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Government Human Services Consulting

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October 24, 2006

Ms. Melody Anthony
Director, Provider Services
Oklahoma Health Care Authority
4545 North Lincoln Boulevard
Oklahoma City, OK 73105

Subject:

**State of Oklahoma Primary Care Case Management Partial Capitation
Provider Rate Certification Letter for January 1, 2007 – December 31, 2007**

Dear Melody:

In partnership with the Oklahoma Health Care Authority (OHCA), Mercer Government Human Services Consulting (Mercer) has developed the capitation rate ranges for the Medicaid Primary Care Provider/Case Manager (PCP/CM) Partial Capitation program for the period January 1, 2007 – December 31, 2007. This letter presents an overview of the analyses and methodology used in the development of the managed care rate ranges (MCRRs), as well as a certification to the actuarial soundness of the MCRRs presented.

Background

Under the State of Oklahoma's (State's) Medicaid managed care program (SoonerCare), the OHCA operates a PCP/CM system for SoonerCare Choice (Choice) eligible individuals. The program enrolls recipients with PCPs/CMs who provide and/or authorize all covered primary care services. The PCP/CM is paid as a monthly capitation rate, including a case management fee, covering the per member per month (PMPM) cost to provide care to eligible individuals. Such care represents medically necessary primary care medical services for the individuals assigned to the PCP/CM. Non-capitated covered services are reimbursed at the Medicaid fee-for-service (FFS) rate. Attachment 3 presents the list of covered services that are provided under the capitation arrangement.

New for 2007, the MCRRs were developed separately for non-University and University physicians (physicians who are employees of either the University of Oklahoma or Oklahoma State University). These two groups of physicians are reimbursed under different fee schedules and the developed rates reflect these differences. Attachment 1 (non-University physicians) and

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Attachment 2 (University physicians) present the actuarially sound MCRRs for the Aged, Blind, and Disabled (ABD) and the Temporary Assistance for Needy Families (TANF) age/gender categories of aid (COAs) listed below.

COA	Age/Gender
TANF	<1 Male and Female
TANF	1 – 5 Male and Female
TANF	6 – 14 Male and Female
TANF	15 – 20 Female
TANF	15 – 20 Male
TANF	21 – 44 Female
TANF	21 – 44 Male
TANF	45 – 64 Male and Female
ABD	<1 Male and Female
ABD	1 – 5 Male and Female
ABD	6 – 14 Male and Female
ABD	15 – 20 Female
ABD	15 – 20 Male
ABD	21 – 44 Female
ABD	21 – 44 Male
ABD	45 – 64 Male and Female

MCCR Development Methodology

Base Data

The base data used for development of capitation rate ranges consisted of a combination of the following data sources.

- Oklahoma SoonerCare FFS and encounter claims, and enrollment data for calendar year (CY) 2004 (1/1/2004 – 12/31/2004); and
- Base data utilized in the development of the actuarially sound CY 2006 rates which included:
 - FFS claims data for CY 2002 (1/1/2002 – 12/31/2002);
 - encounter-based utilization data for CY 2002 (1/1/2002 – 12/31/2002); and
 - financial cost data provided by OHCA.

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The final base data utilized by Mercer reflects a combination of these sources, based on a credibility of 50% assigned to each source.

Introduction of Two Rate Ranges

The previously prepared rate ranges for the PCP/CM program had a very wide rate range to accommodate the varied fee schedule structure for the non-University and University physicians, as well as underlying historical differences. Non-University physicians are currently reimbursed at 100% of the State Medicaid fee schedule, while University physicians are reimbursed at 140% of the State Medicaid fee schedule. In the rate development process for 2007, the same underlying base data was utilized; however, the different fee schedules for non-University physicians (100%) and University physicians (140%) were applied to the 2004 Oklahoma base utilization data to produce two sets of output for this data source. The base data utilized in the development of the broad 2006 rate ranges had already reflected differences for non-University and University physicians. The final two rate ranges represent a blending of the 2004 Oklahoma base data, adjusted for the fee schedule differences to identify non-University and University costs, and the base data utilized in the 2006 rate development.

Trend

Trend for physician services was developed using a combination of the following data sources:

- FFS claims data;
- DRI/CPI inflationary measures;
- encounter-based utilization data; and
- financial cost data provided by OHCA.

The final trend rates of 3.0% for TANF physician services and 2.8% for ABD physician services represent utilization trend only, since the State is holding the physician fees at the current level. If physician fees are updated in the future, an adjustment to the current trend would be necessary.

When using FFS claims data, Mercer utilizes a linear regression model to analyze the trend by category of service (COS). Projections are typically made using the results of the linear regression of rolling 12-month averages, which achieves more statistically credible results by eliminating the effect of seasonal fluctuations.

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The 3.0% TANF and 2.8% ABD trend rates are applied from the midpoint of the base data period to the midpoint of the contract period. The base data reflects the 12 months ending December 31, 2004. The midpoint of this period is July 1, 2004. As noted previously, the rates to be paid to PCP/CM providers under this program are effective for the period January 1, 2007 – December 31, 2007; thus, the midpoint of the contract period is July 1, 2007. Trend is, therefore, applied over a period of 36 months.

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes occurring after the base year. Four adjustments were applied to the base. The first adjustment is for the extension of the eligibility period from 6 to 12 months. This adjustment was only applied to the TANF population. The second adjustment is for changes in the physician fee schedule. The physician fee schedule changes were effective August 1, 2005. The third adjustment is for the change in the implementation of adult immunizations. For 2007, the State is going to implement the current Advisory Committee on Immunization Practices (ACIP) guidelines for adult immunizations. This change includes the introduction of the new CPT code 90715. The fourth adjustment is for the coverage of the cost for the administration of the Human Papilloma virus (HPV) vaccine for 9 to 20 year old females.

Relational Modeling

After adjusting the base data for program changes, Mercer compared the results by premium group within each region. Consistent with Sections AA.5.0 through AA.5.2 of the Centers for Medicare and Medicaid Services (CMS) Rate Checklist, the net change due to relational modeling must be zero across the State. As a result of the introduction of the 2004 SoonerCare data to this most recent rate development, relational modeling was utilized to smooth the changes in specific rate categories; however, the overall net impact of this modeling was zero in total.

Managed Care Adjustments

To the extent that FFS data are used to develop the MCRRs, Mercer utilizes managed care adjustments to account for variations in the health care delivery patterns between FFS and managed care. Because the PCP/CM capitation rate amount is paid directly to providers, Mercer made no allowance for health plan administration when developing the MCRRs.

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Reinsurance

Specific reinsurance is available when a member reaches a FFS equivalent value of \$1,800 in capitated services that were provided by the same PCP/CM, or the same group, during a contract year. Once this attachment point is reached, OHCA covers 90% of the excess and the PCP/CM covers the remaining 10%. This program is not available for individual PCPs/CMs or groups who are employees of either the University of Oklahoma or Oklahoma State University. The separate MCRRs for the respective groups of physicians reflect this difference because an adjustment was only included for the non-University physicians.

Mandatory MCRRs

Statistical error and uncertainty are inherent in any rate development process. The final MCRRs represent a "best estimate" of the range of anticipated cost to provide services during the contract period for the populations to be covered. The lower end of an actuarially sound rate range represents the capitation payment to the provider that is sufficient to result in appropriate access to care for each enrollee. The upper end of the actuarially sound rate range represents the capitation payment to the provider that does not result in payments exceeding the provision of health care for eligible recipients.

Actuarial Certification

Mercer certifies that the attached MCRRs were developed in accordance with generally accepted actuarial practices and principles, by actuaries meeting the qualification standards of the American Academy of Actuaries, for the populations and services covered under the managed care contract. 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.

Mercer has developed these MCRRs on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable law and regulations. These MCRRs are effective for the one-year period beginning January 1, 2007. Use of these MCRRs for any purpose beyond that stated may not be appropriate.

Mercer has relied on data and various information provided by the State in the development of these MCRRs. We have reviewed the data for reasonableness, and we believe them to be free of material error and suitable for rate development purposes for the populations and services covered under the managed care contract. However, we have not audited these data, and if they are materially incomplete or inaccurate, our conclusion may require revision.

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MCRRs developed by Mercer are actuarial projections of future contingent events. Actual health care costs will differ from these projections.

PCP/CM providers are advised that the use of these MCRRs may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rates by PCP/CM providers for any purpose. Mercer recommends that any PCP/CM considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other fiscal requirements for comparison to these rates before deciding whether to contract with the State. Use of these MCRRs for any purpose beyond that stated may not be appropriate.

If you have any question or comments on the assumptions or methodology, please contact me at (602) 522 8597.

Sincerely,



James J. Meulemans, ASA, MAAA

Copy:

Kevin Russell, Mercer

Jeff Smith, Mercer

Tim Doyle, Mercer

Enclosure

JM:lgm

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Attachment 1: MCRRs for Non-University Physicians

Rate Ranges — TANF

	Statewide	
Premium Group	Lower	Upper
< 1 year M & F	\$36.70	\$40.56
1 – 5 years M & F	\$18.37	\$20.31
6 – 14 years M & F	\$11.99	\$13.25
15 – 20 years F	\$22.49	\$24.86
15 – 20 years M	\$9.34	\$10.32
21 – 44 years F	\$25.47	\$28.15
21 – 44 years M	\$19.73	\$21.81
45 – 64 years M & F	\$32.44	\$35.86

Rate Ranges — ABD

	Statewide	
Premium Group	Lower	Upper
< 1 year M & F	\$45.49	\$51.30
1 – 5 years M & F	\$32.69	\$36.86
6 – 14 years M & F	\$18.74	\$21.13
15 – 20 years F	\$21.56	\$24.31
15 – 20 years M	\$13.03	\$14.69
21 – 44 years F	\$28.37	\$31.99
21 – 44 years M	\$17.66	\$19.91
45 – 64 years M & F	\$24.66	\$27.81

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Attachment 2: MCRRs for University Physicians

Rate Ranges — TANF

	Statewide	
Premium Group	Lower	Upper
< 1 year M & F	\$52.57	\$59.29
1 – 5 years M & F	\$26.44	\$29.82
6 – 14 years M & F	\$16.99	\$19.16
15 – 20 years F	\$33.36	\$37.62
15 – 20 years M	\$13.02	\$14.68
21 – 44 years F	\$37.79	\$42.61
21 – 44 years M	\$28.65	\$32.31
45 – 64 years M & F	\$47.82	\$53.93

Rate Ranges — ABD

	Statewide	
Premium Group	Lower	Upper
< 1 year M & F	\$64.62	\$76.62
1 – 5 years M & F	\$46.69	\$55.37
6 – 14 years M & F	\$26.13	\$30.98
15 – 20 years F	\$30.54	\$36.21
15 – 20 years M	\$17.72	\$21.01
21 – 44 years F	\$40.52	\$48.05
21 – 44 years M	\$24.65	\$29.23
45 – 64 years M & F	\$34.44	\$40.84

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Attachment 3: Covered Services

Urinalysis

CPT CODE	SERVICE DESCRIPTION
81002	Without Microscopy, non-automated
81025	Urine pregnancy test

Chemistry

CPT CODE	SERVICE DESCRIPTION
82270	Blood, occult, feces screening
82465	Cholesterol, serum or whole blood
82947	Glucose, quantitative
83718	Lipoprotein, direct measurement; high density cholesterol

Hematology and Coagulation

CPT CODE	SERVICE DESCRIPTION
85013	Spun microhematocrit
85014	Hematocrit, other than spun microhematocrit

Immunology

CPT CODE	SERVICE DESCRIPTION
86308	Mononucleosis screening; heterophile antibodies

Pathology

CPT CODE	SERVICE DESCRIPTION
87804	Influenza test
87880	Streptococcus, group A test

Immunizations/Injections

CPT CODE	SERVICE DESCRIPTION
90371	Hepatitis B immune globulin, human, for intramuscular use
90465	Immunization administration, under 8 years of age, injections
90466	Immunization administration, under 8 years of age, each add'l injection
90467	Immunization administration, under 8 years of age, intranasal or oral

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Immunizations/Injections

CPT CODE	SERVICE DESCRIPTION
90468	Immunization administration, under 8 years of age, each add'l intranasal or oral
90471	Immunization administration, obtained through Vaccines for Children
90472	Immunization administration, obtained through Vaccines for Children, each add'l
90473	Immunization administration by intranasal or oral route
90474	Immunization administration by intranasal or oral route, each add'l
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage, intramuscular use, 2 dose
90634	Hepatitis A vaccine, pediatric/adolescent dosage, intramuscular use 3 dose
90645	Hemophilus influenza b vaccine, HbOC conjugate, intramuscular use
90646	Hemophilus influenza b vaccine, PRP-D conjugate, intramuscular use
90647	Hemophilus influenza b vaccine, PRP-OMP conjugate, intramuscular use
90648	Hemophilus influenza b vaccine, PRP-T conjugate, intramuscular use
90657	Influenza virus vaccine, split virus, children 6-35 months dosage
90658	Influenza virus vaccine, split virus, 3 years and above dosage
90660	Influenza virus vaccine, live, for intranasal use
90669	Pneumococcal conjugate vaccine, intramuscular use, children under 5
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP)
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP)
90702	Diphtheria and tetanus toxoids (DT) absorbed for pediatric use
90703	Tetanus toxoid absorbed
90704	Mumps virus vaccine, live
90705	Measles virus vaccine, live
90706	Rubella virus vaccine, live
90707	Measles, mumps and rubella virus vaccine (MMR), live
90708	Measles and rubella virus vaccine, live
90710	Measles, mumps, rubella and varicella virus vaccine (MMRV), live
90712	Poliovirus vaccine, (any types) (OPV), live, oral use
90713	Poliovirus vaccine, inactivated (IPV)
90715	Diphtheria, tetanus toxoids, and acellular pertussis vaccine, 7 years and above dosage
90716	Varicella virus, vaccine, live
90718	Tetanus and diphtheria toxoids absorbed for adult use (Td)
90719	Diphtheria toxoid

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Immunizations/Injections

CPT CODE	SERVICE DESCRIPTION
90720	Diphtheria, tetanus and pertussis (DTP) and Hemophilus influenza B
90721	Diphtheria, tetanus toxoids, whole cell pertussis and Hemophilus influenza B
90723	Diphtheria, tetanus toxoids, acellular pertussis, Hepatitis B, and polio virus vaccine, inactivated
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage
90743	Hepatitis B vaccine, adolescent dosage, for intramuscular use
90744	Hepatitis B vaccine, pediatric dosage, for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage
90748	Hepatitis B vaccine and Hemophilus influenza b vaccine

Therapeutic or Diagnostic Injections

CPT CODE	SERVICE DESCRIPTION
90782	Therapeutic or diagnostic injection, subcutaneous or intramuscular
90788	Intramuscular injection of antibiotic

Office Visit – New Patient

CPT CODE	SERVICE DESCRIPTION
99201	Office Visit, brief service, new patient
99202	Office Visit, limited service, new patient
99203	Office Visit, intermediate service, new patient
99204	Office Visit, extended service, new patient
99205	Office Visit, comprehensive service, new patient

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Office Visit – Established Patient

CPT CODE	SERVICE DESCRIPTION
99211	Office Visit, minimal service, established patient
99212	Office Visit, brief service, established patient
99213	Office Visit, limited service, established patient
99214	Office Visit, intermediate service, established patient
99215	Office Visit, extended service, established patient

New Patient – Preventative Medicine

CPT CODE	SERVICE DESCRIPTION
99381	Initial preventive medicine, infant, new patient
99382	Initial preventive medicine, age 1-4, new patient
99383	Initial preventive medicine, age 5-11, new patient
99384	Initial preventive medicine, age 12-17, new patient
99385	Initial preventive medicine, age 18-39, new patient
99386	Initial preventive medicine, age 40-64, new patient
99387	Initial preventive medicine, 65 years and over, new patient

Established Patient – Preventative Medicine

CPT CODE	SERVICE DESCRIPTION
99391	Periodic preventive medicine, infant, established patient
99392	Periodic preventive medicine, age 1-4, established patient
99393	Periodic preventive medicine, age 5-11, established patient
99394	Periodic preventive medicine, age 12-17, established patient
99395	Periodic preventive medicine, age 18-39, established patient
99396	Periodic preventive medicine, age 40-64, established patient
99397	Periodic preventive medicine, 65 year and over, established patient
