100%	$85.04
Outpatient Hospital Services	$35.95	20%	$34.93	80%	$35.13
Physician Services	$177.97	20%	$177.47	80%	$177.57
Drug Services	$17.78	50%	$17.78	50%	$17.78
Dental Services	$0.02	50%	$0.02	50%	$0.02
Other Services	$9.12	20%	$11.65	80%	$11.15
Total	**$325.88**		**$326.89**		**$326.69**

**** Inpatient hospital services line reflects FFS claims from 27,087 member months.***

Region: Statewide
Rate Cell: Non-SSI Newborns 3-12 Months

	a	b	c	d	e = a * b + c * d
Category of Service	**CY 2014 Adjusted PMPM Cost - Encounters**	**% Encounter**	**CY 2014 Adjusted PMPM Cost - Financials / IP FFS***	**% Financials**	**Blended CY 2014 PMPM Cost**
Inpatient Hospital Services	$37.44	0%	$37.44	100%	$37.44
Outpatient Hospital Services	$38.17	20%	$37.08	80%	$37.30
Physician Services	$92.21	20%	$91.96	80%	$92.01
Drug Services	$26.10	50%	$26.10	50%	$26.10
Dental Services	$0.10	50%	$0.11	50%	$0.10
Other Services	$4.82	20%	$6.16	80%	$5.89
Total	**$198.83**		**$198.84**		**$198.83**

**** Inpatient hospital services line reflects FFS claims from 256,298 member months.***

Region: Statewide
Rate Cell: Delivery Kick Payment

	a	b	c	d	e = a * b + c * d
Category of Service	**CY 2014 Adjusted PMPM Cost - Encounters**	**% Encounter**	**CY 2014 Adjusted PMPM Cost - Financials / IP FFS***	**% Financials**	**Blended CY 2014 PMPM Cost**
Inpatient Hospital Services	$3,366.53	0%	$3,366.53	100%	$3,366.53
Outpatient Hospital Services	$10.25	20%	$9.95	80%	$10.01
Physician Services	$1,268.70	20%	$1,265.19	80%	$1,265.90
Drug Services	$32.38	50%	$32.38	50%	$32.38
Dental Services	$0.06	50%	$0.06	50%	$0.06
Other Services	$44.56	20%	$56.93	80%	$54.46
Total	**$4,722.47**		**$4,731.05**		**$4,729.33**

**** Inpatient hospital services line reflects FFS claims from 21,359 deliveries.***

Exhibit A4
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
PMPM Medical and Pharmacy Cost Estimates - Excluding Newborn Adjustment

Region: Statewide
Rate Cell: Non-Newborn SSI / Disabled

	a	b	c	d	e	f	g	h	i = a * b * c * d * e * f * g + h
Category of Service	**CY 2014 Adjusted PMPM Cost - Blended**	**Utilization Trend Factors CY 2014 to SFY 2017**	**Charge Trend Factors CY 2014 to SFY 2017**	**CCO Savings Adj**	**PCP E&M Reimbursement Adjustment**	**PDL and FUL Adjustment**	**Newborn Enrollment Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$192.06	1.0767	1.0070	1.0000	1.0000	1.0000	1.0000	$0.00	$208.23
Outpatient Hospital Services	$122.55	1.1297	1.0483	1.0000	1.0000	1.0000	1.0000	$0.00	$145.15
Physician Services	$184.60	1.1297	1.0176	1.0000	0.9806	1.0000	1.0000	$0.00	$208.10
Drug Services	$203.23	1.1030	1.2835	1.0000	1.0000	0.9498	1.0000	$0.00	$273.26
Dental Services	$7.73	1.0508	1.0909	1.0000	1.0000	1.0000	1.0000	$0.00	$8.86
Other Services	$40.89	1.1432	1.0176	1.0000	1.0000	1.0000	1.0000	$13.62	$61.19
Total	**$751.06**								**$904.78**

Region: Statewide
Rate Cell: Foster Care

	a	b	c	d	e	f	g	h	i = a * b * c * d * e * f * g + h
Category of Service	**CY 2014 Adjusted PMPM Cost - Blended**	**Utilization Trend Factors CY 2014 to SFY 2017**	**Charge Trend Factors CY 2014 to SFY 2017**	**CCO Savings Adj**	**PCP E&M Reimbursement Adjustment**	**PDL and FUL Adjustment**	**Newborn Enrollment Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$61.13	1.0767	1.0070	1.0000	1.0000	1.0000	1.0000	$0.00	$66.28
Outpatient Hospital Services	$32.23	1.1297	1.0483	1.0000	1.0000	1.0000	1.0000	$0.00	$38.17
Physician Services	$75.77	1.1297	1.0176	1.0000	0.9800	1.0000	1.0000	$0.00	$85.36
Drug Services	$61.66	1.1030	1.2835	1.0000	1.0000	0.9498	1.0000	$0.00	$82.91
Dental Services	$17.02	1.0508	1.0909	1.0000	1.0000	1.0000	1.0000	$0.00	$19.51
Other Services	$17.05	1.1432	1.0176	1.0000	1.0000	1.0000	1.0000	$13.62	$33.45
Total	**$264.87**								**$325.69**

Region: Statewide
Rate Cell: Breast and Cervical Cancer

	a	b	c	d	e	f	g	h	i = a * b * c * d * e * f * g + h
Category of Service	**CY 2014 Adjusted PMPM Cost - Blended**	**Utilization Trend Factors CY 2014 to SFY 2017**	**Charge Trend Factors CY 2014 to SFY 2017**	**CCO Savings Adj**	**PCP E&M Reimbursement Adjustment**	**PDL and FUL Adjustment**	**Newborn Enrollment Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$188.16	1.0767	1.0070	1.0000	1.0000	1.0000	1.0000	$0.00	$204.01
Outpatient Hospital Services	$1,109.26	1.1297	1.0483	1.0000	1.0000	1.0000	1.0000	$0.00	$1,313.75
Physician Services	$972.57	1.1297	1.0176	1.0000	0.9945	1.0000	1.0000	$0.00	$1,111.93
Drug Services	$248.87	1.1030	1.2835	1.0000	1.0000	0.9498	1.0000	$0.00	$334.64
Dental Services	$18.91	1.0508	1.0909	1.0000	1.0000	1.0000	1.0000	$0.00	$21.68
Other Services	$63.49	1.1432	1.0176	1.0000	1.0000	1.0000	1.0000	$13.62	$87.47
Total	**$2,601.26**								**$3,073.47**

Exhibit A4
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
PMPM Medical and Pharmacy Cost Estimates - Excluding Newborn Adjustment

Region: Statewide
Rate Cell: SSI / Disabled Newborn

	a	b	c	d	e	f	g	h	i = a * b * c * d * e * f * g + h
Category of Service	**CY 2014 Adjusted PMPM Cost - Blended**	**Utilization Trend Factors CY 2014 to SFY 2017**	**Charge Trend Factors CY 2014 to SFY 2017**	**CCO Savings Adj**	**PCP E&M Reimbursement Adjustment**	**PDL and FUL Adjustment**	**Newborn Enrollment Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$1,199.19	1.0767	1.0070	1.0000	1.0000	1.0000	2.8746	$0.00	$3,737.49
Outpatient Hospital Services	$225.78	1.1297	1.0483	1.0000	1.0000	1.0000	0.9699	$0.00	$259.34
Physician Services	$918.02	1.1297	1.0176	1.0000	0.9636	1.0000	1.5035	$0.00	$1,528.82
Drug Services	$568.45	1.1030	1.2835	1.0000	1.0000	0.8526	0.8961	$0.00	$614.83
Dental Services	$0.07	1.0508	1.0909	1.0000	1.0000	1.0000	1.0556	$0.00	$0.08
Other Services	$195.38	1.1432	1.0176	1.0000	1.0000	1.0000	1.0797	$13.62	$259.02
Total	**$3,106.88**								**$6,399.59**

Region: Statewide
Rate Cell: MA Adult

	a	b	c	d	e	f	g	h	i = a * b * c * d * e * f * g + h
Category of Service	**CY 2014 Adjusted PMPM Cost - Blended**	**Utilization Trend Factors CY 2014 to SFY 2017**	**Charge Trend Factors CY 2014 to SFY 2017**	**CCO Savings Adj**	**PCP E&M Reimbursement Adjustment**	**PDL and FUL Adjustment**	**Newborn Enrollment Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$53.40	1.0898	1.0070	1.0000	1.0000	1.0000	1.0000	$0.00	$58.60
Outpatient Hospital Services	$81.78	1.1297	1.0483	1.0000	1.0000	1.0000	1.0000	$0.00	$96.85
Physician Services	$104.28	1.1297	1.0176	1.0000	0.9790	1.0000	1.0000	$0.00	$117.35
Drug Services	$72.91	1.1163	1.2981	1.0000	1.0000	0.9470	1.0000	$0.00	$100.06
Dental Services	$6.98	1.0508	1.0996	1.0000	1.0000	1.0000	1.0000	$0.00	$8.06
Other Services	$13.49	1.1432	1.0176	1.0000	1.0000	1.0000	1.0000	$1.51	$17.20
Total	**$332.83**								**$398.13**

Region: Statewide
Rate Cell: Pregnant Women

	a	b	c	d	e	f	g	h	i = a * b * c * d * e * f * g + h
Category of Service	**CY 2014 Adjusted PMPM Cost - Blended**	**Utilization Trend Factors CY 2014 to SFY 2017**	**Charge Trend Factors CY 2014 to SFY 2017**	**CCO Savings Adj**	**PCP E&M Reimbursement Adjustment**	**PDL and FUL Adjustment**	**Newborn Enrollment Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$83.92	1.0898	1.0070	1.0000	1.0000	1.0000	1.0000	$0.00	$92.10
Outpatient Hospital Services	$78.59	1.1297	1.0483	1.0000	1.0000	1.0000	1.0000	$0.00	$93.08
Physician Services	$207.85	1.1297	1.0176	1.0000	0.9953	1.0000	1.0000	$0.00	$237.81
Drug Services	$32.29	1.1163	1.2981	1.0000	1.0000	0.9470	1.0000	$0.00	$44.31
Dental Services	$1.82	1.0508	1.0996	1.0000	1.0000	1.0000	1.0000	$0.00	$2.10
Other Services	$17.15	1.1432	1.0176	1.0000	1.0000	1.0000	1.0000	$1.51	$21.46
Total	**$421.61**								**$490.85**

Exhibit A4
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
PMPM Medical and Pharmacy Cost Estimates - Excluding Newborn Adjustment

Region: Statewide
Rate Cell: Non-SSI Newborns 0-2 Months

	a	b	c	d	e	f	g	h	i = a * b * c * d * e * f * g + h
Category of Service	**CY 2014 Adjusted PMPM Cost - Blended**	**Utilization Trend Factors CY 2014 to SFY 2017**	**Charge Trend Factors CY 2014 to SFY 2017**	**CCO Savings Adj**	**PCP E&M Reimbursement Adjustment**	**PDL and FUL Adjustment**	**Newborn Enrollment Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$85.04	1.0898	1.0070	1.0000	1.0000	1.0000	9.3794	$0.00	$875.30
Outpatient Hospital Services	$35.13	1.1297	1.0483	1.0000	1.0000	1.0000	0.9698	$0.00	$40.35
Physician Services	$177.57	1.1297	1.0176	1.0000	0.9490	1.0000	1.7142	$0.00	$332.06
Drug Services	$17.78	1.1163	1.2981	1.0000	1.0000	0.8526	0.6723	$0.00	$14.77
Dental Services	$0.02	1.0508	1.0996	1.0000	1.0000	1.0000	3.6758	$0.00	$0.09
Other Services	$11.15	1.1432	1.0176	1.0000	1.0000	1.0000	1.2578	$1.51	$17.82
Total	**$326.69**								**$1,280.39**

Region: Statewide
Rate Cell: Non-SSI Newborns 3-12 Months

	a	b	c	d	e	f	g	h	i = a * b * c * d * e * f * g + h
Category of Service	**CY 2014 Adjusted PMPM Cost - Blended**	**Utilization Trend Factors CY 2014 to SFY 2017**	**Charge Trend Factors CY 2014 to SFY 2017**	**CCO Savings Adj**	**PCP E&M Reimbursement Adjustment**	**PDL and FUL Adjustment**	**Newborn Enrollment Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$37.44	1.0898	1.0070	1.0000	1.0000	1.0000	1.0239	$0.00	$42.07
Outpatient Hospital Services	$37.30	1.1297	1.0483	1.0000	1.0000	1.0000	1.0083	$0.00	$44.54
Physician Services	$92.01	1.1297	1.0176	1.0000	0.9503	1.0000	1.0912	$0.00	$109.68
Drug Services	$26.10	1.1163	1.2981	1.0000	1.0000	0.8526	0.9984	$0.00	$32.19
Dental Services	$0.10	1.0508	1.0996	1.0000	1.0000	1.0000	1.0234	$0.00	$0.12
Other Services	$5.89	1.1432	1.0176	1.0000	1.0000	1.0000	1.0428	$1.51	$8.65
Total	**$198.83**								**$237.24**

Region: Statewide
Rate Cell: Delivery Kick Payment

	a	b	c	d	e	f	g	h	i = a * b * c * d * e * f * g + h
Category of Service	**CY 2014 Adjusted PMPM Cost - Blended**	**Utilization Trend Factors CY 2014 to SFY 2017**	**Charge Trend Factors CY 2014 to SFY 2017**	**CCO Savings Adj**	**PCP E&M Reimbursement Adjustment**	**PDL and FUL Adjustment**	**Newborn Enrollment Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$3,366.53	1.0252	1.0070	1.0000	1.0000	1.0000	1.0000	$0.00	$3,475.43
Outpatient Hospital Services	$10.01	1.0252	1.0483	1.0000	1.0000	1.0000	1.0000	$0.00	$10.76
Physician Services	$1,265.90	1.0252	1.0176	1.0000	0.9996	1.0000	1.0000	$0.00	$1,320.10
Drug Services	$32.38	1.0252	1.2981	1.0000	1.0000	1.0000	1.0000	$0.00	$43.09
Dental Services	$0.06	1.0252	1.0996	1.0000	1.0000	1.0000	1.0000	$0.00	$0.07
Other Services	$54.46	1.0252	1.0176	1.0000	1.0000	1.0000	1.0000	$0.00	$56.81
Total	**$4,729.33**								**$4,906.26**

Exhibit A5
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
Non-Claim Expense Allocation Development

Region: Statewide

	a	b	c	d = (a + b) / (1 - c) - (a + b)	e = b + d	f = a + e
Rate Cell	**SFY 2017 PMPM Cost**	**Fixed Non-Claim Expense Load**	**% of Revenue Non-Claim Expense Load (Including 3% Premium Tax)**	**% of Revenue Non-Claim Expense Allocation**	**Total Non-Claim Expense Allocation**	**Capitation Rates at 1.0 Risk Score**
Non-Newborn SSI / Disabled	$904.78	$4.92	11.25%	$115.31	$120.24	$1,025.02
Foster Care	$325.69	$4.92	11.25%	$41.91	$46.83	$372.52
Breast and Cervical Cancer	$3,073.47	$4.92	11.25%	$390.22	$395.14	$3,468.62
SSI / Disabled Newborn	$6,399.59	$4.92	11.25%	$811.84	$816.76	$7,216.35
MA Adult	$398.13	$4.92	11.25%	$51.09	$56.01	$454.14
Pregnant Women	$490.85	$4.92	11.25%	$62.84	$67.77	$558.61
Non-SSI Newborns 0-2 Months	$1,280.39	$4.92	11.25%	$162.93	$167.85	$1,448.24
Non-SSI Newborns 3-12 Months	$237.24	$4.92	11.25%	$30.70	$35.62	$272.86
Delivery Kick Payment	$4,906.26	$0.00	5.00%	$258.22	$258.22	$5,164.48
Total - All Cap Cells	**$682.03**	**$4.92**	**10.85%**	**$83.62**	**$88.54**	**$770.57**

Exhibit A6
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
Final Capitation Rates

	a	b	c	d = b * c	e	f = e / (1 - 3%) - e	g = d + e + f
Rate Cell	**CY 2014 Enrollment**	**Capitation Rates Statewide**	**Area Adjustments (rounded)**	**Capitation Rates Regional**	**MHAP PMPM (not risk adjusted)**	**Premium Tax on MHAP**	**Total Rate at 1.0 Risk Score**
Non-Newborn SSI / Disabled	758,434	$1,025.02			$89.89	$2.78	$1,117.69
North	259,997		0.9350	$958.39	$89.89	$2.78	$1,051.07
Central	281,119		1.0410	$1,067.04	$89.89	$2.78	$1,159.72
South	217,318		1.0230	$1,048.59	$89.89	$2.78	$1,141.27
Foster Care	49,701	$372.52			$89.89	$2.78	$465.20
North	12,013		0.9350	$348.31	$89.89	$2.78	$440.98
Central	17,269		1.0410	$387.80	$89.89	$2.78	$480.47
South	20,419		1.0230	$381.09	$89.89	$2.78	$473.76
Breast and Cervical Cancer	1,570	$3,468.62			$89.89	$2.78	$3,561.29
North	325		0.9350	$3,243.16	$89.89	$2.78	$3,335.83
Central	599		1.0410	$3,610.83	$89.89	$2.78	$3,703.50
South	646		1.0230	$3,548.39	$89.89	$2.78	$3,641.07
SSI / Disabled Newborn	6,499	$7,216.35			$89.89	$2.78	$7,309.02
North	2,029		0.9350	$6,747.29	$89.89	$2.78	$6,839.96
Central	2,442		1.0410	$7,512.22	$89.89	$2.78	$7,604.89
South	2,028		1.0230	$7,382.32	$89.89	$2.78	$7,475.00
MA Adult	590,706	$454.14			$89.89	$2.78	$546.81
North	207,522		0.9350	$424.62	$89.89	$2.78	$517.29
Central	208,999		1.0410	$472.76	$89.89	$2.78	$565.43
South	174,185		1.0230	$464.59	$89.89	$2.78	$557.26
Pregnant Women	137,220	$558.61			$89.89	$2.78	$651.29
North	42,105		0.9350	$522.30	$89.89	$2.78	$614.98
Central	49,599		1.0410	$581.52	$89.89	$2.78	$674.19
South	45,516		1.0230	$571.46	$89.89	$2.78	$664.13
Non-SSI Newborns 0-2 Months	62,161	$1,448.24			$89.89	$2.78	$1,540.92
North	20,175		0.9350	$1,354.11	$89.89	$2.78	$1,446.78
Central	22,650		1.0410	$1,507.62	$89.89	$2.78	$1,600.29
South	19,336		1.0230	$1,481.55	$89.89	$2.78	$1,574.23
Non-SSI Newborns 3-12 Months	265,105	$272.86			$89.89	$2.78	$365.53
North	84,181		0.9350	$255.13	$89.89	$2.78	$347.80
Central	97,404		1.0410	$284.05	$89.89	$2.78	$376.72
South	83,520		1.0230	$279.14	$89.89	$2.78	$371.81
Delivery Kick Payment	21,359	$5,164.48			$0.00	$0.00	$5,164.48
North	6,861		0.9350	$4,828.79	$0.00	$0.00	$4,828.79
Central	7,749		1.0410	$5,376.23	$0.00	$0.00	$5,376.23
South	6,749		1.0230	$5,283.26	$0.00	$0.00	$5,283.26
Total - All Cap Cells	1,871,396	$770.57			$89.89	$2.78	$863.24
North	628,347		0.9350	$720.48	$89.89	$2.78	$813.16
Central	680,081		1.0410	$802.16	$89.89	$2.78	$894.84
South	562,968		1.0230	$788.29	$89.89	$2.78	$880.97
Total Capitation Dollars - Statewide Capitation Rates	**1,871,396**	**$1,465,855,745**					
Total Capitation Dollars - Regional Capitation Rates	**1,871,396**	**$1,465,916,459**					

APPENDIX B

Capitation Rate Methodology – Non-Newborn Children

APPENDIX B
CAPITATION RATE METHODOLOGY – NON-NEWBORN CHILDREN

This section of our report describes the development of the SFY 2017 MississippiCAN capitation rates for the following non-newborn children populations.

- Medical Assistance (MA) Children
- Quasi-CHIP

Capitation rates for these populations are developed from experience prior to enrollment in MississippiCAN. MA Children capitation rates are developed from CY 2014 fee-for-service (FFS) experience. Quasi-CHIP capitation rates are developed from January to November 2014 financial reporting data while this population was still enrolled in CHIP.

METHODOLOGY OVERVIEW

The methodology used to calculate the capitation rates can be outlined in the following steps:

1. Summarize the CY 2014 base period FFS data and enrollment described in Section IV of the main report for the development of the SFY 2017 MA Children capitation rate.

2. Apply adjustments to MA Children data for Incurred but Not Reported (IBNR) claims, third party liabilities (TPL), and coordinated care assumptions.

3. Summarize the January to November 2014 base period financial reporting data and enrollment described in Section IV of the main report for the development of the SFY 2017 Quasi-CHIP capitation rate.

4. Apply adjustments to Quasi-CHIP data for IBNR claims, provider reimbursement, benefit changes, and program changes.

5. Apply trend and any program or reimbursement changes from base period adjusted experience to SFY 2017, adjust for enhanced PCP payment under ACA for 2014 and continued in 2015, and add provision for non-emergency transportation coverage.

6. Provide an allowance for CCO non-benefit expenses.

7. Adjust for geographic region.

8. Adjust MA Children rates for CCO specific risk scores.

9. Add Mississippi Hospital Access Program (MHAP) payments.

Each of the above steps is described in detail below.

Step 1: Summarize CY 2014 Base Period FFS Data for all SFY 2016 MississippiCAN Eligible Members in the MA Children Rate Cell

In this step, the FFS experience, including any mass adjustments as described in Section IV of the main report, is summarized by service category for the MA Children population eligible to enroll in the MississippiCAN program.

The results are summarized by broad category of service level in Exhibit B1 for CY 2014 on a statewide basis. Tables 1 and 2 below summarize the membership and allowed costs (net paid amount plus beneficiary copays) for the MA Children rate cell.

APPENDIX B
CAPITATION RATE METHODOLOGY – NON-NEWBORN CHILDREN

Table 1
Mississippi Division of Medicaid
Statewide CY 2014 Enrollment by Region

	MA Children	
Region	**Member Months**	**Average Enrollment**
North	1,224,188	102,016
Central	1,427,192	118,933
South	1,143,818	95,318
Statewide	**3,795,198**	**316,267**

Table 2
Mississippi Division of Medicaid
Statewide CY 2014 Enrollment and Fee-for-Service Costs
Rate Cell: MA Children

Region	Allowed Costs	Member Months	PMPM
North	$187,898,539	1,224,188	$153.49
Central	$229,000,973	1,427,192	$160.46
South	$183,644,251	1,143,818	$160.55
Statewide	**$600,543,763**	**3,795,198**	**$158.24**

Step 2: Apply Adjustment Factors for Incurred But Not Reported Claims, Third Party Liabilities, PCP Evaluation and Management Services, and Managed Care Assumptions

In this step, we apply adjustment factors to reflect differences between the base period Medicaid FFS data and the MississippiCAN program. Each adjustment factor is explained in detail below. Exhibit B1 shows the impact of the Step 2 adjustments.

IBNR Adjustment

The adjustment for IBNR claims uses completion factors that we developed based on the FFS historical claims payment patterns. We used the Milliman CREW® model, which employs the classical chain-ladder approach by building claim lag triangles by category of service, to develop IBNR adjustments. For the most recent months we gave weight to trended historical PMPMs in addition to the completion factor-developed approach. We reviewed all historical payment patterns and results for outliers and adjusted when appropriate.

We calculated these adjustments for the MA Children rate cell split by inpatient, outpatient, physician, pharmacy, dental, and all other service categories. Such adjustments are required since we developed the base data with claim payments through June 2015. The IBNR adjustment reflects an estimate of the claims that are paid after this time for CY 2014 incurred claims.

This adjustment is shown in Exhibit B1 in column (c).

Third Party Liability Recoveries and Program Integrity

DOM provided Milliman with a summary of aggregate TPL recoveries that are not reflected in the FFS claims data. Milliman summarized paid claims data by state fiscal year for all Medicaid fee-for-service programs to develop a TPL adjustment factor which averaged 0.90% of all Medicaid claim expenditures for SFY 2010 to SFY 2015. We assume that the CCOs will be at least as aggressive in capturing TPL recoveries, since they have a financial incentive to do so. Therefore, we used a downward adjustment of 0.90% to allowed costs in our capitation rate calculation.

This adjustment is shown in Exhibit B1 in column (d).

Evaluation and Management Adjustment

The Affordable Care Act (ACA) amended sections 1902(a) (13), 1902(jj), 1905(dd), and 1932(f) of the Social Security Act to require that payments to eligible primary care physicians (PCP) for certain primary care services from January 2013 through December 2014 be made at Medicare rates in effect during those years (but not less than the applicable rate using the 2009 Medicare conversion factor). DOM extended these rates through June 30, 2015, after which they will be paid at 100% of Medicare, which is still an enhancement compared to the non-eligible physician services reimbursement rate of 90% of Medicare. Therefore, an adjustment was made to reflect the reimbursement difference between the CY 2014 base period data and the SFY 2017 projection period. The CY 2014 base period data reflects the enhanced rate of approximately 106% of Medicare for the MA Children. However, the Quasi-CHIP base period data was under the CHIP program which was not subject to the enhanced reimbursement. Therefore, the following reimbursement adjustments are applied for applicable services:

- MA Children: Reduction from approximately 106% of Medicare to 100% of Medicare
- Quasi-CHIP: Increase from 90% of Medicare to 100% of Medicare

To the extent that these services (or their successors) are covered under MississippiCAN, the following primary care services are eligible for the enhanced payment:

- Evaluation and Management (E&M) Current Procedural Terminology (CPT) codes 99201 through 99499.

- Vaccine administration codes 90460 – 90461, 90465, and 90471 – 90474. The final rule also updates the interim regional maximum fees for vaccine administration provided under the Vaccines for Children (VFC) program.

Eligible physicians must self-attest that they meet the following qualifications.

1) Specialty designation of family medicine, general internal medicine, and pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association, and

2) One of the following:

   i. Board certified in an eligible specialty or subspecialty, **OR**
   ii. 60% of the Medicaid claims for the prior year were for the services covered by the regulation.

The following criteria were used to determine the portion of the SFY 2017 capitation rates represented by primary care providers and procedure codes eligible for the enhanced reimbursement. Since detailed encounter data for the CHIP program is not available to analyze, we used the detailed MA Children FFS data to develop the PCP reimbursement adjustment as a proxy population with similar service utilization patterns as the Quasi-CHIP population.

The following provider specialties are eligible for the enhanced reimbursement:

- Provider Specialty Code 000 – General Practitioner
- Provider Specialty Code 001 – Pediatrician
- Provider Specialty Code 012 – Internist
- Provider Specialty Code 031 – Family Practice

APPENDIX B
CAPITATION RATE METHODOLOGY – NON-NEWBORN CHILDREN

All specialty fields for a provider within the data received from DOM's Medicaid Management Information Systems (MMIS) vendor were reviewed; and if any specialty field was flagged as one of the these four specialties, the provider was included as being eligible for the enhanced reimbursement.
Eligible services include the following:

- Vaccine Administration Codes: 90460, 90461, 90465 , 90471, 90472, 90473, 90474
- Evaluation and Management Codes: 99201 – 99499

Per the Final Rule, services provided in Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), state health clinics, and nursing homes were excluded. Mississippi state health clinics are reimbursed on an encounter basis and nursing homes are reimbursed on a per diem basis, making them ineligible for the enhanced primary care payment. DOM believes that all physician extenders will be eligible for enhanced payment levels, though the current payment differential of 10% will be maintained.

To develop the final medical component of the revised capitation rates, the portion of the rates associated with PCP services eligible for enhanced reimbursement was adjusted from the base period reimbursement level to 100% of Medicare.

This adjustment is shown in Exhibit B1 in column (e).

Coordinated Care Savings Assumptions

The coordinated care savings adjustments were developed based on savings realized by the CCOs on the original MississippiCAN population and results of implementing managed care in other states.

We applied only 50% of the CCO savings adjustments to non-inpatient behavioral health services, with the expectation that a portion of any inefficient utilization under FFS will be redirected to expanded and more effective utilization under managed care. Inpatient behavioral health services received the full CCO savings adjustment to reflect the expectation of greater community-based treatment of behavioral health conditions.

The coordinated care savings adjustments are shown in Table 3 below. On average, the Table 3 adjustments produce an overall coordinated care savings of about 11%.

Table 3
Mississippi Division of Medicaid
CCO Cost Savings Targets for MississippiCAN Program

Service Category	CCO Savings Targets
Inpatient Hospital	20%
Outpatient Hospital	15%
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Benefit	-10%
Physician – Non-EPSDT	10%
Prescription Drugs	15%
Dental	0%
Other	15%

This adjustment is shown in Exhibit B1 in column (f).

Step 3: Summarize January to November 2014 Base Period Financial Reporting Data for all SFY 2017 MississippiCAN Eligible Members in the Quasi-CHIP Rate Cell

In this step, the CCO financial reporting from the CHIP program is summarized by service category for the Quasi-CHIP enrollees eligible to enroll in the MississippiCAN program.

Children enrolled in the CHIP program for 100% – 133% FPL were not subject to any member cost sharing; therefore, no adjustment was necessary for this issue when using this information for the Quasi-CHIP population rate development under MississippiCAN.

The results are shown in the first two columns of Exhibit B2 for January to November 2014. In December 2014 Quasi-CHIP moved into MississippiCAN. Therefore, the base period used to develop capitation rates is only 11 months.

The coordinated care organizations are responsible for the collection of TPL recoveries for all services. It is assumed that there is no change in the level of TPL recoveries collected under the CHIP program relative to the amount that will be collected under MississippiCAN. Therefore, no additional adjustment was made for changes in TPL recoveries for the Quasi-CHIP population.

Tables 4 and 5 below summarize the membership and allowed costs for the Quasi-CHIP rate cell.

Table 4
Mississippi Division of Medicaid
Statewide January to November 2014 Enrollment by Region

	Quasi-CHIP	
Region	**Member Months**	**Average Enrollment**
North	70,567	6,415
Central	64,558	5,869
South	82,562	7,506
Statewide	**217,687**	**19,790**

Table 5
Mississippi Division of Medicaid
Statewide January to November 2014 Enrollment by Region
Rate Cell: Quasi-CHIP

Region	Allowed Costs	Member Months	PMPM
North	$12,290,644	70,567	$174.17
Central	$14,536,683	64,558	$225.17
South	$12,305,052	82,562	$149.04
Statewide	**$39,132,378**	**217,687**	**$179.76**

Step 4: Apply Adjustments for Incurred But Not Reported Claims, Provider Reimbursement, PCP Evaluation and Management Services, Benefit Changes, and Program Changes

In this step we apply adjustment factors to reflect differences between the base period financial reporting data and the MississippiCAN program. Each adjustment factor is explained in detail below.

Exhibit B2 shows the impact of the Step 4 adjustments.

APPENDIX B
CAPITATION RATE METHODOLOGY – NON-NEWBORN CHILDREN

IBNR Adjustment

The adjustment for IBNR claims uses the best estimate IBNR claims provided in the CCO CHIP financial reporting. We validated the reasonability of these estimates relative to claim payment patterns observed for FFS populations and in CHIP financial reporting from previous periods.

The following high level reasonability checks were performed on the reported IBNR amounts from the CCO CHIP financing reporting, absent any detailed encounter data:

1) Data including IBNR estimates was reported on a quarterly basis. We reviewed the reported IBNR by quarter to determine that there was a reasonable pattern throughout the year (i.e., IBNR amounts held for Q1 2014 were significantly lower than Q4 2014).

2) Based upon our experience with other Medicaid managed care organizations in other states, the IBNR estimates are reasonable for similar periods of claim run-out.

This adjustment is shown in Exhibit B2 in column (c).

Reimbursement Adjustment

The adjustment for reimbursement changes is based on the knowledge provided by DOM staff that CHIP claims for hospital and dental service categories in January to November 2014 experience were paid on a schedule similar to commercial fee schedules and all other services paid on a schedule similar to Medicaid fees. This contrasts the projected Quasi-CHIP population claims which under MississippiCAN will be paid closer to a Medicaid schedule.

Using this knowledge, we developed the adjustment needed to approximate outpatient and dental claims being paid on a Medicaid schedule. The outpatient adjustment was not updated from those used in the SFY 2016 Quasi-CHIP capitation rates, since no significant reimbursement changes occurred between CY 2013 and CY 2014 that would materially impact this adjustment. The dental adjustment was updated to reflect the DOM fee schedule update effective July 1, 2014.

- Outpatient: We analyzed the commercial and Medicare allowed average cost per outpatient service using the Milliman *Health Cost Guidelines* for the commercial and 65+ populations, respectively. We compared the Mississippi area-adjusted average allowed amounts to develop a ratio of Medicare to commercial costs. Based on the results of this analysis we applied a 45% reimbursement adjustment (i.e., 55% downward adjustment) to Quasi-CHIP outpatient claims to reflect reimbursement levels once the members are enrolled in MississippiCAN.

- Dental: We identified the highest utilized dental codes from the MA Children CY 2013 FFS experience. We examined the historical DOM dental fee schedules from January to June 2014 and July to November 2014 and compared these rates to the area-adjusted commercial rates from the Milliman *Dental Cost Guidelines* to develop an overall ratio of reimbursement levels. Based on the results of this analysis the DOM fee schedule was 62% of commercial rates from January to June 2014 and 66% from July 2014 to November 2014. We applied the average of these time periods for a 64% reimbursement adjustment (i.e., 36% downward adjustment) to Quasi-CHIP dental claims to reflect reimbursement levels once the members are enrolled in MississippiCAN.

We validated the reasonability of these estimates relative to PMPM patterns observed between the FFS MA Children experience and the financial summary Quasi-CHIP experience at the category of service level.

These adjustments are shown in Exhibit B2 in column (d).

Evaluation and Management Adjustment

The development of the evaluation and management adjustment for the Quasi-CHIP population is documented in Step 2 to increase reimbursement for eligible providers and services from 90% of Medicare in the base period to 100% of Medicare for SFY 2017.

This adjustment is shown in Exhibit B2 in column (e).

Third Party Liability Recoveries

This adjustment is outlined above in Step 2 and is shown in Exhibit B2 in column (f).

Benefit Changes

We compared the CHIP and MississippiCAN contracts to discern any significant differences between the two contracts' benefits and overall plan designs that would impact costs for children moving from CHIP to MississippiCAN. Table 6 below summarizes these differences and the resulting adjustments.

Table 6
Mississippi Division of Medicaid
CHIP and MississippiCAN Contract Differences

Service Category	CHIP	MississippiCAN	Resulting Adjustment
Vision Care	Vision screening is covered, one pair of eyeglasses per year	2 eye exams per year, 2 pairs of glasses per year	Analyzed Milliman's *Health Cost Guidelines* and deemed the benefit cost difference to be immaterial
Dental Care	$1,500 limit	2 comprehensive evaluations, 4 limited oral evaluations, $2,500 annual limit	Used Milliman's Dental Rating Model to determine benefit change factor (see below)
Non-Emergency Transportation	Not covered	Covered effective 7/1/2014	Developed a PMPM benefit cost add on
Inpatient Hospital	Covered	Covered effective 12/1/2015	Develop rates with inpatient hospital for SFY 2017

After analyzing the differences, we determined the necessary benefit changes to apply in Quasi-CHIP rate development were dental and non-emergency transportation.

The following benefit change adjustments were applied to the January to November 2014 experience period:

Dental Coverage

- The annual limit in the experience under the CHIP contract was $1,500 in CY 2014. The annual limit for this population increases to $2,500 under the MississippiCAN contract. We approximated the impact on claims under this increased limit to be 13%, using Milliman's Dental Rating Model and the dental codes covered under the respective contracts.

This adjustment is shown in Exhibit B2 in column (g).

Non-emergency Transportation

We account for the addition of Non-emergency Transportation services to the capitation rate in Step 5 of this report.

Step 5: Trend Base Period Adjusted Experience to SFY 2017

Table 7 shows the annual utilization and unit cost trends applied to the adjusted base period experience data in order to put it on a SFY 2017 basis. For MA Children, the CY 2014 experience is trended from the base period midpoint, July 1, 2014, to the projection period midpoint of January 1, 2017. For Quasi-CHIP, the January to November 2014 experience is trended from the base period midpoint, June 15, 2014, to the projection period midpoint of January 1, 2017. The hospital inpatient, hospital outpatient, physician, and dental fee schedules are updated on July 1st of each year, as described in detail later in this section. For this rate development iteration, we assume no change to the dental fee schedule for SFY 2017. DOM does not mandate provider reimbursement levels other than to require reimbursement be at least as great as FFS. We assume that CCO reimbursement levels will move in tandem with changes to FFS reimbursement.

Table 7
Mississippi Division of Medicaid
Base Period to SFY 2017 Utilization and Unit Cost Trends

COS	Annualized Utilization Trend	Annualized Unit Cost Trend
Hospital Inpatient	1.00%	0.28%
Hospital Outpatient	3.00%	1.91%
Physician	4.00%	0.70%
Prescription Drugs	2.00%	7.10%
Dental	2.00%	3.22%
Other Professional	3.00%	0.70%

The rest of this section outlines the methodology used to develop these trend values.

Utilization Trend

Utilization trend reflects expected changes in:

- Demand for medical services
- Intensity or mix of medical services
- Provider practice patterns
- Provider coding changes

We reviewed multiple data sources to determine utilization trends for use in the SFY 2017 MississippiCAN Children rate development.

- FFS data for MA Children to analyze utilization trends by major service categories from CY 2011 to CY 2014
- High-level financial reporting from CY 2013 and CY 2014 for Quasi-CHIP experience
- Emerging CY 2015 to Q2 2016 Quasi-CHIP and MA Children experience provided in detailed CCO financial reporting
  - In particular, it appears that new 2016 enrollees may be accessing services more quickly upon enrollment that in previous years, rather than taking a year or more to establish provider relationships
- Experience from similar children programs in other states

Detailed claim data for the Quasi-CHIP population is not available to perform a specific utilization trend analysis for this population prior to December 2014, so we used MA Children as a proxy for this population.

The adjustment resulting from these utilization trends is shown in Exhibit B3 in column (c).

Hospital Inpatient Unit Cost Trend

DOM reimburses hospital inpatient claims using an APG - DRG methodology based upon the 3M Medicaid grouper, with updates to the fee schedule implemented July 1st of each year. These updates were budget neutral updates in SFY 2015 and SFY 2016.

Table 8
Mississippi Division of Medicaid
Inpatient Unit Cost Increase

Effective Date	Rate Increase
7/1/2014	1.00%
7/1/2015	0.00%
7/1/2016	0.20%

The Table 7 Inpatient services unit cost trend of 0.28% is a blend of the values from Table 8. Column (d) in Exhibit B3 includes this adjustment for the Inpatient Hospital Services line.

Hospital Outpatient Unit Cost Trend

DOM updates the hospital outpatient fee schedule July 1st of each year consistent with the Medicare APC Jackson, Mississippi conversion factor update. Historical and projected increases are shown in Table 9 below. The July 1, 2015 increase also accounts for the implementation of outpatient APC Phase II changes, estimated by DOM to have a 4.00% impact.

Table 9
Mississippi Division of Medicaid
Outpatient Unit Cost Increase

Effective Date	Rate Increase
7/1/2014	2.72%
7/1/2015	4.00%
7/1/2016	-0.53%

The Table 7 outpatient services unit cost trend of 1.91% is a blend of the values from Table 9. Column (d) in Exhibit B3 includes this adjustment for the outpatient hospital services line.

Physician and Other Unit Cost Trend

DOM changes most of the physician and other services fee schedules July 1st of each year with the most recent Mississippi Medicare fee change. Historical and projected changes to Medicare's fee schedules, which generally form the basis for FFS reimbursement, are shown in Table 10 below, along with unit cost increases to non-physician other services.

Table 10
Mississippi Division of Medicaid
Physician and Other Services
Unit Cost Increase

Effective Date	Physician / Other
7/1/2014	1.50%
7/1/2015	0.25%
7/1/2016	0.75%

The Table 7 physician services charge trend of 0.70%, as well as the other services charge trends of 0.70% are a blend of the values from Table 10.

The per-encounter FQHC and RHC reimbursement is included in the MississippiCAN capitation rates to provide a steadier cash flow to the RHCs and FQHCs that serve the MississippiCAN population. The CCOs are expected to reimburse FQHCs and RHCs at DOM's per-encounter rates. DOM will monitor the utilization of services at FQHCs and RHCs under MississippiCAN to ensure services are not diverted from FQHCs and RHCs to other providers.

Column (d) in Exhibit B3 includes the adjustment to trend base period adjusted experience to a SFY 2017 basis.

Dental Unit Cost Trend

Effective July 1, 2014, DOM implemented increases to FFS fee schedules. In order to approximate the annual charge trend for rate development, we first identified the most utilized dental codes from the MA Children CY 2013 FFS experience. Then, we examined the historical DOM dental fee schedules and summarized the rates from the prior SFY 2014 and SFY 2015 fee schedules of the most utilized dental codes. We compared the rates between these two fee schedules to arrive at an approximate 13.06% one-time charge increase.

For this rate development iteration, we assume no change to the dental fee schedule for SFY 2017.

Historical and projected increases are shown in Table 11 below.

Table 11
Mississippi Division of Medicaid
Dental Unit Cost Increase

Effective Date	Rate Increase
7/1/2014	13.06%
7/1/2015	2.00%
7/1/2016	0.00%

The Table 7 unit cost trends of 3.22% is a blend of the values from Table 11. Column (d) in Exhibit B3 includes this adjustment for the Dental Services line.

APPENDIX B
CAPITATION RATE METHODOLOGY – NON-NEWBORN CHILDREN

Prescription Drug Unit Cost Trend

Milliman analyzed 2012 to 2015 pharmacy experience for the eligible population and developed utilization and cost summaries by brand, generic, and specialty drug types for 25 top therapeutic classes for non-specialty prescriptions and 5 top therapeutic classes for specially prescriptions. We developed cost projections for CY 2014 to SFY 2017, using those summaries, giving consideration for script utilization per 1,000 increases, and average script cost increases for brand, generic, and specialty drugs. Considerations were made when reviewing prescription drug experience after the movement of MA Children into MississippiCAN beginning in May 2015 in order to only reflect true drug trend and not any managed care savings achieved.

For the preliminary rates we have not modeled the impact of brand patent expiries and resulting shifts in utilization to generic alternatives. Once future updates to the PDL are established we will reevaluate the potential impact of cost and utilization shifts.

As a result of this analysis, we applied an annualized 7.00% unit cost increase to CY 2014 experience for drug services. Column (d) in Exhibit B3 includes this adjustment for the drug services. These assumptions also give consideration to Q1 and Q2 2016 claim experience reported on CCO financial reporting.

The prescription drug unit cost trend was increased by 0.10% to 7.10% to reflect anticipated cost increases for individuals with cystic fibrosis due to the release of Orkambi in 2015. This drug is approved only for individuals ages 12 and over and, therefore, has a minimal impact on the non-newborn children population. The increase to drug trend was developed by identifying individuals aged 12 and over in the MA Children population with cystic fibrosis based upon utilized prescription drugs and diagnosis codes in December 2015. Of these members 40% were assumed to utilize Orkambi in SFY 2017 at an annual cost of $259,000. This additional program cost increases drug spend approximately 0.25% which was translated into an additional 0.10% trend over 30 months.

Pharmacy Reimbursement Changes

There are a number of changes that will be implemented to pharmacy reimbursement in MississippiCAN as a result of the Covered Outpatient Drug final rule (CMS-2345-FC) (81 FR 5170) published by CMS on February 1, 2016.

1) As part of the Affordable Care Act, Federal Upper Limits (FULs) are imposed on generic drug pricing. DOM implemented this change on April 11, 2016.

2) By April 1, 2017 DOM must finalize changes to reimbursement methodology to move to an actual acquisition cost plus professional dispensing fee to be established by DOM.

3) As a result of the implementation of the FULs and change in reimbursement methodology DOM is evaluating changes to the preferred drug list (PDL), with implementation phased in starting as early as January 1, 2017.

These rates also continue to use the same PDL adjustment as SFY 2016 capitation rates which reflects the impact of moving to a uniform PDL on January 1, 2015 and revisions to the PDL implemented on July 1, 2015. Once the PDL is revised for the Covered Outpatient Drug rule, we will review the impact and, if material, make adjustments to SFY 2017 capitation rates.

To determine the impact of the establishment of FULs, we reviewed March 2016 pharmacy claims in conjunction with the March FULs. We repriced prescriptions whose ingredient cost exceeded the FUL and determined that percentage impact on the total cost, including dispensing fee, for that prescription. Prescriptions subject to usual and customary pricing or to “Dispense as Written” instructions were not repriced as part of the analysis. Our estimate of the impact for the FUL on total drug costs is 16.00%. This

impact did not vary significantly across regions or rate cells, except for rate cells with very low utilization of pharmacy services (e.g. 0 – 2 month newborns and delivery kick payment). Following is an example of our calculation for a particular NDC:

In March 2016 pharmacy encounter claims, the most common amount paid for a fill of six units of NDC 59762306001 (azithromycin) is $24.04. Of this paid amount, $4.91 is allocated to dispensing fees based upon the standard DOM dispensing fees. The remaining $19.13 is the ingredient cost, which corresponds to an approximate ingredient cost per pill of $3.19. On the March 2016 FUL list, the maximum allowable ingredient cost per pill for this NDC is $0.50055. Therefore, the ingredient cost for this script using FUL pricing is approximately $3.00 (= 6 x $0.50055) and the total paid amount is $7.91 (= $3.00 + $4.91). For this particular NDC and fill size, this results in a 67% decrease in the paid amount.

In addition to this analysis, CCOs performed their own script-level analyses of the FUL impact using slightly different data sets and analyses resulting in impacts from 15.50% to 17.50%. We reviewed the methodology underlying these analyses and followed up with CCOs with any necessary questions or clarifications.

As a result of the various studies, we incorporated a 16.00% savings assumption to pharmacy costs for the FUL impact across all rates cells, excluding delivery kick payments. This adjustment combined with the SFY 2016 PDL adjustment is shown in column (e) of Exhibit B3.

Non-Emergency Transportation

Effective July 1, 2014 CCOs became responsible for providing non-emergency transportation (NET) services for MississippiCAN members. The NET vendor providing services to FFS members prior to that time did not submit encounter data of sufficient completeness and quality to use in developing a MississippiCAN rate adjustment for this service. Therefore, we solicited utilization and cost per trip information from the CCOs for July to December 2014 experience and developed a $0.66 PMPM subcapitation amount for the MA Children and Quasi-CHIP populations. This estimate was developed by reviewing the MA Adult NET experience from the CCOs and applying the ratio of utilization between an MA adult and MA child population consistent with detailed NET experience we have seen in another large Medicaid program. The cost per trip was then trended forward at 3% per year (CPI unit cost growth plus modest 1% utilization increases) and grossed up to include a load of 20% for NET broker administrative expenses and margin. The resulting PMPM is shown in column (f) of Exhibit B3.

Step 6: Provide an Allowance for CCO Non-Benefit Expenses

Administrative Expenses, Premium Tax and Targeted Margin

The administrative allowance included in the capitation rate is intended to cover administrative costs, including the following:

- Case management
- Utilization management
- Claim processing and other IT functions
- Customer service
- Provider contracting and credentialing
- TPL and program integrity
- Member grievances and appeals
- Financial and other program reporting
- Local overhead costs
- Corporate overhead and business functions (e.g., legal, executive, human resources)

APPENDIX B
CAPITATION RATE METHODOLOGY – NON-NEWBORN CHILDREN

The non-benefit expense allowance for the SFY 2017 capitation rate is comprised of a flat PMPM for fixed administrative costs and a percentage of revenue for variable administrative costs. We also included explicit adjustments of 2.00% of revenue for target underwriting margin and 3.00% for the Mississippi premium tax, for a total variable non-benefit expense allowance of 11.25% as reflected in Exhibit B4. Table 12 displays the allowance included in the capitation rates for non-benefit expenses.

Table 12
Mississippi Division of Medicaid
Non-Benefit Expenses

	MA Children		Quasi-CHIP	
	% of Revenue	**PMPM**	**% of Revenue**	**PMPM**
Fixed Costs*	2.68%	**$4.92**	2.52%	**$4.92**
Variable Costs**	**6.25%**	$11.46	**6.25%**	$12.19
Premium Tax**	**3.00%**	$5.50	**3.00%**	$5.85
Margin**	**2.00%**	$3.67	**2.00%**	$3.90
Total	13.93%	$25.56	13.77%	$26.87

** Included in the rate as a flat PMPM, equivalent percentage of revenue is shown.*
*** Included in the rate as a percentage of revenue, equivalent PMPM is shown.*

Since the same two CCOs administer both CHIP and MississippiCAN, we coordinated the administrative expense development across the two programs. We developed the administration allowance based on an analysis of the actual CY 2014 CHIP and MississippiCAN CCO administrative expenses. The actual CY 2014 reported administrative costs, excluding taxes and fees, were compared to national benchmarks released by the Sherlock Company and in Milliman's annual analysis of administrative costs for Medicaid managed care plans. Adjustments were made as necessary to reduce actual program experience to align with these benchmarks.

We estimated a split of fixed versus variable expenses across all populations. Projected variable expenses, as a percentage of non-kick payment revenue, were kept consistent with adjusted CY 2014 administrative expenses. Similar to last year, we gave consideration to the impact of significantly increased CCO enrollment over which to spread fixed costs between CY 2014 and SFY 2017 due to the roll-in of MA Children in CY 2015, resulting in a lower total fixed administrative allowance on a PMPM basis. An illustration of the development of the administrative cost assumptions in included in Appendix C2.

Health Insurer Fee

DOM will process the capitation rate adjustments for the ACA Health Insurer Excise Fee (HIF) outside of the monthly capitation rate payment system in the form of one annual payment to CCOs for the actual health insurer fee amount (allocated across CCO lines of business by revenue) and the associated income tax impact related to the HIF. We will calculate adjusted capitation rates after the Internal Revenue Service fee notices are distributed to the CCOs and these fee notices are provided to DOM. The annual capitation rate adjustment will be allocated to each managed care contract period effective in 2016, proportional to the revenue associated with each contract. Bill H.R.2029 signed into law on December 18, 2015 put a moratorium on 2017 HIF. Based on the current law, no HIF payments shall be made in calendar year 2017.

The capitation rate adjustment will include consideration for the marginal federal and state corporate tax income rates, as well as the Mississippi premium tax. Using the following assumptions:

- A = Marginal Federal Income Tax % = 35%, subject to CCO verification of actual liability
- B = Marginal State Income Tax % = 0% (Mississippi tax code allows income tax to be offset by premium tax payments.)
- C = State Premium Tax % = 3%

APPENDIX B
CAPITATION RATE METHODOLOGY – NON-NEWBORN CHILDREN

The total capitation rate adjustment to CCOs would be based on the following formula:

*Total Capitation Adjustment = HIF / (1 – A – B *(1 – A)) * 1 / (1 – C) = 1.586 * HIF*

Step 7: Adjust for Geographic Region

CCO capitation payments will vary based on their members' county of residence. We assigned each county to one of the following regions (as defined in Section III): North, Central, or South. Table 13 shows the geographic area factor adjustments that are applied based on a beneficiary's region in Exhibit B5.

Table 13
Mississippi Division of Medicaid
Area Factors

Region	Area Factors
North	0.972
Central	1.019
South	1.006

We developed the geographic area factors on a budget-neutral basis by blending projected claims PMPM across both rate cells weighted upon the statewide rate cell distribution for each region and reviewing the relative difference in PMPM cost for each region. Exhibit B5 includes the resulting capitation rates for each region using these area factors.

Step 8: Adjust for CCO Specific Risk Score (if Applicable)

The capitation rates for the MA Children rate cell will be further adjusted for each CCO using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx). The Quasi-CHIP population will not be risk adjusted due to a lack of detailed historical encounter data.

The CDPS + Rx risk adjuster will be used to adjust for the acuity differences between the enrolled populations of each CCO. Risk adjustment will be budget-neutral to DOM. This risk sharing mechanism is developed in accordance with generally accepted actuarial principles and practices.

To establish these risk scores, the CDPS + Rx risk adjuster was run with weights calculated using Mississippi FFS Medicaid data for the MA Children population. In addition, a beneficiary must have at least six months of eligibility in the data year to be scored. If a beneficiary does not have enough data, they will receive a score equal to the average of those beneficiaries with scores in each cohort (i.e., the CCO-specific average). We will monitor the percentage of CCO enrollees who are not scored and adjust the methodology if necessary.

A CCO's capitation rate will be determined based upon the following formula:

CCO Capitation Rate = Base Capitation Rate x CCO Normalized Risk Factor

The base capitation rates are found in column (d) in Exhibit B5.

The CCO normalized risk factor will equal the average risk factor across all beneficiaries that a CCO enrolls divided by the average risk factor for the rate cell's population. Regional risk scores will be normalized to ensure the risk adjustment process is revenue neutral across all MA Children enrolled in MississippiCAN.

Risk Adjustment for SFY 2017

Each CCO's MA Children adjusted risk factor will be set prospectively for SFY 2017.

The schedule for risk score data sources and calculations is found in Table 14.

Table 14
CCO Capitation Rate Risk Adjustment Schedule
MA Children Rate Cell
SFY 2017

Rate Cell	Capitation Payments	Diagnosis Source Data	Enrollment Source
MA Children	July 2016 – December 2016	CY 2015 FFS / Encounters	April 2016
MA Children	January 2017 - June 2017	SFY 2016 FFS / Encounters	October 2016

Step 9: Add MHAP Payments

Concurrent with the inclusion of Inpatient Hospital services in MississippiCAN capitation rates effective December 1, 2015, the Mississippi Hospital Access Program was established. This program helps to ensure sufficient access to inpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates. MHAP is funded through a broad-based hospital assessment.

The enhanced hospital reimbursement will be $533,110,956 annually, which will be paid by the MississippiCAN CCOs to individual hospitals. The MississippiCAN non-delivery capitation rates include an $89.89 PMPM allowance for the MHAP liability along with its associated premium tax liability of $2.78

PMPM (see Exhibit B5) which does not vary by region, rate cell or risk score. On a PMPM basis, this is a significant decrease from the MHAP PMPM included in the December 2015 to June 2016 MississippiCAN capitation rates. While the total annual amount funded through this program is unchanged from SFY 2016, the payments are spread across a full year rather than seven months.

Monthly MHAP payments based on the projected membership and estimated PMPM will be made to the CCOs until the $533 million threshold has been reached. Due to actual versus projected MississippiCAN membership this estimated PMPM may result in an overpayment or underpayment of MHAP in SFY 2017 if no adjustments are made. If membership is higher than expected payments will be capped at the $533 million funding amount. If membership is lower than expected, the final payments will be grossed up to meet the $533 million funding amount.

Exhibits B1 – B5

Capitation Rate Development

B1 **CY 2014 Fee-For-Service Base Experience Data – MA Children**

B2 **January to November 2014 CCO Financial Reporting Data – Quasi-CHIP**

B3 **PMPM Medical and Pharmacy Cost Estimates Projected to July 1, 2016 – June 30, 2017**

B4 **Non-Claim Expense Allocation Development**

B5 **July 1, 2016 – June 30, 2017 Capitation Rates**

Exhibit B1
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
MA Children Base FFS Experience Data - CY 2014

Region: Statewide

MA Children CY2014 Member Months: 3,795,198

	a	b	c	d	e	f	g = b * c * d * e * f
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**TPL Adjustment**	**Evaluation and Management Adjustment**	**CCO Savings Adjustment**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$56,037,314	$14.77	1.0031	0.9910	1.0000	0.8000	$11.74
Outpatient Hospital Services	$106,916,976	$28.17	1.0043	0.9910	1.0000	0.8610	$24.14
Physician Services	$201,777,734	$53.17	1.0071	0.9910	0.9713	0.9132	$47.06
Drug Services	$139,569,088	$36.78	1.0000	0.9910	1.0000	0.8500	$30.98
Dental Services	$81,969,009	$21.60	1.0013	0.9910	1.0000	1.0000	$21.43
Other Services	$14,273,643	$3.76	1.0054	0.9910	1.0000	0.8538	$3.20
Total	**$600,543,763**	**$158.24**					**$138.56**

Exhibit B2
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
Quasi-CHIP Financial Reporting Data - Jan 2014 - Nov 2014

Region: Statewide

Quasi-CHIP Jan 2014 - Nov 2014 Member Months: 217,687

	a	b	c	d	e	f	g	h = b * c * d * e * f * g
Category of Service	**Total Allowed Dollars**	**Per Capita Monthly Allowed Cost**	**IBNR Adjustment**	**Reimbursement Adjustment**	**Evaluation and Management Adjustment**	**TPL Adjustment**	**Benefit Adjustment**	**Per Capita Monthly Allowed Cost**
Inpatient Hospital Services	$2,388,437	$10.97	1.0012	1.0000	1.0000	1.0000	1.0000	$10.99
Outpatient Hospital Services	$10,645,970	$48.90	1.0014	0.4500	1.0000	1.0000	1.0000	$22.04
Physician Services	$12,108,830	$55.62	1.0013	1.0000	1.0564	1.0000	1.0000	$58.83
Drug Services	$6,304,821	$28.96	1.0000	1.0000	1.0000	1.0000	1.0000	$28.96
Dental Services	$6,329,641	$29.08	1.0013	0.6400	1.0000	1.0000	1.1287	$21.03
Other Services	$1,354,679	$6.22	1.0004	1.0000	1.0000	1.0000	1.0000	$6.23
Total	**$39,132,378**	**$179.76**						**$148.08**

Exhibit B3
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
PMPM Medical and Pharmacy Cost Estimates Projected to July 2016 - June 2017

Region: Statewide

	a	b	c	d	e	f	g = b * c * d * e + f
Category of Service	**Base Period* Enrollment**	**Base Period Adjusted PMPM Cost**	**Utilization Trend Factors Base* to SFY 2017**	**Charge Trend Factors Base* to SFY 2017**	**PDL and FUL Adjustment**	**Non-Emergency Transportation PMPM**	**Per Capita Monthly Allowed Cost**
MA Children							
Inpatient Hospital Services	3,795,198	$11.74	1.0252	1.0070	1.0000	$0.00	$12.12
Outpatient Hospital Services	3,795,198	$24.14	1.0767	1.0483	1.0000	$0.00	$27.25
Physician Services	3,795,198	$47.06	1.1030	1.0176	1.0000	$0.00	$52.83
Drug Services	3,795,198	$30.98	1.0508	1.1871	0.9610	$0.00	$37.13
Dental Services	3,795,198	$21.43	1.0508	1.0825	1.0000	$0.00	$24.38
Other Services	3,795,198	$3.20	1.0767	1.0176	1.0000	$0.66	$4.17
Total		**$138.56**					**$157.87**
Quasi-CHIP							
Inpatient Hospital Services	217,687	$10.99	1.0256	1.0071	1.0000	$0.00	$11.35
Outpatient Hospital Services	217,687	$22.04	1.0780	1.0492	1.0000	$0.00	$24.93
Physician Services	217,687	$58.83	1.1048	1.0179	1.0000	$0.00	$66.16
Drug Services	217,687	$28.96	1.0516	1.1905	0.9465	$0.00	$34.32
Dental Services	217,687	$21.03	1.0516	1.0840	1.0000	$0.00	$23.98
Other Services	217,687	$6.23	1.0780	1.0179	1.0000	$0.66	$7.49
Total		**$148.08**					**$168.22**

*MA Children base period experience is CY 2014. Quasi-CHIP base period experience is January to November 2014.

Exhibit B4
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
Non-Claim Expense Allocation Development Including Inpatient Services

Region: Statewide

	a	b	c	d = (a + b) / (1 - c) - (a + b)	e = b + d	f = a + e
Rate Cell	**Jul 2016 - Jun 2017 PMPM Cost**	**Fixed Non-Claim Expense Load**	**Variable Non-Claim Expense Load (Including 3% Premium Tax)**	**Variable Non-Claim Expense Allocation**	**Total Non-Claim Expense Allocation**	**Pre-MHAP Capitation Rates**
MA Children	$157.87	$4.92	11.25%	$20.64	$25.56	$183.43
Quasi-CHIP	$168.22	$4.92	11.25%	$21.95	$26.87	$195.09

Exhibit B5
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
Final Capitation Rates Including Inpatient Services

	a	b	c	d = b * c	e	f = e / (1 - 3%) - e	g = d + e + f
Rate Cell	**Base Period Enrollment**	**SFY 2017 Capitation Rates Statewide**	**Area Adjustments (rounded)**	**SFY 2017 Capitation Rates Regional**	**MHAP PMPM (not risk adjusted)**	**Premium Tax on MHAP Increase**	**Revised Total Rate at 1.0 Risk Score**
MA Children	3,795,198	$183.43		$183.43	$89.89	$2.78	$276.10
North	1,224,188		0.9720	$178.29	$89.89	$2.78	$270.97
Central	1,427,192		1.0190	$186.91	$89.89	$2.78	$279.59
South	1,143,818		1.0060	$184.53	$89.89	$2.78	$277.20
Quasi-CHIP	217,687	$195.09		$195.09	$89.89	$2.78	$287.76
North	70,567		0.9720	$189.63	$89.89	$2.78	$282.30
Central	64,558		1.0190	$198.79	$89.89	$2.78	$291.47
South	82,562		1.0060	$196.26	$89.89	$2.78	$288.93
Total Capitation Dollars - Statewide Capitation Rates	**4,012,885**	**$738,617,680**					
Total Capitation Dollars - Regional Capitation Rates	**4,012,885**	**$738,513,538**					

APPENDIX C

Additional Supporting Documentation

C1 Hemophilia Definition

C2 Administrative Expense Assumption Support

C3 MississippiCAN Expenditure Estimate for July 1, 2016 to June 30, 2017

Appendix C1
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
ICD9 and NDC List - Hemophillia and Von Willebrand Disease

ICD9	ICD9 Description
2860	CONGENITAL FACTOR VIII DISORDER
2861	CONGENITAL FACTOR IX DISORDER

NDC	Drug Name	Drug Class
00026037220	KOGENATE FS	Antihemophilic Products
00026037230	KOGENATE FS	Antihemophilic Products
00026037250	KOGENATE FS	Antihemophilic Products
00026037920	KOGENATE FS BIO-SET	Antihemophilic Products
00026037930	KOGENATE FS BIO-SET	Antihemophilic Products
00026037950	KOGENATE FS BIO-SET	Antihemophilic Products
00026066520	KOATE-DVI	Antihemophilic Products
00026066530	KOATE-DVI	Antihemophilic Products
00026066550	KOATE-DVI	Antihemophilic Products
00026067020	KOGENATE	Antihemophilic Products
00026067030	KOGENATE	Antihemophilic Products
00026067050	KOGENATE	Antihemophilic Products
00026378220	KOGENATE FS	Antihemophilic Products
00026378330	KOGENATE FS	Antihemophilic Products
00026378550	KOGENATE FS	Antihemophilic Products
00026378660	KOGENATE FS	Antihemophilic Products
00026378770	KOGENATE FS	Antihemophilic Products
00026379220	KOGENATE FS BIO-SET	Antihemophilic Products
00026379330	KOGENATE FS BIO-SET	Antihemophilic Products
00026379550	KOGENATE FS BIO-SET	Antihemophilic Products
00026379660	KOGENATE FS BIO-SET	Antihemophilic Products
00026379770	KOGENATE FS BIO-SET	Antihemophilic Products
00053761505	HUMATE-P	Antihemophilic Products
00053761510	HUMATE-P	Antihemophilic Products
00053761520	HUMATE-P	Antihemophilic Products
00053762005	HUMATE-P	Antihemophilic Products
00053762010	HUMATE-P	Antihemophilic Products
00053762020	HUMATE-P	Antihemophilic Products
00053763302	MONOCLATE-P	Antihemophilic Products
00053763402	MONOCLATE-P	Antihemophilic Products
00053765601	MONOCLATE-P	Antihemophilic Products
00053765602	MONOCLATE-P	Antihemophilic Products
00053765604	MONOCLATE-P	Antihemophilic Products
00053765605	MONOCLATE-P	Antihemophilic Products
00053766801	MONONINE	Antihemophilic Products
00053766802	MONONINE	Antihemophilic Products
00053766804	MONONINE	Antihemophilic Products
00053811001	BIOCLATE	Antihemophilic Products
00053811002	BIOCLATE	Antihemophilic Products
00053811004	BIOCLATE	Antihemophilic Products
00053812001	ANTIHEMOPHILIC FACTOR, RECOMBINANT	Antihemophilic Products
00053812002	ANTIHEMOPHILIC FACTOR, RECOMBINANT	Antihemophilic Products
00053812004	ANTIHEMOPHILIC FACTOR, RECOMBINANT	Antihemophilic Products
00053813001	HELIXATE FS	Antihemophilic Products
00053813002	HELIXATE FS	Antihemophilic Products
00053813004	HELIXATE FS	Antihemophilic Products
00053813005	HELIXATE FS	Antihemophilic Products
00053813102	HELIXATE FS	Antihemophilic Products
00053813202	HELIXATE FS	Antihemophilic Products
00053813302	HELIXATE FS	Antihemophilic Products
00053813402	HELIXATE FS	Antihemophilic Products
00053813502	HELIXATE FS	Antihemophilic Products
00169701001	NOVOSEVEN RT	Antihemophilic Products
00169702001	NOVOSEVEN RT	Antihemophilic Products
00169704001	NOVOSEVEN RT	Antihemophilic Products
00169705001	NOVOSEVEN RT	Antihemophilic Products
00169706001	NOVOSEVEN	Antihemophilic Products
00169706101	NOVOSEVEN	Antihemophilic Products
00169706201	NOVOSEVEN	Antihemophilic Products

Appendix C1
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
ICD9 and NDC List - Hemophillia and Von Willebrand Disease

00944058101	PROPLEX T FACTOR IX COMP FACTOR VII ACTIVITY UNITS 700-3900	Antihemophilic Products
00944130101	MONARC-M	Antihemophilic Products
00944130110	MONARC-M	Antihemophilic Products
00944130201	MONARC-M	Antihemophilic Products
00944130210	MONARC-M	Antihemophilic Products
00944130301	MONARC-M	Antihemophilic Products
00944130310	MONARC-M	Antihemophilic Products
00944130401	MONARC-M	Antihemophilic Products
00944130410	MONARC-M	Antihemophilic Products
00944283110	RECOMBINATE	Antihemophilic Products
00944283210	RECOMBINATE	Antihemophilic Products
00944283310	RECOMBINATE	Antihemophilic Products
00944283401	RECOMBINATE	Antihemophilic Products
00944283410	RECOMBINATE	Antihemophilic Products
00944283501	RECOMBINATE	Antihemophilic Products
00944283510	RECOMBINATE	Antihemophilic Products
00944284110	RECOMBINATE	Antihemophilic Products
00944284210	RECOMBINATE	Antihemophilic Products
00944284310	RECOMBINATE	Antihemophilic Products
00944284410	RECOMBINATE	Antihemophilic Products
00944284510	RECOMBINATE	Antihemophilic Products
00944293001	HEMOFIL M	Antihemophilic Products
00944293101	HEMOFIL M	Antihemophilic Products
00944293201	HEMOFIL M	Antihemophilic Products
00944293301	HEMOFIL M	Antihemophilic Products
00944293501	HEMOFIL M	Antihemophilic Products
00944293502	HEMOFIL M	Antihemophilic Products
00944293503	HEMOFIL M	Antihemophilic Products
00944293504	HEMOFIL M	Antihemophilic Products
00944293801	RECOMBINATE	Antihemophilic Products
00944293802	RECOMBINATE	Antihemophilic Products
00944293803	RECOMBINATE	Antihemophilic Products
00944294001	ADVATE	Antihemophilic Products
00944294002	ADVATE	Antihemophilic Products
00944294003	ADVATE	Antihemophilic Products
00944294004	ADVATE	Antihemophilic Products
00944294010	ADVATE	Antihemophilic Products
00944294110	ADVATE	Antihemophilic Products
00944294210	ADVATE	Antihemophilic Products
00944294310	ADVATE	Antihemophilic Products
00944294410	ADVATE	Antihemophilic Products
00944294510	ADVATE	Antihemophilic Products
00944294610	ADVATE	Antihemophilic Products
13533066520	KOATE-DVI	Antihemophilic Products
13533066530	KOATE-DVI	Antihemophilic Products
13533066550	KOATE-DVI	Antihemophilic Products
32849020138	NOVOSEVEN	Antihemophilic Products
49669320002	PROFILNINE	Antihemophilic Products
49669320003	PROFILNINE	Antihemophilic Products
49669360002	PROFILNINE	Antihemophilic Products
49669460001	ALPHANATE	Antihemophilic Products
49669460002	ALPHANATE	Antihemophilic Products
52769046001	MONARC-M	Antihemophilic Products
52769046402	GENARC	Antihemophilic Products
52769046405	GENARC	Antihemophilic Products
52769046410	GENARC	Antihemophilic Products
55688010602	HYATE	Antihemophilic Products
58394000101	BENEFIX	Antihemophilic Products
58394000105	BENEFIX	Antihemophilic Products
58394000106	BENEFIX	Antihemophilic Products
58394000201	BENEFIX	Antihemophilic Products
58394000205	BENEFIX	Antihemophilic Products
58394000206	BENEFIX	Antihemophilic Products
58394000301	BENEFIX	Antihemophilic Products

58394000305	BENEFIX	Antihemophilic Products
58394000306	BENEFIX	Antihemophilic Products
58394000501	REFACTO	Antihemophilic Products
58394000502	REFACTO	Antihemophilic Products
58394000504	REFACTO	Antihemophilic Products
58394000601	REFACTO	Antihemophilic Products
58394000602	REFACTO	Antihemophilic Products
58394000604	REFACTO	Antihemophilic Products
58394000701	REFACTO	Antihemophilic Products
58394000702	REFACTO	Antihemophilic Products
58394000704	REFACTO	Antihemophilic Products
58394000802	BENEFIX	Antihemophilic Products
58394000803	BENEFIX	Antihemophilic Products
58394001101	REFACTO	Antihemophilic Products
58394001102	REFACTO	Antihemophilic Products
58394001104	REFACTO	Antihemophilic Products
58394001201	XYNTHA	Antihemophilic Products
58394001301	XYNTHA	Antihemophilic Products
58394001401	XYNTHA	Antihemophilic Products
58394001501	XYNTHA	Antihemophilic Products
58394001603	XYNTHA	Antihemophilic Products
59730605907	AUTOPLEX	Antihemophilic Products
63833061502	HUMATE-P	Antihemophilic Products
63833061602	HUMATE-P	Antihemophilic Products
63833061702	HUMATE-P	Antihemophilic Products
64193022203	FEIBA VH IMMUNO	Antihemophilic Products
64193022204	FEIBA VH IMMUNO	Antihemophilic Products
64193022205	FEIBA VH IMMUNO	Antihemophilic Products
64193022302	FEIBA NF	Antihemophilic Products
64193022402	FEIBA NF	Antihemophilic Products
64193022502	FEIBA NF	Antihemophilic Products
64193024402	BEBULIN VH	Antihemophilic Products
67467018101	WILATE	Antihemophilic Products
67467018102	WILATE	Antihemophilic Products
68516320002	PROFILNINE SD	Antihemophilic Products
68516320003	PROFILNINE SD	Antihemophilic Products
68516320004	PROFILNINE SD	Antihemophilic Products
68516320005	PROFILNINE SD	Antihemophilic Products
68516320101	PROFILNINE SD	Antihemophilic Products
68516320202	PROFILNINE SD	Antihemophilic Products
68516320302	PROFILNINE SD	Antihemophilic Products
68516360002	ALPHANINE SD	Antihemophilic Products
68516360004	ALPHANINE SD	Antihemophilic Products
68516360005	ALPHANINE SD	Antihemophilic Products
68516360006	ALPHANINE SD	Antihemophilic Products
68516360102	ALPHANINE SD	Antihemophilic Products
68516360202	ALPHANINE SD	Antihemophilic Products
68516360302	ALPHANINE SD	Antihemophilic Products
68516460001	ALPHANATE	Antihemophilic Products
68516460002	ALPHANATE	Antihemophilic Products
68516460101	ALPHANATE/VON WILLEBRAND FACTOR COMPLEX/HUMAN	Antihemophilic Products
68516460201	ALPHANATE/VON WILLEBRAND FACTOR COMPLEX/HUMAN	Antihemophilic Products
68516460302	ALPHANATE/VON WILLEBRAND FACTOR COMPLEX/HUMAN	Antihemophilic Products
68516460402	ALPHANATE/VON WILLEBRAND FACTOR COMPLEX/HUMAN	Antihemophilic Products

Appendix C2
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
Illustrative Non-Benefit Expense Analysis Using Original Population Experience

Base Administrative Experience		**Formula**
Total CY 2014 MississippiCAN/CHIP PMPM*	$37.76	A from financials
Fixed portion @ 30%	$11.33	B = 30% * A
Variable portion @ 70%	$26.43	C = 70% * A
Population Allocation of Variable Costs		
Total CY 2014 MississippiCAN/CHIP Revenue PMPM	$398.13	D from financials
CY 2014 Original Population Revenue PMPM	$651.48	E from financials
CY 2014 Original Population allocated variable PMPM	$43.26	F = C * E / D
Fixed portion from above	$11.33	G = B
CY 2014 Original Population total admin PMPM	$54.59	H = F + G
Adjustment for Program Growth		
MississippiCAN membership growth factor	2.4	I from rate dev't
Adjusted fixed PMPM	$4.68	J = G / I
Revised total PMPM	$47.94	K = F + J
Adjustment for Adding Inpatient		
Service Cost Increase for IP	1.3	L from rate dev't
Revised variable cost PMPM	$54.46	M = F * L
Revised total CY 2014 PMPM	$59.14	N = J + M
Variable % of Revenue	6.64%	O = M / (E * L)
Trend to SFY 2017		
Annual admin trend assumption	2.00%	P
SFY 2017 fixed costs	**$4.92**	Q = (1+P)^(30/12) * J
SFY 2017 variable costs	$57.22	R = (1+P)^(30/12) * M
Develop Variable % of Revenue		
Annual revenue trend assumption	4.50%	S
Variable % of Revenue	**6.25%**	T = ((1+P)/(1+S))^(30/12)) * O

** Adjusted to align with national benchmarks, excluding taxes and fees, from the Sherlock Company and Milliman's annual review of administrative costs for managed Medicaid organizations.*

Appendix C3
Mississippi Division of Medicaid
July 2016 - June 2017 MississippiCAN Capitation Rate Development
MississippiCAN Expenditure Projection

	a	b	c = a * b	d = c * 100.00% (Quasi-CHIP) d = c * 74.52% (All Other Cells)
Eligibility Category	**Projected SFY 2017 Exposures**	**July 2016 - June 2017 Capitation Rates*** **	**MississippiCAN Estimated Cost**	**Federal Estimated Cost*** **
Original Cap Cells				
Non-Newborn SSI / Disabled	769,044	$1,117.69	$859,553,714	$640,496,450
Foster Care	58,632	$465.20	$27,275,358	$20,324,233
Breast and Cervical Cancer	1,200	$3,561.29	$4,273,547	$3,184,433
SSI / Disabled Newborn	6,348	$7,309.02	$46,397,670	$34,573,224
Total - Original Cap Cells	**835,224**	**$1,122.45**	**$937,500,288**	**$698,578,339**
Expansion Cap Cells				
MA Adult	612,132	$546.81	$334,721,979	$249,418,083
Pregnant Women	138,300	$651.29	$90,072,886	$67,117,811
Non-SSI Newborns 0-2 Months	79,200	$1,540.92	$122,040,616	$90,938,565
Non-SSI Newborns 3-12 Months	262,476	$365.53	$95,944,087	$71,492,737
Delivery Kick Payment	22,312	$5,164.48	$115,227,706	$85,861,925
Total - Expansion Cap Cells**	**1,092,108**	**$694.08**	**$758,007,275**	**$564,829,121**
Children Cap Cells				
MA Children	3,664,464	$276.10	$1,011,766,718	$753,917,970
Quasi-CHIP Children	338,712	$287.76	$97,467,980	$97,467,980
Total - Children Cap Cells	**4,003,176**	**$277.09**	**$1,109,234,699**	**$851,385,950**
Total - All Cap Cells**	**5,930,508**	**$472.93**	**$2,804,742,262**	**$2,114,793,411**

** Mississippi FMAP is 74.17% for July 2016 - September 2016 and 74.63% for October 2016 - July 2017.*
*** Mississippi EFMAP is 100% for July 2016 - July 2017.*
**** Includes MHAP*
***** Excludes exposures for the delivery kick payment cap cell.*

APPENDIX D

CMS Rate Setting Checklist

Appendix D
CMS Rate Setting Checklist

This section of the report lists each item in the November 10, 2014 CMS checklist and discusses how DOM addresses each issue and / or directs the reader to other parts of this report. CMS uses the rate setting checklist to review and approve a state's Medicaid capitation rates.

AA.1.0 – Overview of Rates Being Paid under the Contract

The MississippiCAN SFY 2017 capitation rates are developed using Mississippi FFS Medicaid data, CCO encounter data, and CCO financial reporting data for a comparable population to that enrolled in CCOs. DOM calculates state-set rates by rate category on a statewide basis with area adjustments based on an enrolled member's county of residence. Please refer to Sections III – IV and Appendices A and B of this report for more details.

AA.1.1 – Actuarial Certification

Please refer to Appendix F for our Actuarial Certification of the SFY 2017 capitation rates. The SFY 2017 Mississippi Medicaid Managed Care capitation rates have been developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the contract.

AA.1.2 – Projection of Expenditures

Appendix C3 includes a projection of total expenditures and Federal-only expenditures based on projected SFY 2017 CCO enrollment and the SFY 2017 capitation rates. The fiscal impact of the SFY 2017 capitation rates is $2.805 billion, with $2.115 billion in federal funding. This represents an additional $305.0 million in federal funding compared to the SFY 2016 capitation rates.

AA.1.3 – Risk Contracts

The MississippiCAN program meets the criteria of a risk contract.

AA.1.4 – Modifications

The SFY 2017 rates documented in this report are the draft preliminary capitation rates for the SFY 2017 MississippiCAN contracts. They will need to be updated to address certain items outlined in the rate narrative.

Note: There is no AA.1.5 on the Rate Setting Checklist

AA.1.6 – Limit on Payment to Other Providers

It is our understanding that no payments are made to providers other than those made by participating CCOs for services available under the contract.

AA.1.7 – Risk and Profit

Targeted margin is considered as part of final rate development.

AA.1.8 – Family Planning Enhanced Match

DOM claims an enhanced match for family planning services for the populations covered under this program. The PMPM value of services included in the MississippiCAN capitation rates will be included in the final capitation rate report.

AA.1.9 – Indian Health Service (IHS) Facility Enhanced Match

DOM claims an enhanced match for Indian Health Services for the populations covered under this program. The PMPM value of services included in the MississippiCAN capitation rates will be included in the final capitation rate report.

AA.1.10 – Newly Eligible Enhanced Match

Mississippi did not expand eligibility as part of the Affordable Care Act.

AA.1.11 – Retroactive Adjustments

The SFY 2017 rates documented in this report are the draft preliminary capitation rates for the SFY 2017 MississippiCAN contracts. They will need to be updated to address certain items outlined in the rate narrative.

AA.2.0 – Based only upon Services Covered under the State Plan

The base year utilization and cost data is Medicaid FFS, CCO encounter and CCO financial reporting data only for populations that are eligible to enroll in a CCO.

Only State Plan services that are covered under the MississippiCAN contract have been included in the rate development.

AA.2.1 – Provided under the Contract to Medicaid-eligible Individuals

Data for FFS populations not eligible to enroll in the MississippiCAN program has been excluded from the base data used in rate development. Please refer to Sections III – IV of this report for details.

AA.2.2 – Data Sources

The base year utilization and cost data is CY 2014 Medicaid FFS, CCO encounter and CCO financial reporting data for populations eligible to enroll in a CCO for all rate cells other than Quasi-CHIP. Quasi-CHIP uses a base period of January 2014 to November 2014.

AA.3.0 – Adjustments to Base Year Data

All adjustments to the base year data are discussed in Section IV and Appendices A and B of this report. In addition, each item in the checklist is addressed in items AA.3.1 – AA.3.17 below.

AA.3.1 – Benefit Differences

The base data used to calculate the capitation rates has been adjusted to only include services covered under the CCO contracts. Please refer to Appendices A and B of this report for details regarding benefit differences.

AA.3.2 – Administrative Cost Allowance Calculations

The CCO capitation rates include explicit administrative allowances by rate cell. Please see Appendices A and B of the report for more details regarding the administrative cost calculation.

AA.3.3 – Special Populations' Adjustments

The base data used to calculate the capitation rates is consistent with the CCO population. No special population adjustment was necessary.

AA.3.4 – Eligibility Adjustments

The base CCO financial reporting data and encounter data only reflects experience for time periods where members were enrolled in a CCO. FFS experience was limited to reflect only individuals that will be eligible for MississippiCAN. See Section IV for a discussion of eligibly criterion applied.

AA.3.5 – Third Party Liability (TPL)

The CCOs are responsible for the collection of any TPL recoveries for all services. The capitation rates include a .991 adjustment to reflect additional TPL recoveries that are not reflected in the base year FFS data, consistent with recent DOM experience.

AA.3.6 – Indian Health Care Provider Payments

The CCOs are responsible for the entirety of the Indian Health Care payments, which are fully reflected in encounters.

AA.3.7 – DSH Payments

DSH payments will continue to be paid outside of capitation rates for members enrolled in MississippiCAN.

AA.3.8 – FQHC and RHC Reimbursement

DOM has chosen to include the per-encounter FQHC and RHC reimbursement in the MississippiCAN capitation rates to provide a steadier cash flow to the RHCs and FQHCs that serve the MississippiCAN population. The CCOs are expected to reimburse FQHCs and RHCs at DOM's per-encounter rates. DOM will monitor the utilization of services at FQHCs and RHCs under MississippiCAN to ensure services are not diverted from FQHCs and RHCs to other providers.

AA.3.9 – Graduate Medical Education (GME)

GME costs are currently included in the DRG payment methodology for inpatient services. CCOs will be responsible for providing these payments to facilities. DOM will not make any separate payments outside of the capitation rates for members enrolled in MississippiCAN.

AA.3.10 – Copayments, Coinsurance, and Deductibles in Capitated Rates

The MississippiCAN program does not include member cost sharing. All FFS member cost sharing amounts were added back into the capitation rate calculation.

AA.3.11 – Medical Cost / Trend Inflation

The utilization and unit cost trends used to project expenditures from the base period to SFY 2017 are based on projections of future medical cost inflation.

We are comfortable that the trend rates represent an appropriate expected change in per capita cost between the base period and SFY 2017.

AA.3.12 – Utilization Adjustments

Utilization trend is included in AA.3.10.

AA.3.13 – Utilization and Cost Assumptions

The SFY 2017 capitation rates will use the CDPS + Rx risk adjuster to risk adjust the Non-Newborn SSI / Disabled, MA Adult, and MA Children rates for each participating CCO. CDPS + Rx uses beneficiaries' medical and prescription drug claim information to develop a risk score for each individual. Appendices A and B explain how the risk scores are calculated and applied to the base capitation rate to calculate separate rates for each participating CCO reflecting their member population.

AA.3.14 – Post-Eligibility Treatment of Income (PETI)

Not applicable.

Appendix D
CMS Rate Setting Checklist

AA.3.15 – Incomplete Data Adjustment

The capitation rates include an adjustment to reflect Incurred but Not Reported (IBNR) claims. Please refer to Appendices A and B of this report for more information on the development of these adjustment factors.

Please see Section IV for a discussion of the comparison of encounter data to financial reporting. No additional incomplete data adjustments were applied to encounter data as a result of this analysis.

AA.3.16 – Primary Care Rate Enhancement

The SFY 2017 capitation rate development adjusts applicable claims from the enhanced rates in CY 2014 to 100% of Medicare for SFY 2017 which is consistent with DOM reimbursement methodologies for these services beginning July 1, 2015. Please see Appendices A and B of this report for more details on this calculation.

AA.3.17 – Health Homes

Not Applicable.

AA.4.0 – Establish Rate Category Groupings

Please refer to Sections III – IV of this report.

AA.4.1 – Eligibility Categories

Please refer to Sections III – IV of this report.

AA.4.2 – Age

Please refer to Sections III – IV of this report.

AA.4.3 – Gender

Please refer to Sections III – IV of this report.

AA.4.4 – Locality / Region

Please refer to Sections III – IV of this report.

AA.4.5 – Risk Adjustments

The SFY 2017 capitation rates will use the CDPS + Rx risk adjuster to risk adjust the Non-Newborn SSI / Disabled, MA Adult, and MA Children rates for each participating CCO. CDPS + Rx uses beneficiaries' medical and prescription drug claim information to develop a risk score for each individual. Appendices A and B explain how the risk scores are calculated and applied to the base capitation rate to calculate separate rates for each CCO reflecting their member population. Risk adjustment will be budget-neutral to DOM. This risk sharing mechanism is developed in accordance with generally accepted actuarial principles and practices.

AA.5.0 – Data Smoothing

We did not perform any data smoothing.

AA.5.1 – Cost-Neutral Data Smoothing Adjustment

We did not perform any data smoothing.

AA.5.2 – Data Distortion Assessment

Our review of the base CCO financial reporting and encounter data did not detect any material distortions or outliers.

AA.5.3 – Data Smoothing Techniques

Delivery payments and area adjustments of statewide rates are incorporated into the rate structure to account for potential variation in regional enrollment and distribution of pregnant women between CCOs.

AA.5.4 – Risk Adjustments

The SFY 2017 capitation rates will use the CDPS + Rx risk adjuster to risk adjust the Non-Newborn SSI / Disabled, MA Adult, and MA Children rates for each participating CCO. CDPS + Rx uses beneficiaries' medical and prescription drug claim information to develop a risk score for each individual. Appendices A and B explain how the risk scores are calculated and applied to the base capitation rate to calculate separate rates for each CCO reflecting their member population. Risk adjustment will be budget-neutral to DOM. This risk sharing mechanism is developed in accordance with generally accepted actuarial principles and practices.

AA.6.0 – Stop Loss, Reinsurance, or Risk Sharing Arrangements

Not applicable.

AA.6.1 – Commercial Reinsurance

DOM does not require entities to purchase commercial reinsurance.

AA.6.2 – Stop-Loss Program

Please see AA.6.0.

AA.6.3 – Risk Corridor Program

Not applicable.

AA.7.0 – Incentive Arrangements

Not Applicable.

AA.7.1 – Electronic Health Records (EHR) Incentive Payments

Not Applicable.

APPENDIX E

CMS Managed Care Rate Setting Guide Response

Appendix E
Responses to 2016 Managed Care Rate Setting Guide

I. RESPONSES TO 2016 CMS MANAGED CARE RATE SETTING GUIDE

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

- Rate certification – See Appendix F.
- Final capitation rates – See Exhibits A6 and B5.
- Program descriptions – See Section II for program information and Section III for rate cell definitions.

2. Data

- Service data sources:
  - FFS – See Section IV
  - Encounter Data – See Section IV
  - Financial Reporting – See Section IV
- Validation and quality adjustments – See Section IV for encounter data and financial reporting validation.
- Changes in data sources – Base period FFS data, encounter data, and financial reporting was updated from CY 2013 used to develop SFY 2016 capitation rates to CY 2014 to develop SFY 2017 capitation rates.
- Potential future data improvements – See Section IV for discussion of encounter data.
- Other data adjustments – See Section IV for descriptions of reallocations of financial data using encounter data relationships for Newborn rate cells and the Delivery Kick Payment.

3. Projected Benefit Costs and Trends

- Changes in covered services and benefits:
  - Non-Emergency Transportation became a MississippiCAN covered service on July 1, 2014. Please see Appendix A: Step 5 and Appendix B: Step 5 for a discussion of the development of a PMPM estimate for these services.
  - Inpatient services are covered by MississippiCAN effective December 1, 2015. Please see Section IV for a discussion of the data used to develop the base period for inpatient services.
  - The Mississippi Hospital Access Program (MHAP) went into effect on December 1, 2015. Please see Appendix A: Step 9 and Appendix B: Step 9 for a discussion of the MHAP and how it is reflected in capitation rates.
- Projected benefit cost trends - See Appendix A: Step 5 and Appendix B: Step 5 for a discussion of trends applied to base period CY 2014 data to project costs to SFY 2017.
- Other adjustments:
  - Managed care savings were assumed for the following populations and benefit types:
    - FFS experience for newborns prior to enrollment in MississippiCAN as documented in Appendix A: Step 5
    - MA Children FFS experience as documented in Appendix B: Step 2
- Final projected benefit costs – See Exhibits A4 and B3.

- Conditions of any litigation to which the state is subjected – Not applicable; no impact on rates.

4. Pass-Through Payments

- The Mississippi Hospital Access Program (MHAP) went into effect on December 1, 2015. Please see Appendix A: Step 9 and Appendix B: Step 9 for a discussion of the MHAP and how it is reflected in capitation rates.

5. Projected Non-Benefit Costs

- Base period administrative cost data, projected non-benefit expenses, premium tax, and margin – See Appendix A: Step 6 and Appendix B: Step 6.

- Health Insurer Fee (HIF) treatment – Retroactive capitation rate adjustment; see Appendix A: Step 6 and Appendix B: Step 6.

6. Rate Range Development

- Assumption variation for rate range endpoints – Not applicable.

7. Risk and Contractual Provisions

- Risk adjustment – See Appendix A: Step 8 and Appendix B: Step 8.

- Withholds – None.

- Incentives, MLR requirements, reinsurance requirements – The program includes a minimum MLR requirement of 85% of revenue. The sum of medical expenses and quality initiative expenses, must meet or exceed 85% of revenue. Revenue for premium taxes, MHAP, and HIF are excluded from the MLR calculation. If the 85% threshold is not met, MCOs return revenue to DOM until the threshold is met.

8. Other Rate Development Considerations

- Federal Medical Assistance Percentage (FMAP) – DOM receives an enhanced FMAP for family planning services, Indian health services, and Quasi-CHIP members that prior to the Affordable Care Act were covered under the CHIP program.

- Final certified rates – An actuarial certification is included in Appendix F. Final rates are included in Exhibits A6 and B5.

- Area and rate cell relativity factors – See Appendix A: Step 7 and Appendix B: Step 7 for a discussion of the area factor development for the North, Central, and South regions.

- Enhanced hospital and GME payments – Enhanced hospital payments through MHAP as discussed in Appendix A: Step 9 and Appendix B: Step 9.

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES

This section does not apply as MississippiCAN is not a long-term care service program.

SECTION III. NEW ADULT POPULATION CAPITATION RATES

This section does not apply as the state of Mississippi has not expanded coverage as a results of the Affordable Care Act.

APPENDIX F

Actuarial Certification of SFY 2017 MississippiCAN Capitation Rates

This report assumes that the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set July 1, 2016 – June 30, 2017 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

November 29, 2016

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Michael Cook, FSA, MAAA
Principal and Consulting Actuary

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November 29, 2016

Mississippi Division of Medicaid
Capitated Contracts Ratesetting
Actuarial Certification
SFY 2017 MississippiCAN Capitation Rates

I, Michael Cook, am associated with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I was retained by the Mississippi Division of Medicaid (DOM) to perform an actuarial certification of the Mississippi Coordinated Access Network (MississippiCAN) coordinated care capitation rates for July 1, 2016 – June 30, 2017 (SFY 2017) for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the capitation rate development and am familiar with the following regulation and guidance:

- The relevant requirements of 42 CFR 438.4(b)
- CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting dated November 10, 2014"
- 2016 Medicaid Managed Care Rate Development Guide

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for SFY 2017 dated November 29, 2016 and accompanying this certification.

To the best of my information, knowledge, and belief, for the SFY 2017 period, the capitation rates offered by DOM are in compliance with the relevant requirements of 42 CFR 438.4(b). The attached actuarial report describes the capitation rate setting methodology.

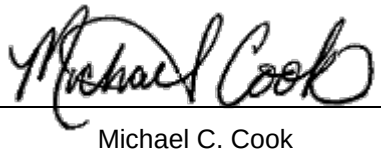
In my opinion, the capitation rates are actuarially sound, as defined in Actuarial Standard of Practice 49, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

In making my opinion, I relied upon the accuracy of the underlying claim and eligibility data records and other information. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary. The reliance letter from DOM is included in Appendix G.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted coordinated care organization's situation and experience.

This Opinion assumes the reader is familiar with the MississippiCAN program, Medicaid coordinated care programs, and actuarial rating techniques. The Opinion is intended for the State of Mississippi and the Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.



Michael C. Cook
Member, American Academy of Actuaries

November 29, 2016

APPENDIX G

Data Reliance Letter

This report assumes that the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set July 1, 2016 – June 30, 2017 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

November 29, 2016

May 6, 2016

Mr. Michael Cook, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
15800 Bluemound Road, Suite 100
Brookfield, WI 53005

Re: Data Reliance for Actuarial Certification of MississippiCAN Capitation Rates

Dear Michael:

I, Will Crump, Executive Administrator for the Mississippi Division of Medicaid (DOM), hereby affirm that the data prepared and submitted to Milliman, Inc. (Milliman) for the purpose of certifying MississippiCAN capitation rates were prepared under my direction and, to the best of my knowledge and belief, are accurate, complete, and consistent with the data used to develop the capitation rates. Capitation rates are effective July 1, 2016 – June 30, 2017.

Provided data or information used in the development of the capitation rates includes:

1. Data from DOM's Medicaid Management Information Systems (MMIS) vendor:
    a. FFS claims through June 2015
    b. Encounter claims through June 2015
    c. Medicaid eligibility through December 2014
2. Supporting documentation provided by DOM:
    a. Documentation of historical third party liability (TPL) recoveries
    b. Jackson OOPS conversion factors for 2012 to 2015
    c. Mississippi Hospital Access Program (MHAP) amount of $533,110,956 to be used in capitation rate development.
    d. July 1, 2016 Dental Fee Schedule
    e. Other computer files and clarifying correspondence

Milliman relied on DOM and their MMIS vendor for the collection and processing of the FFS and CCO encounter. Milliman relied on the CCOs to provide accurate CY 2014 and emerging CY 2015 financial data as certified by each CCO. Milliman did not audit the FFS data, the COO financial data, or the encounter data, but did assess the data for reasonableness as documented in the capitation rate report.

Will Crump
Name

Executive Administrator
Title

5/6/16
Date