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DIAMOND STATE HEALTH PLAN AND DIAMOND STATE HEALTH PLAN PLUS DATA BOOK IN SUPPORT OF CALENDAR YEAR 2018 RATE SETTING

STATE OF DELAWARE
DIVISION OF MEDICAID & MEDICAL ASSISTANCE

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Government Human Services Consulting

MARSH & McLENNAN COMPANIES

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Introduction

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

This data book contains historical managed care financial experience as reported by existing managed care organizations (MCOs). Additionally, this data book provides general information on actuarial adjustments that will be considered in the capitation rate development process. Mercer Government Human Services Consulting (Mercer) produced this data book, with assistance from DMMA, to support the DSHP and DSHP Plus rate development process for the calendar year (CY) 2018 contract rating period.

The State's DSHP segment of the managed care program covers acute services for clients not meeting eligibility criteria for DSHP Plus. Beginning April 1, 2012, DSHP Plus expanded the existing managed care program to cover additional populations and LTSS under full-risk, capitated managed care. Contracting MCOs are responsible to cover both the DSHP and DSHP Plus segments of the program under one contract.

Aspects of the DSHP and DSHP Plus program will be described in more detail in subsequent sections of this data book. The MCOs should also review the managed care contract for additional information regarding program responsibilities.

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

- This data book contains historical MCO-reported experience.
- Historical MCO experience was summarized from MCO-reported financial statements submitted as part of DMMA's financial reporting requirements.
- Demographic information was obtained from DMMA's eligibility determination system.
- The DSHP and DSHP Plus capitation rates will be developed using the historical data contained in this data book, as well as other data that may become available throughout the rate development process. Please refer to Section 4 for more information on adjustments that may be made to the data in the course of rate development.

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

- Please refer to Section 5 for a listing and description of the data exhibits presented in this data book.

In producing this data book, Mercer performed reasonability checks on the data provided by DMMA; however, Mercer did not independently audit the data or the process used by DMMA to provide the data. In Mercer's opinion, the data provided was reasonable and appropriate for the intended purpose.

Please note: DMMA and Mercer continue to review MCO-reported encounter data for completeness and accuracy for use in financial-based analyses and program management. Although DMMA and Mercer have chosen to not include historical managed care encounter data in this data book, DMMA places a high level of importance and value in the collection and submission of complete and accurate encounter data for program management and monitoring purposes. Mercer may evaluate the use of encounter data as a supplemental source of information in the course of developing the CY 2018 capitation rate ranges. In the future, it is expected that encounter data will be used more extensively and could represent the base data for capitation rate development. As partners with the State, DMMA expects contracting MCOs to put forth the necessary efforts to submit complete and accurate encounter data for the State's use.

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

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DSHP Populations and Services

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

DSHP Covered Populations

Individuals eligible for DSHP include the following population groups:

- Temporary assistance to needy families (TANF) adults and children
- Social Security Income (SSI) adults and children
- Title XXI CHIP children
- Pregnant women
- Uninsured adult population under 100% of the federal poverty level (FPL). This expansion was effective with Delaware's 1115 waiver in 1996
- New adult expansion under the federal Affordable Care Act (ACA) up to 138% FPL (effective January 2014)
- Mandatory increases in FPL levels for Medicaid children under age 19 years. This group is referred to as "MCHIP" as an indication that many were formerly eligible for CHIP until Medicaid's income eligibility thresholds were mandatorily increased by the ACA

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

DSHP Actuarial Rate Cell Configuration

The actuarial rate cells for DSHP consolidate aid categories into different rate cells for purposes of monthly capitation payment. Delaware also uses a supplemental, one-time maternity payment to compensate MCOs for the risk of a live birth outcome for MCO members. Medicare dual status also factors into the DSHP rate cell structure, as full-benefit dual eligibles are mandatorily enrolled in DSHP Plus, which is addressed in Section 3 of this data book. Therefore, a prerequisite for inclusion in a DSHP rate cell is the absence of Medicare coverage (i.e., not dual eligible).The configuration of the DSHP rate cells for CY 2018 is shown below:

DSHP Rate Cell	Gender	Age
TANF/MCHIP Newborns	Male and Female	Under age 1 year
TANF Children	Male and Female	Age 1 year through 17 years
TANF Adults	Male and Female	Age 18 years and older
Waiver Expanded (≤ 100% FPL)	Male and Female	All applicable ages
SSI	Male and Female	All applicable ages
CHIP/MCHIP	Male and Female	CHIP: All applicable ages MCHIP: Age 1 year and older as applicable

DSHP Rate Cell	Gender	Age
ACA Expansion (> 100–138% FPL)	Male and Female	Age 19 years through 64 years
Maternity Care Payment	Female	All applicable ages

All rate cells will be developed and paid on a statewide level. This structure may be evaluated and is subject to change.

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

Excluded Populations

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

- Community-based individuals who meet the intermediate care facility for the mentally retarded (ICF/MR) level of care (under the Division of Disability Determination Services for the mentally retarded (DDDS/MR) 1915c Waiver)
- Individuals residing in ICF/MRs (i.e., Stockley Center and Mary Campbell Center)
- Individuals who meet the federal definition of an "inmate of a public institution", unless the individual is an inpatient in a hospital other than the State Department of Corrections (DOC) infirmary per the exception permitted under 42 CFR 435.1010
- Aliens who are only eligible for Medicaid to treat an emergency medical condition under Section 1903(v)(2) of the Social Security Act
- Adults eligible for Delaware Medicaid who were residing outside of the State of Delaware in a nursing facility as of April 1, 2012, as long as they remain in an out-of-state facility
- Individuals who choose to participate in the Program for All-Inclusive Care for the Elderly (PACE).
- Individuals receiving Medicare cost sharing only (i.e., qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, qualifying individuals and qualified and disabled working individuals)
- Presumptively eligible pregnant women
- Individuals in the Breast and Cervical Cancer Program for Uninsured Women
- Individuals in the 30-Day Acute Care Hospital Program
- Individuals eligible only for programs paid for by State general funds (e.g., Chronic Renal Disease Program, Delaware Prescription Assistance Program)

DSHP Covered Services

For individuals covered by DSHP, the MCOs will have responsibility for the coordination and provision of an array of acute and behavioral health services per the managed care contract. The MCOs have the ability to develop creative and innovative solutions to care for their members as long as the contractually required Medicaid services are covered. The summarized MCO financial data in this data book includes historical experience on the Medicaid services that the MCOs were responsible for in the respective year.

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

General Category of Service
Inpatient Hospital
Nursing Facility (limited number of days)
Institute for Mental Disease Facilities
Family Planning Services
Outpatient Hospital and Other Clinics
Emergency Room
Physicians/Specialists
Mental Health and Substance Use Disorder Services[2]
Home Health Care
Hospice
Therapy Services
Durable Medical Equipment and Supplies
Lab and Radiology
Private Duty Nursing
Ambulance
Physician-Dispensed Drugs
School-Based Wellness Center Clinics — New January 1, 2015
Prescription Drugs/Outpatient Pharmacy — New January 1, 2015

Services Excluded From or Limited in DSHP

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

- Day habilitation services for individuals with developmental disabilities (DD) provided under the Rehab Option
- Prescribed pediatric extended care (PPEC) services for children with severe disabilities
- Specialized services for nursing facility residents
- Employment services and related supports provided through the Pathways program for eligible individuals
- Non-emergency medical transportation[3]
- Certain behavioral health/substance abuse services applicable to adults participating in the State's PROMISE program[4]

[2] For certain adults participating in the State's PROMISE behavioral health program, the State will cover some behavioral health services via fee-for-service (FFS).

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

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

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

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DSHP Plus Populations and Services

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

DSHP Plus Covered Populations

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

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

Within these two main population groups, individuals may or may not also have benefits through the separate federal Medicare program under Part A, B or D. One of the objectives of DSHP Plus is to integrate Medicare and Medicaid services to achieve a better-coordinated system of care. Although DSHP Plus does not change or impact Medicare, it is a step in the direction of creating a more organized and simplified system of care for consumers. Accordingly, individuals who are dually entitled to, and receive health care benefits through, both Medicare and Medicaid are included in DSHP Plus. Because of their eligibility to obtain medical services through both Medicare and Medicaid, these individuals are commonly referred to as "full-benefit dual eligibles".[5] Conversely, individuals who do not have Medicare benefits are often referred to as "non-dual eligibles". For purposes of this data book and the resulting DSHP Plus capitation rates, an individual is considered a full-benefit dual eligible if the individual has Medicaid and any combination of Medicare coverage under Part A, B or D.

Individuals in DSHP Plus who do not meet the State's requirements for institutional level-of-care are often referred to as a "community well" group because these individuals do not receive the additional Medicaid-funded LTSS. The term "community well" is only used to help in distinguishing the level-of-care population from the non-level-of-care population and is not meant to imply that individuals who do not or have not yet satisfied the State's requirements for institutional level-of-care are not in need of intensive Medicaid services and supports.

A key financial difference between the institutional level-of-care need and "community well" populations is the relative impact Medicare has in paying for certain services. Medicare primarily covers only preventive and acute services (e.g., hospital, physician and pharmacy services), but Medicare provides little (if any) coverage for LTSS, such as extended care in a nursing facility (NF) or the type of home and community-based services (HCBS) that were available under the State's E&D or AIDS waiver programs. Furthermore, for services that may be eligible for payment by both Medicare and Medicaid, Medicare pays first and then Medicaid pays the co-insurance and deductible; for Medicare Part B claims, Medicaid pays the difference between what Medicare paid

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

and the Medicaid allowable amount, if greater than the Medicare allowed amount.[6] Therefore, the impact of Medicare in reducing the Medicaid expenditures is most pronounced in the Community Well population group because this group does not receive the type of Medicaid-funded LTSS that would typically create a large average expenditure. Conversely, the institutional level-of-care need population has a disproportionately higher share of LTSS paid for by Medicaid and, thus, a relatively high average cost.

DSHP Plus Actuarial Rate Cell Configuration

The actuarial rate cells for the DSHP Plus program consolidate aid categories into different rate cells that the State uses for monthly capitation payment purposes. Medicare dual status also factors into the rate cell structure. The dual status included in each respective DSHP Plus rate cell is shown below (subject to change):

DSHP Plus Rate Cell	Gender	Age	Dual Status
NF/HCBS Dual	Male and Female	All applicable ages	Dual: Any combination of Medicare Part A, B or D
NF/HCBS Non-Dual	Male and Female	All applicable ages	Non-Dual: Does not have any combination of Medicare Part A, B or D
Community Well	Male and Female	All applicable ages	May or may not have coverage under Medicare Part A, B or D

Compared to the DSHP population, the supplemental maternity care payment is **not** applicable to any person in a DSHP Plus rate cell. DMMA will not make a maternity care payment for any female giving birth that is in a DSHP Plus rate cell. Any claims data related to maternity events for DSHP Plus individuals was included in the development of the monthly DSHP Plus capitation rates.

Excluded Populations

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

- Community-based individuals who meet ICF/MR level of care (under the DDDS/MR 1915c Waiver)
- Individuals residing in ICF/MRs (i.e., Stockley Center and Mary Campbell Center)
- Individuals who meet the federal definition of an “inmate of a public institution”, unless the individual is an inpatient in a hospital other than the State DOC infirmary per the exception permitted under 42 CFR 435.1010
- Aliens who are only eligible for Medicaid to treat an emergency medical condition under Section 1903(v)(2) of the Social Security Act
- Adults eligible for Delaware Medicaid who were residing outside of the State of Delaware in a NF as of April 1, 2012, as long as they remain in an out-of-state facility
- Individuals who choose to participate in PACE
- Individuals receiving Medicare cost sharing only (i.e., qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, qualifying individuals and qualified and disabled working individuals)
- Presumptively eligible pregnant women

[6] Medical services that are potentially subject to payment by both Medicare and Medicaid are commonly referred to as “crossover” claims. The MCOs are responsible for crossover claims in DSHP Plus.

- Individuals in the Breast and Cervical Cancer Program for Uninsured Women
- Individuals in the 30-Day Acute Care Hospital Program
- Individuals eligible only for programs paid for by State general funds (e.g., Chronic Renal Disease Program, Delaware Prescription Assistance Program)

DSHP Plus Covered Services

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

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

General Category of Service
DSHP Benefit Package
Additional Medicaid LTSS (for applicable populations)
Nursing Facility (beyond DSHP benefit package limit)
Home and Community-Based Services
Transitional Support Services*
Adult Day Services
Assisted Living
Case Management
Cognitive Services
Day Habilitation Services
Medical Equipment and Supplies
Personal Care/Homemaker Services**
Personal Emergency Response Systems**
Respite Care Services**
Support for Participant Direction (for personal care services)**
Home Modifications***
Home-Delivered Meals***
Mental Health Services
Supplemental Nutrition (HIV/AIDS-related)

* Transitional support services are services that began with the implementation of DSHP Plus for individuals who transition from a nursing home to the community.

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

*** Home modifications and home-delivered meals are new services that began with the implementation of DSHP Plus.

Medicaid Services Excluded From or Limited in DSHP Plus

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

- Day habilitation services for individuals with DD, provided under the Rehab Option
- PPEC services for children with severe disabilities
- Specialized services for NF residents
- Employment services and related supports provided through the Pathways program for eligible individuals
- Non-emergency medical transportation
- Certain behavioral health/substance abuse services applicable to adults participating in the State's PROMISE program

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

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Adjustments in the Capitation Rate Development Process

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

DSHP and DSHP Plus Rate Development Adjustments

DSHP and DSHP Plus capitation rates for CY 2018 will be based on historical, Delaware managed care experience data (e.g., MCO financial data and/or encounter data) for the applicable populations and services. Historical Delaware FFS and historical MCO-reported data will also be used, as needed, to support specific program change adjustments. The following list of adjustments has not been reflected in this data book but will be considered in the rate development process:

- Mercer will review MCO incurred but not reported (IBNR) estimates included within the MCO-reported financial experience and may make adjustments to the data as deemed appropriate.
- Based on a review of MCO-reported financial experience by category of service, Mercer may shift expenses among service categories to improve reporting alignment among the MCOs and improve the data overall in total (budget-neutral adjustment).
- Mercer will exclude maternity expenses from the DSHP non-maternity rate cells in the MCO-reported financial experience and include them in the development of the DSHP maternity care payment (budget-neutral adjustment).
- MCO-reported financial experience will be adjusted to reflect the "net cost of reinsurance" (premiums less recoveries) reported within the financials to account for high-cost claims.
- MCO-reported financial experience may be adjusted to account for funds MCOs collected from third party payers after the initial payment was recorded to reflect the ultimate financial responsibility of the MCOs.
- Historical HCBS patient pay amounts applicable to individuals in the E&D and AIDS waivers will be included in the rate development process as needed.
- Patient liability/patient share of cost for NF residents will be included in the development of the DSHP Plus rate ranges. Mercer's rate ranges will be gross of NF patient liability. The State will deduct member-specific patient liability when making capitation payments to the MCOs. It is expected that the MCO will also deduct the applicable patient liability amount when paying for NF services and require the NF to collect the patient liability amount directly from the resident.
- Expenses related to non State Plan approved services will be removed from MCO-reported financial experience unless deemed to be a cost-effective in lieu of service expenditure.
- Mercer will develop prospective trend factors through a review of the historical data, input from DMMA, Mercer's knowledge of the Delaware marketplace and Mercer's knowledge of health care trends in other states. The resulting trend factors will be annual factors Mercer will use to project the base data to a future rating period. The number of months/years the annual trend factors will be applied will be equivalent to the months of movement measured between the midpoint of the base period and the midpoint of the rating period.
- Mercer may adjust MCO-reported financial experience to reflect historical and proposed program changes as deemed appropriate.

- Mercer may consider differences between managed care and FFS for new benefits being added to the MCO covered benefits.
- After trend and program changes have been reflected, Mercer may apply relational modeling, as necessary, to mitigate rate volatility over time (budget-neutral adjustment).
- Mercer may make adjustments to the MCO experience data for missed opportunities to effectively manage and coordinate member care (e.g., preventable hospitalizations, unnecessary emergency room use).
- Mercer may consider differences in network/provider composition or other risk factors not addressed through other adjustments.
- An allowance for an MCO administrative/profit/risk contingency, non-medical expense load will be added to the projected managed care claims cost based on a percentage of premium.
- Mercer may make adjustments for applicable health care taxes, as needed, consistent with federal and/or State policy and actuarial soundness requirements.

Actuarially Sound Rate Ranges and Risk Adjustment

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

DSHP Risk-Adjustment Process

DMMA uses the CDPS+Rx model to further adjust the applicable DSHP base capitation rates. The CDPS+Rx model uses both diagnosis data on facility and professional records in addition to pharmacy data to classify individuals into disease conditions, along with member demographics (age and sex categories) to measure a population's anticipated health risk. The health risk for each MCO is calculated at the consolidated risk-adjustment rating categories level of detail. The TANF/MCHIP Newborn and Maternity Care Payment rate cells are not subject to the CDPS+Rx risk adjustment process at this time. DMMA and Mercer intend to apply the CDPS+Rx risk adjustment process to the ACA Expansion rate cell in CY 2018.

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

The combination of the CDPS+Rx categories and the appropriate cost weights produces a risk score for each recipient, referred to as an acuity factor. Acuity factors are only developed for recipients with at least six months of Medicaid eligibility within the 12-month study period (if newborns become subject to risk adjustment, this policy may be modified). The recipient-level risk scores will then be aggregated by statewide rate cells and by MCOs. To ensure that the risk adjustment process does not increase or decrease the total capitation payments, the aggregated

risk scores are adjusted for budget neutrality. The intent of this adjustment is to recalibrate the MCO risk scores to yield a population average of 1.000. DMMA intends to update the individual and MCO risk scores on a semiannual basis. DMMA and Mercer continually discuss innovations and/or alternative approaches to risk adjustment, and changes to DMMA's approach to risk adjustment may occur and will be communicated with the MCOs as needed.

DSHP Plus Risk Adjustment Process

Due to unique issues associated with the DSHP Plus populations (e.g., lack of Medicare claims data, nature of long-term needs/risk), DMMA does not use the CDPS+Rx risk adjustment process for the NF/HCBS and Community Well rate cells. Instead, for the CY 2018 rating period, DMMA and Mercer intend to develop NF/HCBS capitation rate ranges that reflect MCO-specific member mix information to reflect differences in actual selection risk related to institutionalized residents and HCBS enrollees. This may result in the NF/HCBS rate ranges varying by MCO if the percentage mix of institutionalized and HCBS members varies by MCO. At the discretion of the State, at some point in the future, DMMA may introduce a more sophisticated risk adjustment process developed specifically for LTSS populations that factors in acuity, health status, family supports, assessment data, plan of care data and/or other indicators and determinants of risk.

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Exhibit Descriptions

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

MCO Financial Summary Exhibits

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

- Exhibit 1: CY 2015 summarized DSHP managed care audited financial experience
- Exhibit 2: CY 2015 summarized DSHP Plus managed care audited financial experience
- Exhibit 3: CY 2015 summarized maternity delivery events and maternity-related expenses
- Exhibit 4: CY 2015 summarized DSHP Plus subpopulation mix and financial experience

Users of this data book are advised to review the information in Section 4 regarding adjustments that will be considered in the actuarial rate development process.

Mercer (US) Inc.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 6500