Acute Care Actuarial Memorandum

I. Purpose

The purpose of this actuarial memorandum is to demonstrate that the Acute Care capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

AHCCCS intends to update these capitation rates for January 1, 2013 to include changes to the physician fee schedule resulting from mandated Health Care Reform requirements and any other necessary changes.

II. Overview of Rate Setting Methodology

The contract year ending 2013 (CYE13) rates were developed as a rate update from the contract year ending 2012 (CYE12) capitation rates. The CYE13 rates cover the twelve month contract period of October 1, 2012 through September 30, 2013.

The Acute Care rates were developed from historical Acute Care data including Arizona Medicaid managed care encounter data (via an extract that provides utilization and cost data, referred to as the "databook"), as well as health plan financial statements. Other data sources include programmatic changes, anticipated Arizona Health Care Cost Containment System (AHCCCS) Fee-For-Service rate changes, anticipated Arizona Department of Health Services (ADHS) transportation increases, Center for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) Report estimates and Global Insight Prospective Hospital Market Basket Inflation Index (GI) information.

The contract between the AHCCCS and the health plans (HPs) specifies that the HPs may cover additional services. Non-covered services were removed from the databook and not included in the rates.

Trend rates were calculated from the databook and other sources on a unit cost and/or utilization basis by category of service (COS) and a cap was applied to limit the negative and positive trends to a reasonable level. Unit cost trends were further refined by actual and anticipated changes in AHCCCS Fee-For-Service rates. These adjustments also include state mandates, court ordered programs and other program changes, if necessary. Additional analysis was performed on all prospective populations due to shifts in the economy and policy impacts that have caused deviations from the historical encounter data costs and trends. In order to capture these changes AHCCCS used more recent encounter data as well as the most recent financial data and applied an experience adjustment factor to all prospective populations. For more information on trends and experience adjustments see Section III Projected Trend Adjustments and Section IV Projected Experience Adjustments.

The Acute Care program has a large membership base, which allows for the experience data to be analyzed by different rate cells. These rate cells are comprised of members with similar risk characteristics. The rate cells were analyzed by major categories of aid (COA), i.e. risk groups, and COS. In addition, AHCCCS develops rates by Geographic Service Area (GSA).

The experience data includes only Acute Care Medicaid eligible expenses for Acute Care Medicaid eligible individuals, as well as reinsurance amounts. The Prior Period Coverage (PPC) rates and the Non-MED rates are reconciled to a maximum 2% profit or loss. The remainder of the risk groups are reconciled based on a tiered methodology (see Section XVI CMS Rate Setting Checklist for additional information). Additional payments are made for members giving birth via a Maternity Delivery Payment.

The general process in developing the prospective rates involves trending the CYE12 capitation rates to the midpoint of the effective period, which is April 1, 2013. The next step involves applying programmatic and experience adjustments. This creates a CYE13 medical per member per month (PMPM) rate from which the reinsurance offsets are deducted. Following this calculation, the projected administrative expenses, risk/contingency margin and premium tax are added to the projected claim PMPMs to obtain the capitation rates. In the final step, a risk adjustment factor is applied creating budget neutral results. Each step is described in the sections below. In addition there are sections dedicated to the development of other rates including, but not limited to, the Maternity Delivery Payment and PPC rates.

III. Projected Trend Adjustments

The trend analysis includes both the financial data experience and the encounter data experience. Financial data experience is from the contract year ending September 2009 through March 2012. Encounter data experience is from the contract year ending September 2009 through March 2012. Encounter data was used from those plans that provided reasonably complete and accurate encounter submissions for the trend analysis. The resulting data provides an actuarially sound data set for which to trend the CYE12 rates forward. In addition to using encounter and financial data, AHCCCS used information from CMS NHE Report estimates, GI information, and changes in AHCCCS' Inpatient rates, Professional and Outpatient Fee Schedules, Dental Fee Schedule, Transportation Fee Schedule and other sources. AHCCCS developed utilization and unit cost trend estimates using the encounter data. These trends were developed by major COA and COS, with a cap on the percentage increase and decrease to smooth out exceptional trends.

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors' Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 to SFY 2011, encounter-reported COB cost avoidance grew by greater than 39%, from $391 million to $544 million. Additionally, Acute Contractors cost-avoided $253 million in SFY 2011 in additional claims for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and therefore those services are excluded completely from

capitation expenditure projections. AHCCCS continues to emphasize the importance of COB activities with the Acute Contractors.

Once these trends were developed they were analyzed by comparing the results to reports and studies (for example the CMS NHE report). The utilization and unit cost trend rates used in projecting the claim costs are summarized in Appendix I. The prospective PMPM trends are shown below in Table I. These trends do not reflect the impact of any program changes.

Table I: Prospective Average Annual PMPM Trends

	PMPM Trends			
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-0.9%	2.7%	-2.8%	-0.9%
Outpatient Facility	2.1%	-0.3%	-0.5%	-0.1%
Emergency Room	3.2%	-2.3%	7.4%	-1.3%
Primary Care	1.4%	2.1%	2.5%	-1.5%
Referral Physician	4.0%	8.7%	6.1%	-2.0%
Other Professional	5.2%	4.7%	3.7%	0.8%
Pharmacy	6.5%	3.9%	3.9%	2.9%
Other	-4.0%	-1.1%	-1.7%	-1.8%

Hospital Inpatient Trends

Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the inpatient utilization varied from -5.2 to -2.0 percent annually, depending upon risk group. AHCCCS used encounter data, as adjusted for prior years' fee schedule rate changes, to develop the hospital inpatient unit cost trends. On a combined basis, the PMPM trends for inpatient hospital have been trended at -2.8 to 2.7 percent, depending upon risk group. These ranges are summarized in Appendix I.

Hospital Outpatient and Emergency Room Trends

Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the hospital outpatient and emergency room utilization varied from -5.3 to 5.4 percent annually, depending upon risk group and category of service. On a combined basis, the PMPM costs for hospital outpatient and emergency room have been trended at -2.3 to 7.4 percent, depending upon risk group. These ranges are summarized in Appendix I.

Physician and Related Service Trends

Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the assumed utilization for physicians and other professionals ranged from -2.0 to 7.8 percent annually, depending upon risk group and category of service. AHCCCS primarily used encounter data, as adjusted for prior years' fee schedule rate changes, to develop the physician and other professionals unit cost trends. On a combined basis, the PMPM costs for physicians and other professionals have been

trended at -2.0 to 8.7 percent, depending upon risk group. These ranges are summarized in Appendix I.

Pharmacy Trends
Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the assumed pharmacy utilization increased by -2.0 to 5.0 percent, depending upon risk group. Based on a review of the same sources, unit costs have been trended at -1.0 to 5.0 percent. On a combined basis, the PMPM costs for pharmacy have been trended at 2.9 to 6.5 percent, depending upon risk group. These ranges are summarized in Appendix I.

IV. Projected Experience Adjustments

Based on recent changes in the AHCCCS population resulting from previously unforeseen economic conditions which resulted in rapid growth, in addition to the freeze of the non-MED risk group effective July 8, 2011, AHCCCS is applying an experience adjustment to the CYE13 capitation rates. The projected experience adjustments are calculated by risk group, by GSA for the prospective population.

The projected experience adjustments are a function of two components: a financial component and an encounter component. The financial component is based on three different views of the health plans' submitted financials: reported profit/loss for CYE11 adjusted to CYE12; reported profit/loss through March 31, 2012; and reported CYE12 medical expense (for two quarters) compared to the CYE12 medical expense built into the capitation rates. The encounter component is based on three different views: CYE11 databook encounters (PMMIS point-in-time extract) over CYE11 medical expense built into the capitation rates adjusted for CYE12 changes to medical expense; COGNOS encounters for two quarters of CYE12 over CYE12 medical expense in the capitation rates; and COGNOS encounters for two quarters of CYE12 with seasonality applied over CYE12 medical expense in the capitation rates. These components were then analyzed, in conjunction with historical medical PMPMs, to arrive at the necessary experience adjustments. These experience adjustments are applied to the final medical rate, before reinsurance, admin, risk contingency and premium tax. The impact of the experience adjustment on a statewide basis ranges from -9.8 to 19.3 percent, depending upon the risk group and GSA.

V. State Mandates, Court Ordered Programs, Program Changes and Other Changes

340B Pharmacy Pricing
Effective April 2012, all Contractors are required to reimburse claims for 340B drugs consistent with the requirements in AHCCCS Rule A.A.C. R9-22-710 C. In general, this provision requires that claims for drugs identified on the 340B pricing file dispensed by FQHCs and FQHC Look Alike pharmacies be reimbursed at the lesser of: 1) the actual acquisition cost or 2) the 340B ceiling price, plus a dispensing fee listed in the AHCCCS capped fee-for-service (FFS) schedule. For more detail regarding reimbursement of 340B drugs, please refer to the AHCCCS Rule. The estimated statewide savings to the acute program is approximately $5 million.

Psych Consults
Effective July 1, 2012, the Acute Care Behavioral Health Contractor (Arizona Department of Health Services/Behavioral Health Services – ADHS/BHS) is responsible for payment of medically necessary psychiatric consultations and evaluations provided to acute care members in inpatient facilities in medical/surgical beds regardless of the bed or floor where the member is placed. This includes emergency departments, even when the member is being treated for other co-morbid physical conditions. The estimated statewide savings to the acute program is approximately $168,000.

ER Transportation
Effective July 1, 2012, the Acute Contractors will pay for all emergency transportation for a behavioral health member, unless the emergency transport is to a behavioral health facility. Historically, the RBHAs were financially responsible for emergency transportation for a behavioral health member. The estimated statewide impact to the acute program is an increase of approximately $259,000.

Taxi Copay
Beginning April 1, 2012, Childless Adult (non-Med) members in Maricopa and Pima counties will be charged a $2 mandatory copayment for taxi services per one-way trip. Mandatory copayments permit taxi providers to deny services due to lack of member payment. The estimated statewide savings to the acute program is approximately $209,000.

Family Planning Devices
Effective February 1, 2012, AHCCCS increased the reimbursement rates for certain family planning services. Rates for two devices, Paragard and Mirena, and for the Essure procedure, were adjusted to address providers' costs related to these cost-effective services. The estimated statewide impact to the acute program is an increase of approximately $3.4 million.

Out of Network QMB Duals
CMS published new guidance regarding Medicare cost-sharing for QMB dual eligible members. The guidance clarifies that AHCCCS Contractors are required to pay cost-sharing for all services provided to QMB dual members regardless of a provider's network status, as long as the provider is registered with AHCCCS. The estimated statewide impact to the acute program is an increase of approximately $3 million.

Hepatitis C
In May 2011, the FDA granted approval for two new drug therapies for hepatitis C (Incivek and Victrelis). Both drugs were made available to AHCCCS members beginning in early 2012. It is expected that these therapies will reduce the need for liver transplants for hepatitis C patients. The estimated statewide impact to the acute program is an increase of approximately $7 million.

Claims Processing Standards
Effective January 1, 2012, Contractors were required to adjust their claims processing systems to recognize two cost-saving standards including multiple surgery occurrences and bundled services. When multiple surgeries occur on the same day, the surgery with the lowest cost is valued at 50% of the standard allowed amount for that surgery. Encounter data identified with status code B reflects bundled services where no additional payment is allowed for certain services that are performed together (e.g. anesthesia provided during an outpatient surgery). The estimated statewide savings to the acute program is approximately $1.3 million.

Breast and Cervical Cancer Treatment Program (BCCTP)
Effective August 2, 2012, a change in Arizona law (ARS 36.2901.85) modifies the definition of an eligible person for BCCTP by expanding the number of providers recognized by the Arizona Well Woman Healthcheck Program (WWHP). Prior to this change, only women who were screened and diagnosed through the WWHP qualified for the BCCTP. The new law allows for all women that meet the qualification of the BCCTP, but were diagnosed outside of WWHP, to enroll in the treatment program provided they meet the BCCTP eligibility requirements. The estimated statewide impact to the acute program is an increase of approximately $4.2 million.

Shift to Ambulatory Surgical Centers (ASCs)
Capitation rates effective October 1, 2012 include an adjustment to recognize savings that may be generated by transitioning certain procedures that are currently performed in hospital outpatient settings to more cost-effective Ambulatory Surgical Centers (ASC). AHCCCS reviewed the utilization and costs of services that may be performed in both of these outpatient settings, as well as data from ASCs on their available capacity, and determined that such savings could be realized if Contractors increase ASC service utilization by 20% statewide. The estimated savings for the acute program is approximately $6.6 million.

In-Lieu of Services
Included in the base rates is funding for "in lieu of" services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. State approved FFS rates at inpatient non-specialty hospitals are approximately 93.5% more expensive than those provided in alternative inpatient settings. The proposed capitation rates allow for the provision of services in alternative inpatient settings that are licensed by Arizona Department of Health Services/Arizona Licensing Services/Office of Behavioral Health License, in lieu of services in an inpatient non-specialty hospital, thus no increase to cap rates is included.

VI. Prospective Projected Net Claim PMPM

The CYE12 utilization, unit costs and net claims' PMPMs are trended forward and adjusted for experience trends, state mandates, court ordered programs and program changes to arrive at the CYE13 utilization, unit costs and net claims PMPMs for each COS and COA.

VII. Prospective Reinsurance Offsets

The CYE12 reinsurance offsets were reviewed by AHCCCS for appropriateness and reasonableness using reinsurance encounter and payment information. Appropriate adjustments were made to the reinsurance offsets based upon this review. All contractors remain at the same deductible levels as CYE12.

VIII. Prospective Administrative Expenses and Risk Contingency

The administrative expense ratio remains at the ratio in place for the CYE12 rates for general administration, which was determined to be appropriate to cover the contractors' average expenses. The risk contingency load also remains the same for all rate cohorts at 1%.

IX. Prospective Proposed Capitation Rates and Their Impacts

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VI) less the reinsurance offsets (in section VII) and the projected administrative expenses and risk contingency PMPM (in section VIII), divided by one minus the two percent premium tax. The final adjustment, which is a budget neutral adjustment, is the risk adjustment factor (in Section X). Appendix II contains the proposed capitation rates and the budget impact for all capitation rates using projected CYE13 member months and actual health plan reinsurance deductible levels.

X. Risk Adjustment Factor

For CYE13, AHCCCS will apply the same risk factors used for the CYE12 capitation rates.

XI. Maternity Delivery Payment

The methodology followed in developing the Maternity Delivery Payment is similar to the methodology used in the development of the prospective capitation rates. This methodology involves updating CYE12 rates with utilization and unit cost trends and program changes. The impact is a 4.7% increase per delivery to the overall global maternity payment rate over the CYE12 rate.

XII. Extended Family Planning Services (FPS)

The methodology followed in developing the FPS rate is similar to the methodology used in the development of the prospective capitation rates. This methodology involves updating CYE12 rates with utilization and unit cost trends and program changes. The impact is a 0.1% decrease to the overall global FPS rate over the CYE12 rate.

XIII. KidsCare Rates

Continuing with the methodology of previous years, AHCCCS contractors will be paid one blended capitation rate that includes experience from both the traditional TANF Medicaid population and the Title XXI SCHIP population. For CYE13, the Title XXI population includes those children enrolled in KidsCare II as well as those members in the traditional KidsCare program. On April 6, 2012, CMS approved a new 2012 Waiver Amendment, which included funding for KidsCare II. KidsCare II provides coverage to children who have income levels up to 175% of the federal poverty level (FPL) and meet other eligibility requirements. The rate cohorts whose experience is blended together are detailed as follows:

- TANF < 1 and KidsCare < 1;
- TANF 1– 13 M&F and KidsCare 1 – 13 M&F;
- TANF 14 – 44 F and KidsCare 14 – 18 F;
- TANF 14 – 44 M and KidsCare 14 – 18 M; and

The related member month, capitation rate and dollar information is as follows:

KidsCare Info	CYE13 Projected Member Months	Proj Cap Rate-CYE13	Total Annual Dollars CYE13 based on CYE13 Proj MMs
KC <1	391	$ 482.36	$ 188,490
KC 1-13	244,296	$ 103.21	$ 25,213,797
KC 14-44F	63,138	$ 225.41	$ 14,231,844
KC 14-44M	70,231	$ 143.02	$ 10,044,366

XIV. Prior Period Coverage Rates (PPC)

PPC rates cover the period of time from the effective date of eligibility to the day a member is enrolled with the Contractor. PPC rates are established using a similar methodology that was followed in developing the prospective capitation rates. The administration and risk contingency percentages are the same as the prospective rates. The overall statewide impact is an increase of 4.8%. The PPC rates are reconciled to a maximum 2.0% profit or loss in CYE13.

XV. Final Capitation Rates and Their Impact

Table II below summarizes the adjustments made to the CYE12 rates. The impact to Contractors ranges from 1.6% to 6.0%. Individual health plan capitation rates will be impacted as shown in Section B of the contracts.

Table II: Adjustments to CYE12 Rates

AHCCCS Medicaid Managed Care Summary			
Adjustments to CYE12 Rate	Prospective	PPC	Weighted Average
Trend:			
1. Utilization	-0.39%	1.58%	-0.35%
2. Inflation	1.19%	2.49%	1.22%
Experience Adjustment			
1. Total	0.85%	0.00%	0.83%
Program Changes			
1. ER Transportation	0.01%	0.00%	0.01%
2. 340B Pharmacy Pricing	-0.17%	0.00%	-0.17%
3. Taxi Copay	-0.01%	0.00%	-0.01%
4. Family Planning Devices	0.11%	0.00%	0.11%
5. Hepatitis C	0.24%	0.00%	0.23%
6. Claim Processing Standards	-0.04%	0.00%	-0.04%
7. Psych Consults	-0.01%	0.00%	-0.01%
8. Out of Network QMB Duals	0.10%	0.00%	0.10%
9. BCCTP	0.13%	0.22%	0.14%
10. ASCs	-0.22%	0.00%	-0.22%
Misc			
1. Reinsurance Offset Change	0.94%	n/a	0.92%
2. Other Changes (ie Admin, Risk, Prem Tax)	0.17%	0.48%	0.18%
Total Percentage Change	2.91%	4.77%	2.95%

XVI. CMS Rate Setting Checklist

1. Overview of rate setting methodology

A.A.1.0: Overview of rate setting methodology

AHCCCS is performing a rate update from the rates in effect for contract year ending 2012 (CYE12) under 42 CFR 438.6(c). Please refer to Section II.

AA.1.1: Actuarial certification

Please refer to Section XVII.

AA.1.2: Projection of expenditure

Please refer to Appendix II.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Competitive Procurement contracting method.

AA.1.5: Risk contract

AHCCCS limits risk for the Non-MED and all PPC risk groups to 2% profit or loss. The remainder of the risk groups are reconciled as follows:

Profit	MCO Share	State Share	Maximum MCO Profit
<=3%	100%	0%	3%
>3% and <=5%	75%	25%	1.5%
>5% and <=7%	50%	50%	1.0%
>7% and <=9%	25%	75%	0.5%
>9%	0%	100%	0%
Total			6.0%

Loss	MCO Share	State Share	Maximum MCO Loss
<=3%	100%	0%	3%
>3% and <=6%	50%	50%	1.5%
>6%	0%	100%	0%
Total			4.5%

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to providers, except for Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Critical Access Hospitals. GME is paid in accordance with state plan. DSH and Critical Access Hospital payments are paid in accordance with the Waiver Special Terms and Conditions. None of the additional payments to providers were included in the capitation calculation.

AA.1.7: Rate modification

Please refer to Sections II through V, VII, VIII, and X through XIV.

XVII. Actuarial Certification of the Capitation Rates

I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board.

The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the twelve-month period beginning October 1, 2012.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the health plans and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the health plan auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Windy J. Marks — 08/30/12

Windy J. Marks — Date

Fellow of the Society of Actuaries
Member, American Academy of Actuaries

Appendix I

Prospective Trends

Utilization per 1,000 trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-3.0%	-5.2%	-2.5%	-2.0%
Outpatient Facility	-1.8%	-3.8%	1.6%	-1.7%
Emergency Room	-0.8%	-5.3%	5.4%	-2.0%
Primary Care	-0.1%	1.3%	1.3%	-2.0%
Referral Physician	3.4%	7.8%	7.0%	-1.6%
Other Professional	3.2%	3.4%	1.3%	-1.9%
Pharmacy	5.0%	1.3%	4.9%	-2.0%
Other	n/a	n/a	n/a	n/a

Unit Cost Trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	2.2%	8.3%	-0.3%	1.2%
Outpatient Facility	4.0%	3.7%	-2.1%	1.6%
Emergency Room	4.0%	3.2%	1.9%	0.7%
Primary Care	1.5%	0.8%	1.1%	0.5%
Referral Physician	0.6%	0.8%	-0.8%	-0.4%
Other Professional	1.9%	1.3%	2.3%	2.8%
Pharmacy	1.5%	2.6%	-1.0%	5.0%
Other	n/a	n/a	n/a	n/a

PMPM Trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-0.9%	2.7%	-2.8%	-0.9%
Outpatient Facility	2.1%	-0.3%	-0.5%	-0.1%
Emergency Room	3.2%	-2.3%	7.4%	-1.3%
Primary Care	1.4%	2.1%	2.5%	-1.5%
Referral Physician	4.0%	8.7%	6.1%	-2.0%
Other Professional	5.2%	4.7%	3.7%	0.8%
Pharmacy	6.5%	3.9%	3.9%	2.9%
Other	-4.0%	-1.1%	-1.7%	-1.8%

Acute Capitation Rate Analysis (Renewal Rates--pending approval)
Point in Time Comparison--no member growth factor
CYE '13
APPENDIX II

		CYE13 Projected Member Months [1]	Cap Rate- '12 based on CYE13 Proj Member Months [2]	Total Annual Dollars CYE '12 based on CYE13 Proj MMs	Cap Rate- CYE13 based on CYE13 Proj Member Months [2]	Total Annual Dollars CYE13 based on CYE13 Proj MMs	Difference	% Increase
Title XIX Waiver Group								
	Prospective-non-MED	753,428	$ 397.38	$ 299,397,252	$ 400.69	$ 301,891,099	$ 2,493,847	0.8%
	Total non-MED	753,428		$ 299,397,252		$ 301,891,099	$ 2,493,847	0.8%
TXIX								
	<1	567,607	$ 465.40	$ 264,164,091	$ 482.36	$ 273,790,698	$ 9,626,607	3.6%
	1-13	5,424,396	$ 99.65	$ 540,541,020	$ 103.21	$ 559,851,868	$ 19,310,848	3.6%
	14-44F	2,739,406	$ 222.98	$ 610,832,681	$ 225.41	$ 617,489,437	$ 6,656,756	1.1%
	14-44M	1,339,485	$ 140.09	$ 187,648,494	$ 143.02	$ 191,573,186	$ 3,924,692	2.1%
	45+	455,356	$ 358.34	$ 163,172,350	$ 378.05	$ 172,147,421	$ 8,975,071	5.5%
	SSI w/Med	982,494	$ 133.03	$ 130,701,124	$ 139.92	$ 137,470,505	$ 6,769,381	5.2%
	SSI w/o Med	815,065	$ 713.49	$ 581,540,904	$ 737.20	$ 600,866,101	$ 19,325,197	3.3%
	SFP	51,678	$ 14.16	$ 731,755	$ 14.14	$ 730,721	$ (1,034)	-0.1%
	Delivery Supplemental Payment	35,706	$ 5,813.22	$ 207,564,657	$ 6,085.66	$ 217,292,298	$ 9,727,641	4.7%
	Total Prospective-non-TWG	12,411,191		$ 2,686,897,077		$ 2,771,212,237	$ 84,315,159	3.1%
	PPC'<1	11,496	$ 899.97	$ 10,346,034	$ 955.29	$ 10,981,991	$ 635,957	6.1%
	PPC'1-13	184,471	$ 52.95	$ 9,767,726	$ 56.41	$ 10,405,994	$ 638,269	6.5%
	PPC '14-44F	132,754	$ 184.21	$ 24,454,692	$ 187.59	$ 24,903,402	$ 448,710	1.8%
	PPC '14-44M	58,369	$ 147.30	$ 8,597,817	$ 155.92	$ 9,100,962	$ 503,144	5.9%
	PPC '45+	19,510	$ 293.00	$ 5,716,331	$ 305.16	$ 5,953,569	$ 237,238	4.2%
	PPC 'SSI w/Med	13,456	$ 119.69	$ 1,610,501	$ 118.78	$ 1,598,257	$ (12,245)	-0.8%
	PPC 'SSI w/o Med	30,327	$ 336.17	$ 10,195,192	$ 366.44	$ 11,113,205	$ 918,013	9.0%
	PPC All non-TWG rate codes	450,383		$ 70,688,293		$ 74,057,379	$ 3,369,087	4.8%
	Total Title XIX-non-TWG	12,861,575		$ 2,757,585,370		$ 2,845,269,616	$ 87,684,246	3.2%
Grand Total Capitation				**$ 3,056,982,622**		**$ 3,147,160,715**	**$ 90,178,093**	2.9%

[1] Population estimates for CYE13 are taken from DBF projections.

[2] Reinsurance levels are the same level for plans in CYE13 as CYE12 with two plans at the $35,000 level and the rest at $20,000