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STATE OF OKLAHOMA  
HB2842 PMPM COST ANALYSIS



METHODOLOGY AND FINDINGS

THE PACIFIC HEALTH POLICY GROUP  
APRIL 2007

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## INTRODUCTION

During its most recent session, the Oklahoma State Legislature enacted House Bill 2842 (HB2842) – The Oklahoma Medicaid Reform Act of 2006. One provision of HB2842 directed the Oklahoma Health Care Authority (OHCA) to develop a mechanism for enrolling a portion of the non-aged Medicaid beneficiary population into private health plans, when such enrollment would be cost effective for the program. More specifically, the pertinent sections of the law state instruct OHCA to:

*“Provide Medicaid consumers who are younger than sixty-five (65) years of age and considered insurable more options in the selection of a health care plan that meets the needs of consumers and allows consumers to exercise greater control over the medical care that consumers receive. For purposes of this section “insurable” means that the cost of enrolling an individual in a private plan is equal to or less than the cost to the state of the individual remaining in the current Medicaid program.*

*“(OHCA shall) develop an actuarially sound cost per Medicaid consumer within different age groups and other relevant categories including health status to provide medically necessary services which may be separated to cover comprehensive care, enhanced services, and catastrophic care. This cost would be converted into a credit or instrument of value for the Medicaid consumer to purchase qualified health insurance policies.”*

HB2842 instructed OHCA to begin with a two-county pilot program. OHCA selected Comanche County, which includes Lawton, and neighboring Tillman County for the pilot.

In January 2007, OHCA retained the Pacific Health Policy Group (PHPG) to analyze expenditures in the two counties and calculate per member per month (PMPM) costs for Medicaid beneficiaries covered by HB2842. PHPG is an Irvine, California-based firm that has served as a consultant to OHCA since 1994. PHPG has conducted numerous cost studies for the agency, including development of PMPM expenditure forecasts for the *SoonerCare* and O-EPIC waiver programs, and capitation rates for the Cherokee PACE long term managed care program.

## SCOPE OF WORK

OHCA directed PHPG to do the following:

- ✓ Obtain an eligibility/claims extract from the Oklahoma Medicaid Management Information System (MMIS) for Comanche and Tillman counties and prepare the data for analysis
- ✓ Calculate PMPM benchmark medical costs for the period covered by the extract, segmented by age/gender/aid category, to the extent practicable given data size limitation (this included a targeted analysis of IHS beneficiary costs)
- ✓ Calculate PMPM benchmark medical costs for individuals with selected diagnoses, in order to meet the “health status” directive of HB2842
- ✓ Include a factor for the expected net increase in administrative costs associated with managing the pilot program
- ✓ Trend forward the PMPM costs from the period covered by the extract to year one of the pilot program (SFY 2008).

The next section of the report describes the methodology followed to calculate the benchmark rates. The second and third following sections contain, respectively, the benchmark values by age/aid category and disease type.

## NOTE ON INTERPRETING FINDINGS

The findings shown in this report are based on a relatively small two-county population. Some of the tables in the methodology section break-out the demographic and expenditure data into smaller groups – such as age/gender cohorts. Similarly, some of the disease-specific PMPM tables are for diagnoses affecting small numbers of beneficiaries. In both cases, the data is included for informational purposes, but should be interpreted with caution. As a rule, the larger the cell (population) sizes are within a particular rate category, the more stable the data is likely to be.

# METHODOLOGY

The benchmark costs for Comanche/Tillman counties were developed in five steps. Specifically:

- ✓ Creation of eligibility/claims extract
- ✓ Selection of analysis population
- ✓ Grouping by aid category
- ✓ Analysis by age and gender
- ✓ Incorporation of expenditure data

## ELIGIBILITY/CLAIMS EXTRACT

OHCA provided PHPG with an extract of eligibility and claims data for all Medicaid beneficiaries in Comanche and Tillman Counties. The extract, which was produced in February 2007, contained monthly eligibility files and claims with dates-of-service for the period April 2004 – June 2006 (twenty-seven months). The most recent twelve months of data – July 2005 through June 2006 (SFY 2006) – was used to calculate the PMPM expenditures; the full twenty-seven months was used to develop claims completion factors, as discussed later in the section.

The MMIS claims subsystem contains data for the vast majority of medical expenditures incurred in the Medicaid program, including capitation payments to primary care providers participating in the *SoonerCare* program. However, a small number of dollars were paid outside of the claims system over the twenty-seven month period (e.g., to out-of-state hospitals with rates negotiated for a single admission). Information on these payments was provided to PHPG in a separate file for incorporation into the larger database.

## SELECTION OF ANALYSIS POPULATION

The HB2842 two-county pilot program will be open to a subset of the Medicaid/SCHIP population: non-aged beneficiaries eligible for *SoonerCare* and not already covered by a major health insurance plan in addition to Medicaid. Because the extract contained the entire universe of Medicaid beneficiaries in the pilot counties, PHPG began by identifying and removing member months and expenditures associated with ineligible beneficiaries. This occurred in several steps.

First, the eligibility file was examined by Program Code, to identify and remove beneficiaries not enrolled in *SoonerCare*. As shown below in Exhibit 1, which separately reports Comanche, Tillman and total numbers, this resulted in the retention of about one-quarter of the total file, in terms of member months<sup>1</sup>. The retained *SoonerCare* population actually fell into categories – Indian Health Service (IHS) *SoonerCare* beneficiaries and others.

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<sup>1</sup> Member months are presented throughout the report, instead of beneficiaries, as the benchmark costs ultimately are calculated on a per member per month basis

The IHS group was flagged for further analysis as a stand alone group because of the separate pricing schedule used for payment of services rendered to IHS beneficiaries at IHS/tribal provider sites. These services are reimbursed using a 100 percent federally funded pricing schedule with higher payment rates. IHS beneficiary access to IHS/tribal providers also is protected by law and cannot be restricted through enrollment in a health plan. The results of the separate IHS analysis are presented in the next section.

The member months (and associated expenditures) falling into other eligibility categories were removed from the analysis. It should be noted that some individuals changed eligibility categories mid-month, in which case they were counted twice in that month. Also, some beneficiaries were co-enrolled in more than one program, resulting in multiple member month counts. For example, *SoonerCare* and many other Medicaid beneficiaries are enrolled with the state's non-emergency transportation vendor, resulting in their member months appearing in both categories. And the Title 19 category is an all purpose one, including most of the beneficiaries from the other categories. As a result, the total member months do not reflect an unduplicated beneficiary member month count.

PHPG chose to limit the study to only members enrolled in the SoonerCare Choice program. To ensure the integrity of the analysis, a review was completed to remove members who were enrolled in both SoonerCare and another group, with the exception of the Title 19 and Non Emergency Transportation categories.

**Exhibit 1 – Selection of SoonerCare Beneficiaries**

Program Code	Member Months			
	Comanche	Tillman	Total	Pct of Total
Child Custody	6,911	420	7,331	1.2%
DDSD Non Federal Medical	773	48	821	0.1%
DDSD Supported Living Arrangement	773	48	821	0.1%
Employer Sponsored Insurance	185	2	187	0.0%
Family Planning	10,914	917	11,831	2.0%
ICF/MR Level of Care	57		57	0.0%
Non Emergency Transportation	167,252	21,420	188,672	31.8%
PASRR NH Exams	17	5	22	0.0%
PKU	24		24	0.0%
Presumptive Eligibility	25	5	30	0.0%
Qualifying Individual Group 1	974	172	1,146	0.2%
SLMB	3,867	834	4,701	0.8%
<b>SoonerCare</b>	<b>131,465</b>	<b>16,494</b>	<b>147,959</b>	<b>24.9%</b>
SoonerCare IHS/ASO	2,274	111	2,385	0.4%
Title 19	197,852	24,608	222,460	37.5%
Tuberculosis	24		24	0.0%
Waiver Advantage	2,181	555	2,736	0.5%
Waiver Homeward Bound	36		36	0.0%
Waiver ICF/MR	1,137	156	1,293	0.2%
Waiver In Home Support Adult	375	24	399	0.1%
Waiver In Home Support Child	102	2	104	0.0%
All Others	233	13	246	0.0%
TOTAL	527,268	65,824	593,092	100.0%

✓ (Retain)  
(Analyze separately)

Note: Individuals enrolled in two or more categories in the same month are counted within each category

Although *SoonerCare* is not intended for Medicaid beneficiaries who also have Medicare coverage (“Dual Eligibles”), or who receive long term care services, a handful of *SoonerCare* enrollees were identified as falling into one of these categories or the other. The likeliest explanation is that these persons had recently moved into one of the two categories and had not yet been disenrolled from *SoonerCare*. Exhibits 2 and 3 below document the small number who were identified within each group and removed from the analysis database.

**Exhibit 2 – Removal of Long Term Care Level of Care (LOC) Member Months**

Member Months				
LOC Code	Comanche	Tillman	Total	Percent of Total
None	131,306	16,467	147,773	99.9%
ICF I	19	3	22	0.0%
SNF Pediatric	12	-	12	0.0%
Personal Care	128	24	152	0.1%
Total	131,465	16,494	147,959	100.0%

**Exhibit 3 – Removal of Dual Medicare/Medicaid Member Months**

Member Months				
Dual Status Indicator	Comanche	Tillman	Total	Percent of Total
Medicaid Only (64 and under)	131,239	16,452	147,691	99.94%
Dual	67	15	82	0.06%
Total	131,306	16,467	147,773	100%

The final group to be removed consisted of beneficiaries with major health insurance in addition to Medicaid. Exhibit 4 below identifies the types of coverage held by *SoonerCare* beneficiaries. While most had no other coverage, a small percentage had Major Medical, Medical or general Hospitalization coverage<sup>2</sup>. These coverage types were deemed substantial enough to distort the Medicaid cost profile of the beneficiaries, since a significant portion of the medical expenses potentially were being paid by another insurer.

<sup>2</sup> Note that a small number of beneficiaries with Part A and B coverage also were identified, even though persons categorized as “Dual Eligible” had already been removed from the database. The Part A/Part B beneficiaries – who were nominal in size – were removed from the database at this stage.

Beneficiaries with other types of coverage – such as dental, vision or pharmacy, were retained in the analysis database on the presumption that Medicaid would have paid a representative portion of their costs.

**Exhibit 4 – Removal of Beneficiaries with other Major Health Insurance**

Coverage Code	Member Months			Percent of Total	
	Comanche	Tillman	Total		
Accident Coverage Non-Auto	12	12	24	0.0%	✓
Dental	623	120	743	0.5%	✓
Hospitalization	27	24	51	0.0%	
Hospitalization - Surgical	37	-	37	0.0%	✓
Major Medical	9,108	1,063	10,171	6.9%	
Medical	11	-	11	0.0%	
Medicare Supplemental for Part B	34	3	37	0.0%	
Medicare Supplemental Insurance for Part A	34	3	37	0.0%	
None	112,233	14,205	126,438	85.6%	✓
Optical/Vision	178	37	215	0.1%	✓
Pharmacy	8,942	985	9,927	6.7%	✓
Total	131,239	16,452	147,691	100.0%	
Sub-Total Retained	122,025	15,359	137,384	93.0%	

**GROUPING BY AID CATEGORY**

The *SoonerCare* population consists of two major aid category groupings – Temporary Aid to Needy Families (TANF) beneficiaries and related groups and non-Medicare Aged, Blind and Disabled (ABD) beneficiaries. TANF & Related beneficiaries are primarily children (including SCHIP eligibles), pregnant women and mothers. The ABD population includes both children and adults with physical and behavioral health disabilities, although HB2842’s exclusion of persons over age 64 means the small number of non-Medicare aged beneficiaries enrolled in *SoonerCare* ultimately would be excluded from the pilot study<sup>3</sup>.

<sup>3</sup> Member months for this cohort are shown in the next table for informational purposes, but persons age 65 and older were ultimately removed from the analysis. A few persons classified as Aged were, according to their birthdates, actually below age 65. Their placement in the Aged category was likely a clerical error.

At this time, the decision also was made to separately track costs for women who qualified for Medicaid on the basis of a pregnancy. These women fell into either of two TANF & Related categories, depending on whether they qualified as an SCHIP (CHIP) or Medicaid beneficiary (see exhibit). The decision was made to model separately the impact of their costs on overall PMPM values because of their unique cost profile.

While other TANF & Related groups contain some pregnant women, the women in those groups have a separate basis for eligibility which extends beyond their period of pregnancy. By contrast, women in the two pregnancy-related groups are enrolled mid-pregnancy and usually lose eligibility shortly after giving birth. Their monthly costs therefore are much higher, on average, than the costs of other TANF & Related women.

Exhibit 5 below identifies the individual aid categories and indicates into which group – TANF & Related or ABD – each category was mapped. These groupings conform to the ones used in *SoonerCare* for payment of primary care capitation to primary care providers.

Note that women qualifying for Medicaid on the basis of having breast or cervical cancer were removed from the analysis database at this stage. This was a policy decision by OHCA based on the expectation that these women would not be enrolled in the pilot.

Note also that the subtotal carried over from Exhibit 4 is different than the total for Exhibit 5. This is due to the fact that members could be eligible for multiple aid categories or coverage codes during the same member month. Prior to developing Exhibit 5, PHPG eliminated these double counts in order to create an unduplicated member month profile for the remaining analyses.

**Exhibit 5 – Aid Category Groupings**

Aid Category	Comanche	Tillman	Total	Percent of Total	
Breast and Cervical Cancer	119	31	150	0.1%	
<b>CHIP- CN TANF</b>	<b>12,293</b>	<b>2,164</b>	<b>14,457</b>	<b>10.7%</b>	✓ TANF
CHIP-CN related to pregnancy	27	12	39	0.0%	(Track separately)
Categorically Needy, Aged	111	20	131	0.1%	✓ ABD
Categorically Needy, Disabled	518	78	596	0.4%	✓ ABD
Categorically Needy, Pregnant	5,923	705	6,628	4.9%	(Track separately)
Categorically Needy, TANF	78,754	9,669	88,423	65.3%	✓ TANF
Public Assistance, Aged	1	-	1	0.0%	✓ ABD
Public Assistance, Blind	81	-	81	0.1%	✓ ABD
Public Assistance, Disabled	14,413	1,585	15,998	11.8%	✓ ABD
Public Assistance, TANF	7,429	768	8,197	6.0%	✓ TANF
Refugee	35	-	35	0.0%	✓ TANF
Transitional Medical - TANF	717	40	757	0.6%	✓ TANF
Total	120,439	15,072	135,511	100.0%	
<i>Sub-Total Retained (excludes two pregnancy-related groups)</i>	<i>114,352</i>	<i>14,324</i>	<i>128,676</i>	<i>95.0%</i>	

**ANALYSIS BY AGE AND GENDER**

The two aid category groupings were segmented by gender and age cohort, in order to evaluate cell sizes prior to developing the benchmark PMPM values. Exhibits 6 - 8 below present the results by gender, and age cohort/gender. Based on the small number of member months observed within many of the cells, PHPG made the decision not to segment by gender, and to combine the two adults age cohorts into one category, resulting in the following segmentation: children/adolescents (ages 0 – 17) and adults (ages 18 – 64). The decision also was made to analyze Comanche and Tillman data together, given the small size of the Tillman population.

Although males and females were combined going forward, Exhibit 8 does show the number of TANF & Related member months attributable to women in the two pregnancy-related categories. Throughout the remainder of the report, TANF & Related expenditures are reported inclusive and exclusive of these women, so their effect on PMPM costs can be evaluated.

**Exhibit 6 – Aid Category by Age**

	Member Months				Percent of Total
	Age Groupings	Comanche	Tillman	Total	
<b>Aged, Blind, Disabled (Medicaid-only)</b>	0 - 17	4,770	316	5,086	30.3%
	18 -44	4,800	510	5,310	31.6%
	45 - 64	5,554	857	6,411	38.1%
	<b>Total</b>	<b>15,124</b>	<b>1,683</b>	<b>16,807</b>	<b>100.0%</b>
<b>TANF (excluding eligible due to pregnancy)</b>	0 - 17	87,998	11,583	99,581	89.0%
	18 - 44	10,583	965	11,548	10.3%
	45 - 64	647	93	740	0.7%
	<b>Total</b>	<b>99,228</b>	<b>12,641</b>	<b>111,869</b>	<b>100.0%</b>

*Additional TANF MM if pregnancy groups are included:*                      **5,950**                      **717**                      **6,667**

**Exhibit 7 – ABD Aid Categories by Age and Gender**

	Member Months				Percent of Total
	Age Groupings	Comanche	Tillman	Total	
<b>Aged, Blind, Disabled - Males</b>	0 - 17	2,986	213	3,199	19.0%
	18 - 44	2,132	267	2,399	14.3%
	45 - 64	1,936	304	2,240	13.3%
	<b>Sub-Total</b>	<b>7,054</b>	<b>784</b>	<b>7,838</b>	<b>46.6%</b>
<b>Aged, Blind, Disabled - Females</b>	0 - 17	1,784	103	1,887	11.2%
	18 - 44	2,668	243	2,911	17.3%
	45 - 64	3,618	553	4,171	24.8%
	<b>Sub-Total</b>	<b>8,070</b>	<b>899</b>	<b>8,969</b>	<b>53.4%</b>
<b>Grand Total</b>		<b>15,124</b>	<b>1,683</b>	<b>16,807</b>	<b>100%</b>

**Exhibit 8 – TANF & Related Aid Categories by Age and Gender**

	Member Months				Percent of Total
	Age Groupings	Comanche	Tillman	Total	
<b>TANF &amp; Related - Males</b>	0 - 17	44,509	6,105	50,614	45.2%
	18 - 44	1,338	188	1,526	1.4%
	45 - 64	88	22	110	0.1%
	<b>Sub-Total</b>	<b>45,935</b>	<b>6,315</b>	<b>52,250</b>	<b>46.7%</b>
<b>TANF &amp; Related - Females without persons eligible due to pregnancy</b>	0 - 17	43,489	5,478	48,967	43.8%
	18 - 44	9,245	777	10,022	9.0%
	45 - 64	559	71	630	0.6%
	<b>Sub-Total</b>	<b>53,293</b>	<b>6,326</b>	<b>59,619</b>	<b>53.3%</b>
<b>Grand Total</b>	<b>99,228</b>	<b>12,641</b>	<b>111,869</b>	<b>100.00%</b>	
<b>Additional pregnancy related member months</b>	0 - 17	184	51	235	0.2%
	18 - 44	5,757	666	6,423	5.7%
	45 - 64	9	-	9	0.0%
	<b>Total</b>	<b>5,950</b>	<b>717</b>	<b>6,667</b>	<b>6.0%</b>

**INCORPORATION OF EXPENDITURE DATA**

Once the analysis population was defined, paid claims data was appended to each beneficiary record. The claims data included: date(s) of service; provider ID; provider type; diagnosis code(s) and paid amounts.

Prior to determining expenditures by provider type, the claims data was adjusted through application of claims completion factors. Using April, 2004 as the “base month”, PHPG examined seventeen months of history to determine the percentage of claims that had been paid for three different provider type groupings: hospitals, physicians and all other categories, excluding pharmacy<sup>4</sup>.

The results of the analysis are shown in Exhibit 9 below. The paid claims data was adjusted upward by the appropriate completion factors to account for services provided in SFY 2006 for which no claim had yet been submitted and paid at the time the extract was made. (For example, 96.1 percent of hospital claims were estimated to have been paid by the time the extract was produced; hospital expenditure totals therefore were increased to reflect 100 percent of estimated payments.)

**Exhibit 9 – Claims Completion Factors**

Category of Service	Completion Factor
Hospital (Inpatient & Outpatient)	96.1 percent
Physicians/Clinics	99.4 percent
All Other (excluding pharmacy)	97.9 percent

<sup>4</sup> Prescription drugs typically are paid almost immediately and do not require a completion factor.

The paid claims data also was trended forward twenty-four months, from SFY 2006 to SFY 2008, to coincide with the anticipated first year of the pilot. PHPG used trend factors supplied by OHCA that incorporated both medical inflation and anticipated changes in per beneficiary utilization of the two-year period. These trend factors were originally developed by OHCA for budgeting purposes.

Exhibit 10 below presents the trend factors by category of service and fiscal year.

**Exhibit 10 – Trend Factors**

Category of Service	FY07 Growth (as a percentage)	FY08 Growth (as a percentage)
Behavioral Health	3.50	2.52
Clinics <sup>5</sup>	3.50	2.52
Dentists <sup>6</sup>	80.00	2.10
Home Health	3.50	13.10
Hospitals	2.70	3.35
Lab & Radiology	19.20	26.40
Managed Care	3.50	2.52
Medical Supplies	3.50	2.52
Other Practitioners <sup>7</sup>	3.50	2.52
Physicians	3.50	8.40
Prescription Drugs	10.00	6.80
Transportation	3.50	2.52

Upon application of the claims completion and trend factors, PHPG calculated total medical expenditures by category of service for each of the two aid category groupings.

**ADMINISTRATIVE ADJUSTMENTS**

Adjustments for administrative costs were made to determine the amount of money that the state can expend for coverage in private health insurance plans and remain budget neutral. A line item for SoonerCare’s estimated administrative costs was included to derive the total cost (medical and administrative) of serving the targeted populations under the current program. A separate line item then offsets the new administrative costs that OHCA would incur for issuance of the instruments of value and enrollment of beneficiaries into private health plans. The pilot’s administrative costs were calculated by assuming participants in the pilot study would have a PMPM administrative cost structure similar to that of individuals enrolled in the O-EPIC premium assistance program.

Exhibit 11 below provides expenditures by category of service<sup>8</sup> (trended to SFY 2008) for ABD beneficiaries, segmented into the two age cohorts. Exhibit 12 provides the same information for TANF & Related beneficiaries. Note that cost data for women eligible due to a pregnancy is separately reported at the bottom of Exhibit 12.

<sup>5</sup> Includes: Ambulatory Surgery Center (ASC); Clinic; ESRD

<sup>6</sup> Dental utilization grew dramatically in 2005 following introduction of a significantly higher dental fee schedule, resulting in a near doubling of expenditures. Utilization and expenditures largely stabilized in 2006.

<sup>7</sup> Includes: Advance Nurse Practitioner; Audiologist; Case Manager; Mid-level practitioner; Optician; Optometrist

<sup>8</sup> Pharmacy expenditures are net of rebates

**Exhibit 11 – ABD SFY 2008 Total Expenditures (Projected)**

Category of Service	ABD Total Expenditures		
	Age 0 - 17	Age 18+	Total
Advance Nurse Practitioner	\$17,204	\$18,469	\$35,673
ASC	\$6,141	\$15,779	\$21,920
Audiologist	\$7,983		\$7,983
Case Manager	\$3,922	\$13,187	\$17,109
Clinic	\$294,588	\$872,719	\$1,167,307
Dentist	\$37,643	\$38,857	\$76,500
DME/Medical Supply Dealer	\$208,326	\$224,645	\$432,971
ESRD	\$0	\$203,886	\$203,886
Home Health Agency	\$974	\$36,088	\$37,063
Hospital	\$480,234	\$754,070	\$1,234,304
Laboratory	\$10,549	\$45,870	\$56,420
Mental Health Provider	\$87,838	\$265,578	\$353,417
Mid-Level Practitioner	\$1,040	\$7,485	\$8,525
Optician	\$1,659	\$452	\$2,112
Optometrist	\$15,417	\$2,257	\$17,674
Pharmacy	\$660,111	\$2,078,277	\$2,738,388
Physician	\$132,675	\$502,919	\$635,595
Podiatrist	\$1,800	\$690	\$2,490
Transportation Provider	\$30,933	\$91,829	\$122,762
X-Ray Clinic	\$0	\$269	\$269
SoonerCare Administration	\$39,181	\$101,397	\$140,578
Pilot Administration	(20,090)	(46,298)	(66,388)
Total	\$2,018,130	\$5,228,426	\$7,246,556

**Exhibit 12 – TANF & Related 2008 Total Expenditures (Projected)**

Category of Service	TANF Total Expenditures		
	Age 0 - 17	Age 18+	Total
Advance Nurse Practitioner	\$341,401	\$22,852	\$364,253
ASC	\$98,767	\$4,818	\$103,585
Audiologist	\$61	\$0	\$61
Case Manager	\$48,323	\$1,612	\$49,935
Clinic	\$3,105,647	\$751,116	\$3,856,763
Dentist	\$811,358	\$86,148	\$897,506
DME/Medical Supply Dealer	\$177,856	\$19,686	\$197,542
ESRD	\$0	\$0	\$0
Home Health Agency	\$12,472	\$13,386	\$25,858
Hospital	\$3,066,572	\$616,289	\$3,682,860
Laboratory	\$120,938	\$71,904	\$192,841
Mental Health Provder	\$384,567	\$59,509	\$444,075
Mid-Level Practitioner	\$42,507	\$7,820	\$50,327
Optician	\$29,260	\$2,108	\$31,369
Optometrist	\$206,309	\$11,763	\$218,072
Pharmacy	\$1,955,692	\$564,168	\$2,519,861
Physician	\$1,413,990	\$336,509	\$1,750,499
Podiatrist	\$2,200	\$0	\$2,200
Transportation Provider	\$381,638	\$64,917	\$446,556
X-Ray Clinic	\$479	\$0	\$479
SoonerCare Administration	\$239,121	\$51,638	\$290,759
Pilot Administration	(393,345)	(48,538)	(441,883)
<b>Total</b>	<b>\$12,045,811</b>	<b>\$2,637,706</b>	<b>\$14,683,517</b>

<b>Additional - Pregnancy Groups</b>	\$105,961	\$2,324,559	\$2,430,521
<b>Revised Total</b>	<b>\$12,151,773</b>	<b>\$4,962,265</b>	<b>\$17,114,038</b>

The next section presents the PMPM values to be used in establishing the instruments of value and judging the cost effectiveness of enrollment into a private health plan.

# PMPM EXPENDITURES BY AID CATEGORY

## ABD/TANF & RELATED

The expenditure data was divided by member months to calculate a PMPM value by category of service and in total. Exhibit 13 below provides PMPM expenditures (trended to SFY 2008) for ABD beneficiaries, segmented into the two age cohorts. Exhibit 14 provides the same information for TANF & Related beneficiaries. Note that cost data for women eligible due to a pregnancy is separately reported at the bottom of Exhibit 14.

**Exhibit 13 – ABD 2008 PMPM Expenditures (Projected)**

Category of Service	ABD PMPM Expenditures		
	Age 0 - 17	Age 18+	Total
Advance Nurse Practitioner	\$3.38	\$1.58	\$2.12
ASC	\$1.21	\$1.35	\$1.30
Audiologist	\$1.57	\$0.00	\$0.48
Case Manager	\$0.77	\$1.13	\$1.02
Clinic	\$57.92	\$74.46	\$69.45
Dentist	\$7.40	\$3.32	\$4.55
DME/Medical Supply Dealer	\$40.96	\$19.17	\$25.76
ESRD	\$0.00	\$17.39	\$12.13
Home Health Agency	\$0.19	\$3.08	\$2.21
Hospital	\$94.42	\$64.33	\$73.44
Laboratory	\$2.07	\$3.91	\$3.36
Mental Health Provider	\$17.27	\$22.66	\$21.03
Mid-Level Practitioner	\$0.20	\$0.64	\$0.51
Optician	\$0.33	\$0.04	\$0.13
Optometrist	\$3.03	\$0.19	\$1.05
Pharmacy	\$129.79	\$177.31	\$162.93
Physician	\$26.09	\$42.91	\$37.82
Podiatrist	\$0.35	\$0.06	\$0.15
Transportation Provider	\$6.08	\$7.83	\$7.30
X-Ray Clinic	\$0.00	\$0.02	\$0.02
SoonerCare Administration	\$7.70	\$8.65	\$8.36
Pilot Administration	(3.95)	(3.95)	(3.95)
Total	\$396.80	\$446.07	\$431.16



**Exhibit 15 – 2008 Summary PMPM Data (Projected)**

		Overall		
		Reimbursement	Member Months	PMPM
<b>Aged, Blind, Disabled</b>	0 - 17	\$ 2,018,130	5,086	\$ 396.80
	18 and over	\$ 5,228,426	11,721	\$ 446.07
	Sub-Total	\$ 7,246,556	16,807	\$ 431.16
<b>TANF &amp; Related (excluding eligible due to pregnancy)</b>	0 - 17	\$ 12,045,811	99,581	\$ 120.96
	18 and over	\$ 2,637,706	12,288	\$ 214.66
	Sub-Total	\$ 14,683,517	111,869	\$ 131.26
<b>TANF &amp; Related (including eligible due to pregnancy)</b>	0 - 17	\$ 12,151,773	99,816	\$ 121.74
	18 and over	\$ 4,962,265	18,720	\$ 265.08
	Total	\$ 17,114,038	118,536	\$ 144.38

## ADJUSTMENT FOR OUT-OF-POCKET COSTS

The state likely would include an offset for pilot participants' out-of-pocket cost sharing obligations under a private plan. The additional cost to the state for this out-of-pocket cost adjustment will need to be offset from the PMPM costs reported in the previous section of this report.

Monthly premiums for commercial health insurance policies vary by the scope of covered benefits and the individual cost sharing obligations. Low-premium policies frequently have higher cost sharing obligations and may offer a limited scope of benefits. Conversely, high-premium policies tend to have lower cost sharing obligations and more extensive benefits.

Because premiums, cost sharing and covered benefits are inter-related and vary widely among commercial policies, adjustment for out-of-pocket costs must be done on a case-by-case basis in order to determine whether a particular commercial policy is a cost-effective alternative to coverage available through the Oklahoma Medicaid program.

The adjustment for out-of-pocket costs is made by multiplying the average utilization by the individual out-of-pocket obligations for a particular plan. Exhibit 16 on the following page presents the average utilization for Medicaid-covered services within each of the pilot's aid categories. The utilization is expressed as "average claims per member month".

**Exhibit 16 – Average Claims Utilization Summary**

Category of Service	Average Claims per Member Month			
	ABD		TANF	
	Age 0 - 17	Age 18+	Age 0 - 17	Age 18+
Advance Practice Nurse	0.13139	0.04910	0.19571	0.06687
ASC	0.00255	0.00235	0.00193	0.00072
Audiologist	0.00084	-	0.00001	-
Case Manager	0.01693	0.01742	0.00609	0.00192
Clinic	0.59999	0.71357	0.44585	0.53922
Dentist	0.02612	0.00939	0.02617	0.01960
DME/Medical Supply Dealer	0.09181	0.11946	0.00919	0.00979
ESRD	-	0.00635	-	0.00005
Home Health Agency	0.00070	0.01248	0.00044	0.00515
Hospital	0.16726	0.30890	0.06638	0.23624
Laboratory	0.01216	0.08083	0.01114	0.08544
Mental Health Provider	0.19068	0.13219	0.04019	0.05027
Mid-Level Practitioner	0.01472	0.03721	0.03459	0.03249
Optician	0.00452	0.00045	0.00358	0.00203
Optometrist	0.02554	0.00150	0.01663	0.00818
Pharmacy	1.26390	2.16399	0.37806	0.92718
Physician	1.18927	1.23347	0.94859	0.98800
Podiatrist	0.00147	0.00091	0.00012	-
Transportation Provider	1.14321	1.23632	1.09640	1.11390
X-Ray Clinic	-	0.00002	0.00007	-

The impact of out-of-pocket cost adjustments on PMPM values is provided on the following page for two sample plans. Exhibit 17 provides an example of a commercial plan with relatively low out-of-pocket obligations. As indicated in the exhibit, the impact of the adjustments is a modest reduction in the PMPM values, ranging from 5.7 to 10 percent. Exhibit 18 provides an example of a commercial plan with more typical cost sharing obligations. As indicated by this example, the out-of-pocket cost adjustment could reduce funds available for commercial premiums by as much as 36 percent.

**Exhibit 17 – Offset for Cost Sharing Adjustment: Sample Plan A**

Category of Service	Plan Cost Sharing	PMPM Offset Amount			
		ABD		TANF	
		Age 0 - 17	Age 18+	Age 0 - 17	Age 18+
Advance Practice Nurse	\$ 5.00	\$ (0.66)	\$ (0.25)	\$ (0.98)	\$ (0.33)
ASC					
Audiologist	\$ 5.00	\$ (0.00)	\$ -	\$ (0.00)	\$ -
Case Manager					
Clinic	\$ 5.00	\$ (3.00)	\$ (3.57)	\$ (2.23)	\$ (2.70)
Dentist	\$ 10.00	\$ (0.26)	\$ (0.09)	\$ (0.26)	\$ (0.20)
DME/Medical Supply Dealer					
ESRD					
Home Health Agency	\$ 15.00	\$ (0.01)	\$ (0.19)	\$ (0.01)	\$ (0.08)
Hospital					
Laboratory					
Mental Health Provider					
Mid-Level Practitioner					
Optician	\$ 5.00	\$ (0.02)	\$ (0.00)	\$ (0.02)	\$ (0.01)
Optometrist	\$ 5.00	\$ (0.13)	\$ (0.01)	\$ (0.08)	\$ (0.04)
Pharmacy	\$ 10.00	\$ (12.64)	\$ (21.64)	\$ (3.78)	\$ (9.27)
Physician	\$ 5.00	\$ (5.95)	\$ (6.17)	\$ (4.74)	\$ (4.94)
Podiatrist	\$ 5.00	\$ (0.01)	\$ (0.00)	\$ (0.00)	\$ -
Transportation Provider					
X-Ray Clinic					
<b>Total Offset Amount</b>		<b>\$ (22.68)</b>	<b>\$ (31.92)</b>	<b>\$ (12.10)</b>	<b>\$ (17.57)</b>
<b>Projected PMPM</b>		<b>\$ 396.80</b>	<b>\$ 446.07</b>	<b>\$ 120.96</b>	<b>\$ 214.66</b>
<b>Projected PMPM, Net of Adjustment</b>		<b>\$ 374.12</b>	<b>\$ 414.15</b>	<b>\$ 108.86</b>	<b>\$ 197.09</b>

**Exhibit 18 – Offset for Cost Sharing Adjustment: Sample Plan B**

Category of Service	Plan Cost Sharing	PMPM Offset Amount			
		ABD		TANF	
		Age 0 - 17	Age 18+	Age 0 - 17	Age 18+
Advance Practice Nurse	\$ 15.00	\$ (1.97)	\$ (0.74)	\$ (2.94)	\$ (1.00)
ASC					
Audiologist	\$ 15.00	\$ (0.01)	\$ -	\$ (0.00)	\$ -
Case Manager					
Clinic	\$ 20.00	\$ (12.00)	\$ (14.27)	\$ (8.92)	\$ (10.78)
Dentist	\$ 20.00	\$ (0.52)	\$ (0.19)	\$ (0.52)	\$ (0.39)
DME/Medical Supply Dealer					
ESRD					
Home Health Agency	\$ 25.00	\$ (0.02)	\$ (0.31)	\$ (0.01)	\$ (0.13)
Hospital	\$ 50.00	\$ (8.36)	\$ (15.45)	\$ (3.32)	\$ (11.81)
Laboratory					
Mental Health Provider					
Mid-Level Practitioner					
Optician	\$ 15.00	\$ (0.07)	\$ (0.01)	\$ (0.05)	\$ (0.03)
Optometrist	\$ 15.00	\$ (0.38)	\$ (0.02)	\$ (0.25)	\$ (0.12)
Pharmacy	\$ 25.00	\$ (31.60)	\$ (54.10)	\$ (9.45)	\$ (23.18)
Physician	\$ 20.00	\$ (23.79)	\$ (24.67)	\$ (18.97)	\$ (19.76)
Podiatrist	\$ 15.00	\$ (0.02)	\$ (0.01)	\$ (0.00)	\$ -
Transportation Provider					
X-Ray Clinic					
<b>Total Offset Amount</b>		<b>\$ (78.74)</b>	<b>\$ (109.76)</b>	<b>\$ (44.43)</b>	<b>\$ (67.21)</b>
<b>Projected PMPM</b>		<b>\$ 396.80</b>	<b>\$ 446.07</b>	<b>\$ 120.96</b>	<b>\$ 214.66</b>
<b>Projected PMPM, Net of Adjustment</b>		<b>\$ 318.06</b>	<b>\$ 336.31</b>	<b>\$ 76.53</b>	<b>\$ 147.45</b>

## IHS BENEFICIARIES

As discussed in the previous section, PHPG isolated IHS beneficiary data at the beginning of the analysis to allow for a separate calculation of PMPM values for this group. Exhibit 19 below presents IHS beneficiary member month and expenditure totals, by aid category grouping. While it is important to recognize that the total member months are small, it also is clear that IHS beneficiaries have significantly higher PMPM costs than their non-IHS counterparts. ABD PMPM costs are more than double, while TANF & Related costs are about 50 percent higher.

**Exhibit 19 – 2008 IHS Beneficiary Summary PMPM Data (Projected)**

		Overall		
		Reimbursement	Member Months	PMPM
<b>Aged, Blind, Disabled</b>	Ages 0 - 17	\$ 22,350	78	\$ 286.53
	Ages 18 & Over	\$ 280,532	229	\$ 1,225.03
	Sub-Total	\$ 302,882	307	\$ 986.59
<b>TANF &amp; Related (excluding eligible due to pregnancy)</b>	Ages 0 - 17	\$ 305,478	1,622	\$ 188.33
	Ages 18 & Over	\$ 65,242	256	\$ 254.85
	Sub-Total	\$ 370,721	1,878	\$ 197.40
<b>Grand Total</b>		<b>\$ 673,602</b>	<b>2,185</b>	<b>\$ 308.28</b>
<b>TANF &amp; Related (including eligible due to pregnancy)</b>	Ages 0 - 17	\$ 314,989	1,627	\$ 193.60
	Ages 18 & Over	\$ 148,723	397	\$ 374.62
	Total	\$ 463,713	2,024	\$ 229.11

The higher IHS costs are likely driven in part by poorer average IHS beneficiary health status. However, the special payment structure for IHS/tribal providers also is a factor. Exhibit 20 below breaks out total expenditures for IHS beneficiaries by IHS/tribal and other providers. As it shows, over half of the medical expenditures for these beneficiaries (including those eligible due to pregnancy) were incurred at IHS/tribal provider sites.

**Exhibit 20 – IHS/Tribal and Other Provider Expenditures**

Category of Service	IHS Comparison	
	Tribal Provider	Non-Tribal Provider
Advance Practice Nurse	\$ -	\$ 3,030
ASC	\$ -	\$ 679
Capitation Provider	\$ 5,334	\$ -
Case Manager	\$ -	\$ 4,200
Clinic	\$ -	\$ 89,015
Dentist	\$ -	\$ 10,249
DME/Medical Supply Dealer	\$ -	\$ 10,847
End-Stage Renal Disease Clinic	\$ -	\$ 14,702
Home Health Agency	\$ -	\$ 4,928
Hospital	\$ 363,437	\$ 88,172
Laboratory	\$ -	\$ 2,450
Mental Health Provider	\$ -	\$ 15,731
Optician	\$ -	\$ 972
Optometrist	\$ -	\$ 3,588
Pharmacy	\$ 73,357	\$ 59,544
Physician	\$ -	\$ 16,544
Transportation	\$ -	\$ 10,715
X-Ray Clinic	\$ -	\$ 462
Total	\$ 442,127	\$ 335,828

While the IHS/tribal provider rates are higher than standard Medicaid rates, it is important to remember that the rates are 100 percent federally funded. Thus, from a state budgetary perspective, the appropriate PMPM instrument of value for IHS/tribal beneficiaries would arguably be the net costs attributable to non-IHS/tribal providers.

## PMPM EXPENDITURES BY DISEASE TYPE

HB2842 directed OHCA to take health status into consideration when calculating the PMPM instruments of value. To comply with this mandate, PHPG developed PMPM expenditure profiles for beneficiaries with claims falling into six disease categories. These categories were selected because they represent high cost conditions that are relatively prevalent among Medicaid beneficiaries, particularly those in the ABD aid categories.

The six disease types, and their associated ICD-9 diagnosis codes, were:

1. Asthma (ICD-9 403)
2. Behavioral Health (ICD-9 290-319)
3. Congestive Heart Failure (ICD-9 428)
4. Diabetes (ICD-9 250)
5. End Stage Renal Disease (ICD-9 403)
6. Hemophilia (ICD-9 286)

In the case of behavioral health, PHPG did not isolate specific conditions, such as schizophrenia, but instead grouped all conditions in ICD-9 range 290 to 319.

The major challenge in performing the analysis was overcoming the relatively small size of the analysis sample. To ensure that all beneficiaries with particular conditions were identified, PHPG included everyone with at least one paid claim with a qualifying diagnosis. PHPG also permitted persons with more than one qualifying disease to be included in each analysis for which they qualified<sup>9</sup>.

Once all beneficiaries with a particular disease were identified, the PMPM costs for these beneficiaries were calculated. For comparison purposes, the PMPM costs beneficiaries without the diagnosis also were derived. The PMPM costs include all expenditures, not just those associated with the relevant diagnosis.

Exhibits 21 - 26 on the following pages present the PMPM values for each of the six disease types. Note that TANF & Related values do not include women from the pregnancy-related groups. Also note that population sizes for some diagnoses are very small.

Exhibit 27 at the end of the section presents PMPM values for beneficiaries not having any of the targeted diseases. As the exhibit illustrates, this residual population, which includes about 40 percent of the ABD beneficiaries and 80 percent of the TANF & Related, is significantly less costly than the segment with one or more of the targeted diagnoses: less than half as costly in the

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<sup>9</sup> In actuality, if OHCA were to establish instruments of value based on disease type, the agency would have to establish a hierarchy of classification for persons with multiple conditions, based on average cost. For example, persons with ESRD and Asthma would likely be placed in the ESRD group. After making these classifications, PMPM values would be recalibrated within the disease groups and a PMPM value also would be calculated for persons having none of the targeted diagnoses.

case of ABD beneficiaries and about a third less costly in the case of TANF & Related beneficiaries.

**Exhibit 21 – PMPM Values for Persons with Asthma (2008 Projection)**

		Aged, Blind Disabled			
		Reimbursement	Member Months	PMPM	
<b>Asthma</b>	Ages 0 - 17	\$ 608,702	876	\$ 695	
	Ages 18 & Over	\$ 1,178,251	1,448	\$ 814	
	Total	\$ 1,786,953	2,324	\$ 769	
<b>All Other</b>	Ages 0 - 17	\$ 1,409,428	4,210	\$ 335	
	Ages 18 & Over	\$ 4,050,174	10,273	\$ 394	
	Total	\$ 5,459,602	14,483	\$ 377	
		TANF (excl. eligible due to preg.)			
		Reimbursement	Member Months	PMPM	
<b>Asthma</b>	Ages 0 - 17	\$ 2,096,583	8,387	\$ 250	
	Ages 18 & Over	\$ 320,448	950	\$ 337	
	Total	\$ 2,417,031	9,337	\$ 259	
<b>All Other</b>	Ages 0 - 17	\$ 9,949,228	91,194	\$ 109	
	Ages 18 & Over	\$ 2,317,258	11,338	\$ 204	
	Total	\$ 12,266,486	102,532	\$ 120	
		All Beneficiaries			
		Reimbursement	Member Months	PMPM	
<b>Asthma</b>	Ages 0 - 17	\$ 2,705,285	9,263	\$ 292	
	Ages 18 & Over	\$ 1,498,699	2,398	\$ 625	
	Total	\$ 4,203,984	11,661	\$ 361	
<b>All Other</b>	Ages 0 - 17	\$ 11,358,656	95,404	\$ 119	
	Ages 18 & Over	\$ 6,367,432	21,611	\$ 295	
	Total	\$ 17,726,088	117,015	\$ 151	

  

Difference (Disease - Oth)	
\$	360
\$	419
\$	392

  

Difference (Disease - Oth)	
\$	141
\$	133
\$	139

  

Difference (Disease - Oth)	
\$	173
\$	330
\$	209

**Exhibit 22 – PMPM Values for Persons with Behavioral Health Conditions (2008 Projection)**

		Aged, Blind Disabled			
		Reimbursement	Member Months	PMPM	
<b>Behavioral Health</b>	Ages 0 - 17	\$ 1,630,228	2,595	\$ 628	Difference (Disease - Oth) \$ 472 \$ 306 \$ 354
	Ages 18 & Over	\$ 3,295,875	5,389	\$ 612	
	Total	\$ 4,926,103	7,984	\$ 617	
<b>All Other</b>	Ages 0 - 17	\$ 387,902	2,491	\$ 156	Difference (Disease - Oth) \$ 325 \$ 216 \$ 299
	Ages 18 & Over	\$ 1,932,551	6,332	\$ 305	
	Total	\$ 2,320,453	8,823	\$ 263	
		TANF (excl. eligible due to preg.)			
		Reimbursement	Member Months	PMPM	
<b>Behavioral Health</b>	Ages 0 - 17	\$ 2,163,915	5,037	\$ 430	Difference (Disease - Oth) \$ 391 \$ 305 \$ 390
	Ages 18 & Over	\$ 1,192,235	3,184	\$ 374	
	Total	\$ 3,356,150	8,221	\$ 408	
<b>All Other</b>	Ages 0 - 17	\$ 9,881,896	94,544	\$ 105	Difference (Disease - Oth) \$ 391 \$ 305 \$ 390
	Ages 18 & Over	\$ 1,445,471	9,104	\$ 159	
	Total	\$ 11,327,367	103,648	\$ 109	
		All Beneficiaries			
		Reimbursement	Member Months	PMPM	
<b>Behavioral Health</b>	Ages 0 - 17	\$ 3,794,143	7,632	\$ 497	Difference (Disease - Oth) \$ 391 \$ 305 \$ 390
	Ages 18 & Over	\$ 4,488,110	8,573	\$ 524	
	Total	\$ 8,282,253	16,205	\$ 511	
<b>All Other</b>	Ages 0 - 17	\$ 10,269,798	97,035	\$ 106	Difference (Disease - Oth) \$ 391 \$ 305 \$ 390
	Ages 18 & Over	\$ 3,378,022	15,436	\$ 219	
	Total	\$ 13,647,820	112,471	\$ 121	

**Exhibit 23 – PMPM Values for Persons with Congestive Heart Failure (2008 Projection)**

		Aged, Blind Disabled			
		Reimbursement	Member Months	PMPM	
<b>Congestive Heart Failure</b>	Ages 0 - 17	\$ 3,496	19	\$ 184	Difference (Disease - Oth) \$ (214) \$ 743 \$ 721
	Ages 18 & Over	\$ 977,932	862	\$ 1,134	
	Total	\$ 981,428	881	\$ 1,114	
<b>All Other</b>	Ages 0 - 17	\$ 2,014,634	5,067	\$ 398	Difference (Disease - Oth) \$ 2,454 \$ 407 \$ 823
	Ages 18 & Over	\$ 4,250,494	10,859	\$ 391	
	Total	\$ 6,265,128	15,926	\$ 393	
		TANF (excl. eligible due to preg.)			
		Reimbursement	Member Months	PMPM	
<b>Congestive Heart Failure</b>	Ages 0 - 17	\$ 48,908	19	\$ 2,574	Difference (Disease - Oth) \$ 1,245 \$ 788 \$ 933
	Ages 18 & Over	\$ 56,876	92	\$ 618	
	Total	\$ 105,783	111	\$ 953	
<b>All Other</b>	Ages 0 - 17	\$ 11,996,904	99,562	\$ 120	Difference (Disease - Oth) \$ 1,245 \$ 788 \$ 933
	Ages 18 & Over	\$ 2,580,830	12,196	\$ 212	
	Total	\$ 14,577,734	111,758	\$ 130	
		All Beneficiaries			
		Reimbursement	Member Months	PMPM	
<b>Congestive Heart Failure</b>	Ages 0 - 17	\$ 52,404	38	\$ 1,379	Difference (Disease - Oth) \$ 1,245 \$ 788 \$ 933
	Ages 18 & Over	\$ 1,034,808	954	\$ 1,085	
	Total	\$ 1,087,211	992	\$ 1,096	
<b>All Other</b>	Ages 0 - 17	\$ 14,011,537	104,629	\$ 134	Difference (Disease - Oth) \$ 1,245 \$ 788 \$ 933
	Ages 18 & Over	\$ 6,831,324	23,055	\$ 296	
	Total	\$ 20,842,862	127,684	\$ 163	

**Exhibit 24 – PMPM Values for Persons with Diabetes (2008 Projection)**

		Aged, Blind Disabled			
		Reimbursement	Member Months	PMPM	
<b>Diabetes</b>	Ages 0 - 17	\$ 110,145	117	\$ 941	Difference (Disease - Oth) \$ 557 \$ 265 \$ 280
	Ages 18 & Over	\$ 1,624,840	2,480	\$ 655	
	Total	\$ 1,734,985	2,597	\$ 668	
<b>All Other</b>	Ages 0 - 17	\$ 1,907,985	4,969	\$ 384	Difference (Disease - Oth) \$ 420 \$ 384 \$ 437
	Ages 18 & Over	\$ 3,603,586	9,241	\$ 390	
	Total	\$ 5,511,571	14,210	\$ 388	
		TANF (excl. eligible due to preg.)			
		Reimbursement	Member Months	PMPM	
<b>Diabetes</b>	Ages 0 - 17	\$ 185,482	344	\$ 539	Difference (Disease - Oth) \$ 509 \$ 360 \$ 485
	Ages 18 & Over	\$ 299,458	514	\$ 583	
	Total	\$ 484,940	858	\$ 565	
<b>All Other</b>	Ages 0 - 17	\$ 11,860,330	99,237	\$ 120	Difference (Disease - Oth) \$ 509 \$ 360 \$ 485
	Ages 18 & Over	\$ 2,338,248	11,774	\$ 199	
	Total	\$ 14,198,577	111,011	\$ 128	
		All Beneficiaries			
		Reimbursement	Member Months	PMPM	
<b>Diabetes</b>	Ages 0 - 17	\$ 295,627	461	\$ 641	Difference (Disease - Oth) \$ 509 \$ 360 \$ 485
	Ages 18 & Over	\$ 1,924,298	2,994	\$ 643	
	Total	\$ 2,219,925	3,455	\$ 643	
<b>All Other</b>	Ages 0 - 17	\$ 13,768,314	104,206	\$ 132	Difference (Disease - Oth) \$ 509 \$ 360 \$ 485
	Ages 18 & Over	\$ 5,941,834	21,015	\$ 283	
	Total	\$ 19,710,148	125,221	\$ 157	

**Exhibit 25 – PMPM Values for Persons with End Stage Renal Disease (2008 Projection)**

		Aged, Blind Disabled			
		Reimbursement	Member Months	PMPM	
<b>ESRD</b>	Ages 0 - 17	\$ 2,866	8	\$ 358	Difference (Disease - Oth) \$ (39) \$ 2,199 \$ 2,082
	Ages 18 & Over	\$ 361,449	138	\$ 2,619	
	Total	\$ 364,315	146	\$ 2,495	
<b>All Other</b>	Ages 0 - 17	\$ 2,015,264	5,078	\$ 397	Difference (Disease - Oth) \$ 8,377 \$ 910 \$ 2,333
	Ages 18 & Over	\$ 4,866,976	11,583	\$ 420	
	Total	\$ 6,882,240	16,661	\$ 413	
		TANF (excl. eligible due to preg.)			
		Reimbursement	Member Months	PMPM	
<b>ESRD</b>	Ages 0 - 17	\$ 33,992	4	\$ 8,498	Difference (Disease - Oth) \$ 2,937 \$ 2,133 \$ 2,324
	Ages 18 & Over	\$ 20,211	18	\$ 1,123	
	Total	\$ 54,203	22	\$ 2,464	
<b>All Other</b>	Ages 0 - 17	\$ 12,011,820	99,577	\$ 121	Difference (Disease - Oth) \$ 2,937 \$ 2,133 \$ 2,324
	Ages 18 & Over	\$ 2,617,494	12,270	\$ 213	
	Total	\$ 14,629,314	111,847	\$ 131	
		All Beneficiaries			
		Reimbursement	Member Months	PMPM	
<b>ESRD</b>	Ages 0 - 17	\$ 36,858	12	\$ 3,071	Difference (Disease - Oth) \$ 2,937 \$ 2,133 \$ 2,324
	Ages 18 & Over	\$ 381,661	156	\$ 2,447	
	Total	\$ 418,519	168	\$ 2,491	
<b>All Other</b>	Ages 0 - 17	\$ 14,027,083	104,655	\$ 134	Difference (Disease - Oth) \$ 2,937 \$ 2,133 \$ 2,324
	Ages 18 & Over	\$ 7,484,471	23,853	\$ 314	
	Total	\$ 21,511,554	128,508	\$ 167	

**Exhibit 26 – PMPM Values for Persons with Hemophilia (2008 Projection)**

		Aged, Blind Disabled			
		Reimbursement	Member Months	PMPM	
<b>Hemophilia</b>	Ages 0 - 17	\$ 18,253	2	\$ 9,126	
	Ages 18 & Over	\$ 34,876	52	\$ 671	
	<b>Total</b>	\$ 53,129	54	\$ 984	
<b>Difference (Disease - Oth)</b>					
					\$ 8,733
					\$ 226
					\$ 554
		TANF (excl. eligible due to preg.)			
		Reimbursement	Member Months	PMPM	
<b>Hemophilia</b>	Ages 0 - 17	\$ 7,116	30	\$ 237	
	Ages 18 & Over	\$ 11,722	16	\$ 733	
	<b>Total</b>	\$ 18,838	46	\$ 410	
<b>Difference (Disease - Oth)</b>					
					\$ 116
					\$ 519
					\$ 278
		All Beneficiaries			
		Reimbursement	Member Months	PMPM	
<b>Hemophilia</b>	Ages 0 - 17	\$ 25,369	32	\$ 793	
	Ages 18 & Over	\$ 46,598	68	\$ 685	
	<b>Total</b>	\$ 71,967	100	\$ 720	
<b>Difference (Disease - Oth)</b>					
					\$ 659
					\$ 359
					\$ 550

**Exhibit 27 – PMPM Values for Persons without a Targeted Disease**

		Non-Targeted Diseases		
		Reimbursement	Member Months	PMPM
<b>Aged, Blind, Disabled</b>	0 - 17	\$377,171	2,170	\$173.81
	18 and over	\$1,026,946	4,788	\$214.48
	<b>Total</b>	\$1,404,117	6,958	\$201.80
<b>TANF &amp; Related (excluding eligible due to pregnancy)</b>	0 - 17	\$7,617,959	81,483	\$93.49
	18 and over	\$1,249,935	8,422	\$148.41
	<b>Total</b>	\$8,867,893	89,905	\$98.64
<b>Total</b>	ABD	\$1,404,117	6,958	\$201.80
	TANF	\$8,867,893	89,905	\$98.64
	<b>Total</b>	\$10,272,010	96,863	\$106.05