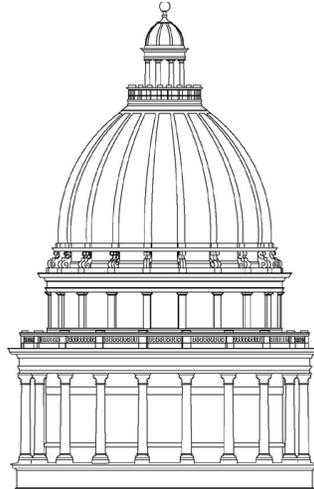


REPORT TO THE
UTAH LEGISLATURE

Number 2010-01



**A Performance Audit
of
Utah Medicaid Managed Care**

January 2010

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah



STATE OF UTAH

Office of the Legislative Auditor General

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JOHN M. SCHAFF, CIA
AUDITOR GENERAL

January 19, 2010

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of Utah Medicaid Managed Care** (Report #2010-01). A digest is found on the blue pages located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

John M. Schaff, CIA
Auditor General

JMS/km

Digest of A Performance Audit of Utah Medicaid Managed Care

The Division of Health Care Financing (HCF or Utah Medicaid program) has provided insufficient oversight over its managed care program. For fiscal year 2009, Utah's total Medicaid enrollment was just under 180,000 recipients for a total cost of about \$1.7 billion. Utah's two managed care plans served about 69,000 recipients for a total cost of \$218.4 million. The Bureau of Managed Health Care (BMHC) within Utah's Medicaid program has not been aware of the adjusted costs or utilization of the managed health care plans (health plans).

Insufficient oversight has led to higher than necessary costs in the Medicaid program. We contracted with Milliman Incorporated, a recognized leader in actuarial consulting services in the health industry, to provide risk-adjusted experience by rate cell for each of the three Utah Medicaid health plans in calendar year 2008. Milliman found that cost-saving opportunities are available for Utah. We also identified several other practices, not directly related to managed care, that if changed or improved could produce cost savings to the Medicaid program. In total, we identified about \$13 to \$19 million in potential future cost-saving opportunities for the Medicaid program. The cost savings are broken out the following way:

- **\$6-12 million** represents approximate future annual cost saving opportunities in the managed care plans that can be realized over time. This savings was identified using HCF's data and Milliman's risk-adjusted results. Additional unknown savings can be obtained by the health plans achieving "well-managed" cost and utilization status.
- **\$7 million** is an approximate overpayment by HCF for ER care that can be collected for the past year and will be a savings for following years. Also, we believe additional cost savings are available by further reducing non-emergent use of the ER.

These cost savings hinge largely on Medicaid expanding its management vision to be more dynamic, best-practice driven, and cost-savings centered.

Managed Care Plans Have Few Cost Control Incentives. In the past, the cost-plus reimbursement structure used for paying managed care plans created an incentive to increase utilization which can result in higher total costs. To correct this payment structure deficiency, Utah Medicaid should continue to seek out reimbursement methodologies that encourage cost control. However, in this structure, HCF must be diligent in its oversight and must compare plans to benchmarks to ensure the capitated rates are not set too high.

Chapter II Past Managed Care Structure Lacked Sufficient Cost Control Incentives

**Chapter III
Cost Reduction
Opportunities
Possible in
Managed Care**

Improvements To Managed Care Can Reduce Costs. Using HCF's data and Milliman's risk-adjusted results for calendar year 2008, we calculated the optimal savings possible if each of the plans could achieve the rates of the current lowest cost provider. These calculations show optimal savings of \$16 to \$20 million for calendar year 2008, of this Milliman believes that \$6 to \$12 million of annual savings can be realized in the future. We concur that \$6 to \$12 million can likely be obtained through utilizing risk-adjusted analysis. However, Milliman indicated that unknown additional savings can be achieved through improved health plan contracts, utilization management efforts, and a review of provider reimbursement levels.

**Chapter IV
Medicaid Is Not
Providing Effective
Oversight**

Current Oversight Tools Are Insufficient. The current tools used by Utah Medicaid to conduct oversight of cost and utilization of the managed health care plans are ineffective. Consequently, Utah Medicaid has not realized utilization cost savings. Utah Medicaid's current cost controls are basic, minimal oversight functions that are largely focused on compliance with federal standards and are simply not strong enough to provide insightful oversight of the health plans' cost and utilization.

To Realize Future Savings, Medicaid Must Implement Better Oversight. Utah Medicaid was not fully aware of the potential cost reduction opportunities noted in Chapter III and consequently could not capture this savings potential. To accomplish this savings, Medicaid should use claim data to understand the cost of medical services, gather administrative cost data, utilize prior authorization information, and establish appropriate contracts.

**Chapter V
Quality-of-Care
Oversight Is Good,
But Some
Improvements Still
Needed**

Utah Medicaid Can Improve Its Use of External Quality Review Data. Utah Medicaid can better use the quality-of-care information it receives through the federally mandated external quality review process. While we are encouraged with HCF's efforts in fulfilling federal requirements, we believe that Utah Medicaid can better use the external quality review process to improve health plan performance.

**Chapter VI
Medicaid Should
Implement More
Cost-Saving
Options**

Utah Medicaid Should Focus on Implementing Cost-Saving Options. Utah Medicaid can reduce expenditures by focusing on cost-saving options that reduce utilization of services while maintaining a healthy Medicaid-served population. Cost-saving options can be implemented and strengthened across the Medicaid program. For example, an HCF payment error has resulted in paying emergency room claims incorrectly. By correcting this payment error, HCF should save approximately \$7 million during the current fiscal year. Also, by instituting ER programs to redirect non-emergent use of the ER, HCF should be able to reduce expenditures.

REPORT TO THE UTAH LEGISLATURE

Report No. 2010-01

A Performance Audit Of Utah Medicaid Managed Care

January 2010

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Table of Contents

	Page
Digest	i
Chapter I	
Introduction.....	- 1 -
Delivery of Medicaid Services Is Determined by States.....	- 2 -
Managed Care Expenditures Are Increasing	- 6 -
Utah’s Medicaid Managed Care Is an Evolving Program	- 6 -
Audit Scope and Objectives	- 7 -
Chapter II	
Past Managed Care Structure Lacked Sufficient Cost Control Incentives.....	- 9 -
Structure of Managed Care Plans Varies Widely.....	- 10 -
Managed Care Plans Have Few Cost Control Incentives	- 13 -
Recommendations.....	- 23 -
Chapter III	
Cost Reduction Opportunities Possible in Managed Care	- 25 -
Improvements to Managed Care Can Reduce Costs	- 26 -
Some Improvements Possible With Disease Management	- 34 -
Recommendations.....	- 37 -

Chapter IV

Utah Medicaid Should Improve

Oversight of Cost and Utilization - 39 -

 Current Oversight
 Tools Are Insufficient - 40 -

 To Realize Future Savings, Utah Medicaid
 Must Implement Better Oversight - 44 -

 Recommendations..... - 53 -

Chapter V

Quality-of-Care Oversight Is Good,

But Some Improvements Still Needed - 55 -

 External Quality Review Process
 Provides Valuable Quality Information - 55 -

 Utah Medicaid Can Improve Its Use
 Of External Quality Review Information - 57 -

 BMHC-Required Quality Improvement Reports Need Development - 61 -

 Recommendations..... - 63 -

Chapter VI

Medicaid Should Implement

More Cost-Saving Options - 65 -

 Utah Medicaid Should Focus On Implementing
 Proven Cost-Saving Options..... - 65 -

 National Best Practices Reveal Programs
 That Utah Medicaid Should Consider - 74 -

 Recommendations..... - 80 -

Appendices..... - 81 -

Agency Response - 129 -

Chapter I

Introduction

The Division of Health Care Financing (HCF or Utah Medicaid program) has provided insufficient oversight over its managed care program. For fiscal year 2009, Utah's total Medicaid enrollment was just under 180,000 recipients for a total cost of about \$1.7 billion. Utah's two managed care plans served about 69,000 recipients for a total cost of \$218.4 million. The Bureau of Managed Health Care (BMHC) within Utah's Medicaid program has not been aware of the adjusted costs or utilization of the managed health care plans (health plans).

Insufficient oversight has led to higher than necessary costs in the Medicaid program. We contracted with Milliman Incorporated, a recognized leader in actuarial consulting services in the health industry, to provide risk-adjusted experience by rate cell for each of the three Utah Medicaid health plans in calendar year 2008. Milliman found that cost-saving opportunities are available for Utah. We also identified several other practices, not directly related to managed care, that if changed or improved could produce cost savings to the Medicaid program. In total, we identified about \$13 to \$19 million in potential future cost-saving opportunities for the Medicaid program. The cost savings are broken out the following way:

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These cost savings hinge largely on Medicaid expanding its management vision to be more dynamic, best-practice driven, and cost-savings centered.

The audit work in this report focused on the current delivery system of health care benefits through managed care organizations. We realize that various other delivery methods exist or have been considered. We also realize that health care is in a current state of reexamination. We are unaware of precisely how these other models would behave in Utah's Medicaid program. Therefore, the audit recommendations in this report focus on improving the current delivery structure.

Delivery of Medicaid Services Is Determined by States

Medicaid was established in 1965 as a joint federal-state entitlement program to provide medical services for individuals and families with limited assets and income. The federal government pays the majority of Medicaid costs in Utah, while the state provides administration. In Utah, for fiscal year 2009, the Federal Medical Assistance Percentage (FMAP) was 70.71 percent of program costs, and the state's portion was 29.29 percent. However, due to the federal stimulus plan recently passed, federal participation has increased to 77.83 percent and will continue at that level until the end of calendar year 2010.

The administrative costs of running the program are split equally between the state and federal governments. Although Medicaid is run at the state level, Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees states' Medicaid programs. States have some discretion and autonomy in administering the Medicaid program and developing policies and rules for the program; consequently, no two states' Medicaid programs are exactly alike. The delivery of physical health care in Utah is provided through managed care plans along the four Wasatch Front counties and on a fee-for-service (FFS) basis in the rest of the state.

Medicaid in Utah Employs Both Fee-For-Service and Managed Care

Two main arrangements are utilized for the delivery and payment of Medicaid physical health services in Utah: fee-for-service and managed care. In order to implement a program, such as managed

Utah administers the state's Medicaid program; the federal government pays for about 70 percent of program cost.

Administrative costs are split equally between the state and federal government.

Two main arrangements exist for the delivery and payment of physical health services in Utah Medicaid; fee-for-service and managed care.

care, that impacts the fee-for-service delivery system, a state must receive Social Security Act section 1915(b)(1) waiver authority from CMS.

The Utah Department of Health has received and implemented this authority and mandates that all Medicaid members in the four urban Wasatch Front counties (defined as Davis, Salt Lake, Utah, and Weber) be enrolled with a managed care plan. The following paragraphs illustrate the main differences between fee-for-service and managed care:

- **Fee-For-Service (FFS).** Rural FFS enrollment comprises 32 percent of the total Utah Medicaid population. Including the HCF-administered plan (Select Access) that is reimbursed on the FFS payment schedule, 61.5 percent of total Medicaid recipients are on the FFS payment schedule. With FFS, the state retains responsibility for all administrative services and costs, such as medical provider contracting for the delivery of care (Select Access has a network lease agreement), preauthorization of procedures, member services, and payment of covered health care services. Under this system, recipients are free to receive care from any certified Medicaid provider in the state. This system provides all services for the vast majority of rural recipients and covers new urban members during transition to a managed care plan. There are also certain medical services that are covered only under FFS in Utah, such as pharmacy coverage, dental services, and long-term care. These are referred to as carve-out services. FFS does not include administrative oversight functions, such as recipient case management and disease management programs to control cost and health care service utilization.
- **Managed Care.** CMS provides a broad definition of managed care that encompasses a variety of specific delivery and payment arrangements. Under this broad definition, Medicaid’s Select Access plan is counted as managed care. However, in practice only two Utah Medicaid plans actually do “managed care.” These plans are Healthy U (HU) and Molina Healthcare Utah (Molina or MHU). These plans account for 38.5 percent of the total Medicaid population. Each plan is currently contracted under a different managed care delivery and

Fee-For-Service (FFS) means the state retains responsibility for all administrative services and costs.

Managed care means the state contracts to an outside provider to deliver and pay for medical services.

The managed care plans in Utah have not been given the proper incentives to control utilization and costs.

payment arrangement; however, they all must provide the same set of medical services according to their contracts with the state. Managed care means that the health plans contract for health services, engage in utilization control methods, and provide health and disease case management to improve health and lower costs.

One main purpose of managed care is to provide an alternative delivery system to FFS that is mindful of and actively seeks potential cost savings and utilization control of medical services. This is accomplished through contracting, administrative oversight of utilization reviews, case management, disease management, and healthy behavior incentive programs. For managed care to work, there must be strong oversight and proper incentives for the health plans. Utah has had minimal cost-control incentives in place for the last seven years and, consequently, utilization of services has been high, according to actuarial review of costs and utilization discussed in Chapter III.

Most Utah Medicaid Recipients Are Not in Managed Care Programs

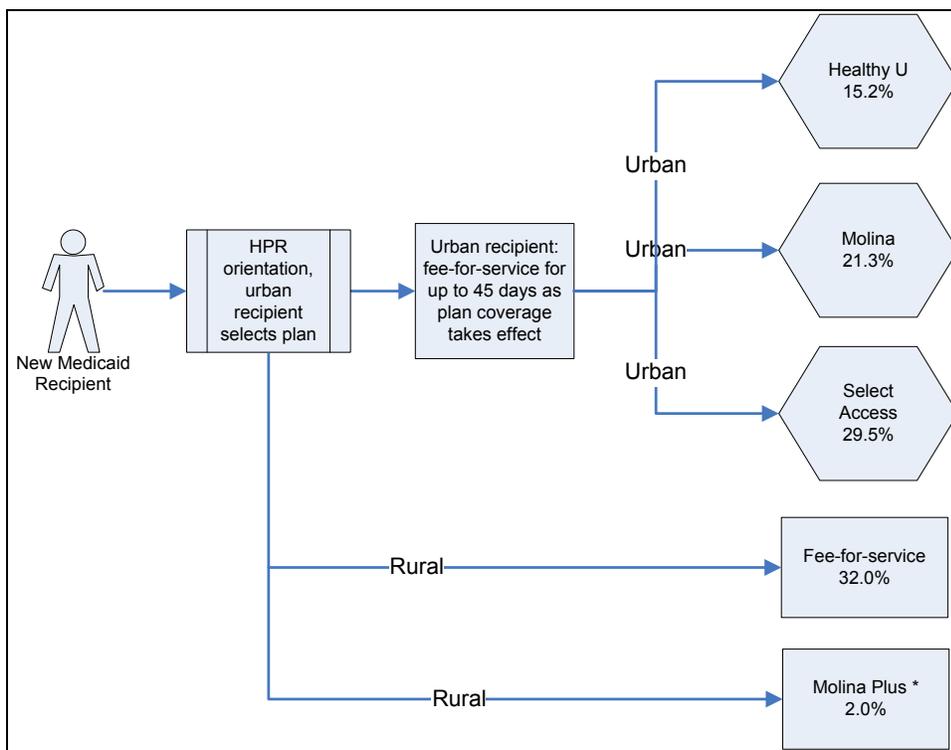
While the broad CMS definition of managed care places a large percentage of Utah Medicaid in a managed care plan, we believe that a more specific definition of managed care is more appropriate for the makeup of Utah Medicaid. The Select Access plan is a network lease with Intermountain Health Care (IHC) that is administered by Medicaid under the fee-for-service fee schedule and receives little patient case management and utilization oversight; therefore, we believe only 38.5 percent of Utah Medicaid is served under true managed care. This amounts to 61.5 percent of recipients receiving care under the FFS model.

Medicaid recipients are given 20 days to choose a managed care plan.

After an individual has received confirmation of Medicaid eligibility in the mail, he or she has a 20-day window to attend an orientation meeting with a DOH health program representative (HPR) at the Department of Workforce Services, or at a local health department in rural counties. During this orientation, the individual receives information about Utah's Medicaid program, learns of patient rights and responsibilities, and chooses a managed care plan if residing in the four urban Wasatch Front counties. Individuals who fail to

attend the orientation are assigned to a plan by the HPR. Urban recipients remain on FFS coverage for up to 45 days until their managed care coverage takes effect. Figure 1.1 shows the managed care plan selection process and plan percentages of total Medicaid enrollment.

Figure 1.1 Medicaid Plan Selection Process. This flow chart explains how urban recipients enroll in health plans and how rural recipients remain under FFS coverage. This chart breaks out the Select Access population from FFS to show a Medicaid recipient’s choices in plans. The chart also shows plan percentages of total Medicaid enrollment.



Note: The Molina Plus option, in rural areas, is not mandatory for recipients to enroll in.

After managed care plan selection or assignment in urban counties, the Medicaid recipient is given 90 days to switch to another plan if he or she desires. Then, he or she is only allowed to change plans during an annual open enrollment period that is in effect during July of each year.

In the four urban Wasatch Front counties, Medicaid recipients are enrolled into one of three health plans. In all other counties, Medicaid recipients go into FFS.

Managed Care Expenditures Are Increasing

Managed care expenditures have increased about \$39 million, or 22 percent, over the last five years. Figure 1.2 shows expenditures for each of the managed care plans for the past five years. Expenditures for Healthy U and Molina show both administrative and medical expenses.

Figure 1.2 Managed Care Plan Expenditures. This chart shows HCF's managed care expenditures for fiscal years 2005-2009.

Plan	2005	2006	2007	2008	2009
Healthy U	\$75,693,168	\$83,696,938	\$81,344,911	\$81,482,221	\$89,754,765
Molina	103,580,343	117,148,521	107,183,166	107,509,189	128,633,240
Total	\$179,273,511	\$200,845,459	\$188,528,077	\$188,991,410	\$218,388,005

Source: HCF

Expenditures for managed care have increased about 22 percent since 2005. Expenditures dropped slightly in 2007 and 2008, then peaked in 2009. As shown in Figure 2.2 in the next chapter, Medicaid enrollment has also increased during this time period.

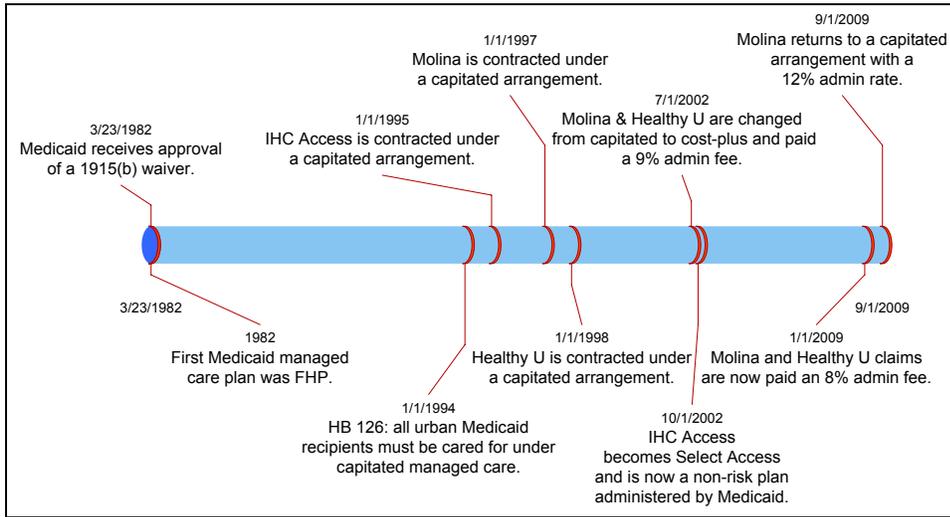
Utah's Medicaid Managed Care Is an Evolving Program

The state's Medicaid managed care program has undergone many changes over the years. The most notable change took place in 2002 when managed care plans transferred from capitated contracts to cost-plus contracts. Capitation is defined as an arrangement in which the managed care plan is paid a fixed per-member-per-month fee by the state and is at risk for changes in costs and utilization of medical services. Under a cost-plus or non-risk contract, the managed care plan receives a full reimbursement for medical services rendered, and the state carries the risk of changes in costs and utilization. We have pieced together available information during the audit to provide the most accurate record possible. Figure 1.3 shows the significant changes that have occurred during the history of managed care in Utah.

Expenditures for managed care have increased about 22 percent since 2005.

Managed care has undergone several changes over the years and is currently in a state of transition.

Figure 1.3 Utah Medicaid Timeline. This shows the significant events in the history of Utah Medicaid.



Note: A detailed timeline containing our complete history compilation is found in Appendix A.

Medicaid managed care plans were under capitated (comprehensive risk) contracts from 1995 to 2002. In 2002, Healthy U and Molina changed from capitated contracts to cost-plus or non-risk contracts and became federally defined as non-risk prepaid inpatient health plans (PIHPs). This change appears to have occurred due to one-time savings the state received in the transition of these plans. Soon after, in 2002, Select Access became a HCF administered plan that pays Intermountain Health Care (IHC) for access to their network of hospitals and providers. Therefore, for the past seven years, managed care plans have been contracted under non-risk arrangements.

Audit Scope and Objectives

We were asked to audit the Division of Health Care Financing (HCF), also known as Utah’s Medicaid program, to determine if the program is adequately administering the managed care program. The scope of the audit was to review the following objectives:

- Determine if the Utah Medicaid program is providing an adequate level of oversight over the managed care plans.

- Determine if Utah Medicaid is ensuring that the managed care plans are aware of and utilizing the most effective cost-saving, utilization-controlling, and quality-promoting programs, methods, and tools.
- Review other state Medicaid programs' cost-saving options.

Chapter II

Past Managed Care Structure Lacked Sufficient Cost Control Incentives

For the last seven years, the Division of Health Care Financing (HCF or Utah Medicaid) has had a cost-plus reimbursement structure in place for the managed health care plans (health plans); this structure has provided little cost control. The cost-plus or non-risk reimbursement structure used for paying managed care plans created an incentive to increase utilization and provided little incentive to control costs. HCF's contracted actuary, Milliman Incorporated, who is a leader in health care actuarial analysis, reported to HCF in July 2009 that additional savings were available by moving a health plan from a cost-plus contract to a capitated contract.

To correct this payment structure deficiency, Utah Medicaid should continue to seek out reimbursement methodologies, such as a capitated reimbursement system, that encourages cost control. A risk-based, capitated structure incentivizes plans to maintain costs by paying them a flat per-member-per-month (PMPM) fee. The plans make a profit by keeping their costs below the monthly PMPM fee. However, in this structure, HCF must be diligent in oversight and must compare plans to benchmarks to ensure the PMPM fee is not set too high.

Between fiscal years 2003 and 2009, the state has had three health plans: two of them were under cost-plus, and the other was administered by Utah Medicaid. University of Utah Health Plans (Healthy U) and Molina Health Care (Molina) have operated as cost-plus programs. The other HCF administered plan, Select Access, is a network lease agreement with Intermountain Health Care (IHC) for Medicaid access to their panel of providers. Medicaid does very little in the way of traditional managed care activities for the Select Access plan. Medicaid has not tracked the cost performance of the three plans and has never conducted a cost analysis to determine an appropriate level for administrative reimbursement.

For seven years, Utah Medicaid has had cost-plus contracts with managed care that have provided minimal cost control incentives.

Utah Medicaid should seek out cost control reimbursement methodologies.

Structure of Managed Care Plans Varies Widely

About 38.5 percent of Utah Medicaid is covered by “true” managed care.

The two “true” managed care plans in Utah operate primarily in the four urban Wasatch Front counties of Weber, Davis, Salt Lake, and Utah. These two plans account for 38.5 percent of Utah’s total Medicaid population. The remaining 61.5 percent of the Medicaid population is in a fee-for-service (FFS) arrangement that is administered by the state Medicaid program. This 61.5 percent is broken out between HCF’s Select Access health plan (29.5 percent) and general FFS (32 percent). While Utah Medicaid and the Centers for Medicare and Medicaid Services (CMS or federal Medicaid) call the Select Access plan a managed care plan, in functionality, it is actually a FFS plan that limits access to IHC providers and includes some basic pediatric case management.

Managed Care in Utah Is in Transition

Managed care is currently in transition with Molina entering a capitated contract effective September 1, 2009.

The structure of Utah Medicaid has remained the same since 2002, but it is now changing. After seven years of cost-plus contracting, the state entered into a capitated (comprehensive-risk) agreement with Molina effective September 1, 2009. However, Healthy U continues to operate with a cost-plus contract. The Select Access plan as noted is administered by the Utah Medicaid program. Figure 2.1 provides a brief description of Utah’s Medicaid managed care plans.

Figure 2.1 Description of Utah’s Medicaid Managed Care Plans.
Utah has three managed care plans that each operate under unique contracts.

Plan	Federally Defined Contract Type	Contract Details
Healthy U (HU)	Cost-Plus PIHP ¹	HU (belonging to the University of Utah Health Care network) is responsible for all administrative functions and costs. The state reimburses HU for all covered claims paid plus an administrative fee that has historically been 9%; thus, the state carries the risk of changes in cost and utilization. Healthy U served about 15.2% of the total Medicaid population in FY 2009.
Molina	Capitated MCO ²	On September 1, 2009, Molina entered into a capitated (comprehensive risk) contract with the state. Previously, Molina was under a similar contract as Healthy U. Molina is responsible for all administrative functions and costs. The state pays Molina a fixed per-member-per-month (PMPM) fee. Now, Molina carries the full risk of changes in cost and utilization. This arrangement encourages Molina to control utilization and contain costs. Molina served about 23.3% of the total Medicaid population in FY 2009.
Select Access (SA)	State-Run PCCM ³	This state-run plan pays Intermountain Healthcare a \$0.695 PMPM fee for access to the IHC network. The state retains all administrative functions and costs and carries the risk of changes in cost and utilization. Medical services are paid according to the Utah Medicaid fee schedule. Select Access served about 29.5% of the total Medicaid population in FY 2009.

Source: 42 C.F.R. Part 438—Managed Care

1. Prepaid Inpatient Health Plan-A plan that provides inpatient hospital services but does not have a comprehensive risk contract
2. Managed Care Organization-A federally qualified HMO that has a comprehensive risk contract
3. Primary Care Case Management-A system under which case management services are provided

The goal of a managed care plan is to reduce system cost while providing the same level of care by being proactive with the client. Both Healthy U and Molina have made efforts to identify recipients who have the greatest health care needs and to provide them with necessary, timely care to reduce costs and keep patients as healthy as possible. Each plan has contracting, case management, disease management, health management, and health incentive programs that are designed to reduce overutilization, save Medicaid dollars, and keep Medicaid recipients healthy. Select Access does not provide

Based on federal definition, Utah has three managed care plans. In functionality, Utah Medicaid actually has two plans.

Molina and Healthy U report strong managed care activities. Select Access reports no such activities.

comprehensive managed care activities. It acts primarily as a fee-for-service plan, with one exception: the plan has four pediatric nurses who provide basic care management to children.

Of the three managed care plans, Molina, by accepting a capitated cost agreement, is the only plan that currently carries the risk of changes in cost and utilization of medical services. A risk contract is defined as “a contract under which the contractor assumes the risk for cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payment under the contract.” Therefore, Molina is the only plan that fully fits the federal definition of a managed care organization (MCO) by operating under a comprehensive risk contract. Healthy U provides managed care functions and administrative responsibility but does not accept the burden of risk.

Managed Care and FFS Enrollment Populations Are Growing

For fiscal year 2009, Utah’s average Medicaid enrollment was just under 180,000 recipients. Enrollment in June 2009 reached about 195,000 recipients. Only 38.5 percent, or about 69,000 recipients, are served in one of Utah’s two comprehensive managed care plans. This means that just over one-third of Utah’s Medicaid population is served by managed care.

Due to the recent recession, there has been an influx of new Medicaid enrollment. Total enrollment population of 200,000 was reached in September 2009. Figure 2.2 provides Utah Medicaid enrollment numbers for fiscal years 2008 and 2009.

Just over one-third of Utah’s Medicaid population is in “true” managed care.

Due to the recent recession Medicaid enrollment has grown substantially.

Figure 2.2 Medicaid Enrollment. This chart shows that the average Utah Medicaid enrollment has increased 12 percent from fiscal year 2008 to 2009.

FY	Healthy U	Molina	Select Access	FFS (Rural and Urban)	Total
FY 2008	24,747	36,669	47,347	51,244	160,006*
FY 2009	27,218	41,774	52,787	57,409	179,188
% Change	+10%	+14%	+11%	+12%	+12%

Sources: Bureau of Managed Health Care & Governor's Office of Planning and Budget (GOPB)
 Note: Molina serves a small rural population known as Molina Plus. This has been added into the "Molina" population of this chart. Molina Plus is about 9 percent of the total Molina population.
 * Manual calculation of FY 2008 figures will not exactly equal total due to rounding of source data.

Average Medicaid enrollment has increased 12 percent from FY 2008 to FY 2009.

Managed Care Plans Have Few Cost Control Incentives

In the past, the cost-plus reimbursement structure used for paying managed care plans created an incentive to increase utilization which can result in higher total costs. The plans have historically been paid an additional 9 percent of claims as an administrative fee. To correct this payment structure deficiency, Utah Medicaid should continue to seek out reimbursement methodologies that encourage cost control, such as a capitated reimbursement system. A risk-based, capitated structure incentivizes plans to maintain costs by paying them a flat per-member-per-month (PMPM) fee. The plans make a profit by keeping their costs below the monthly PMPM fee. However, in this structure, HCF must be diligent in oversight and must compare plans to benchmarks to ensure the PMPM fee is not set too high.

We believe that to conduct adequate cost comparisons of the plans, in the future, it would be helpful for HCF to have more risk-based contracts. Utah Medicaid recently negotiated such a contract with Molina and is actively seeking other reimbursement methodologies for Healthy U. Currently, Healthy U is in appeal with CMS over some Medicaid payments received by the University of Utah Hospitals and Clinics that were disallowed by CMS. The details of this issue have impacted Healthy U's transition to a risk contract. Once this issue is resolved, HCF should review risk-based reimbursement methodologies for Healthy U.

The cost-plus reimbursement structure of the last seven years has provided little cost-control in managed care.

The 2009 Utah Legislature approved funding to transition Healthy U and Molina away from cost-plus and into capitated contracts.

The 2009 Legislature approved funding of Healthy U and Molina’s transition to risk-based, capitated contracts, thus signaling their intent for Utah Medicaid to move in this incentivized, cost control direction. The Legislature may also wish to provide additional policy direction for the Select Access population. We believe cost control reimbursement methodologies, such as risk-based capitated contracts, should be reviewed as an option for Select Access.

A greater number of health plans can provide the Utah Medicaid program with a means of comparing plans within a healthy, competitive environment. We understand that this may be difficult for the Department of Health (DOH), as some health insurance plans are reluctant to do business with Utah Medicaid due to past reinsurance and funding concerns.

Cost-Plus Plans Have Little Incentive to Control Costs

Molina has transitioned to capitated contracts, but Healthy U remains on a cost-plus contract.

The cost-plus structure (sometimes referred to as “non-risk”) that HCF has used for the last seven years offers little incentive to control costs. In fact, in such an arrangement, there is little incentive to manage clients. Healthy U remains on this contract structure. Cost-plus plans have an incentive not to control member overutilization because the plans get paid an administrative fee for each claim. Utah Medicaid paid a 9 percent administrative fee prior to January 2009. Due to budget cuts over the last year, the fee was reduced to 8 percent and later to 6.5 percent.

Utah Medicaid operated with capitated contracts with its health plans until fiscal year 2003. The change to cost-plus contracts was spurred by a one-time cost savings of about \$34 million that resulted from the 60-day payment delay of typical claim processing. Essentially, in fiscal year 2003, the state was able to achieve 12 months of services for 10 months of payments.

Now bringing the plans back to a capitated contract, the state had to pay 14 months of payments for 12 months of service. The 2009 Legislature funded this payout with \$9.5 million from the General Fund, or about \$31.5 million in federal and state funds. The 2009 payout of \$31.5 million is less than the \$34 million cost savings in fiscal year 2003, due to fewer Medicaid recipients in managed care in

2009. HCF did not have official enrollment numbers for 2002 but estimated that about 66 percent were in managed care in 2002, compared to 38.5 percent in 2009.

Even though federal Medicaid, or CMS, was aware of the over-utilization potential in cost-plus plans, they questioned the actuarial findings that were developed as part of the fiscal year 2010 rate negotiations for the new capitated contract with Molina. The actuary noted in its July 2009 study for HCF, that further health management savings were possible in the current cost-plus system. We believe the actuary's view is significant in that it shows the potential of cost-reduction opportunities that existed in the cost-plus (non-risk) contracts. HCF has begun to put a framework in place to reverse the cost-plus contracts by moving Molina away from cost-plus to a capitated contract in September 2009.

The results of Milliman's actuarial analysis demonstrate that greater utilization controls are available in Utah managed care. Utilization control is addressed in *Utah Code* 26-18-2.3(3), which states,

The director of the division shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.

We believe that Utah Medicaid can and must do more to control cost and utilization. Further results of the cost and utilization study can be found in the next chapter.

CMS Supportive of Utah Moving Away from Cost-Plus Contracts. CMS officials have voiced concern with the way Utah has been reimbursing its health plans. CMS officials say they are very supportive of Utah moving to a capitated plan because it promotes cost control. CMS says federal regulation allows states to choose plans and administer within those guidelines; however, it is their experience that significant challenges exist with cost-plus plans. A CMS official said that their experience is that cost-plus plans do little to contain cost.

Milliman Incorporated, HCF's actuary, reported in July 2009 to HCF that additional savings opportunities exist.

We believe Utah Medicaid can and must do more to control cost and utilization.

CMS, or federal Medicaid, told us that Utah is unusual to have had cost-plus contracts in place for so long.

CMS told us that Utah is unusual in that it has used a cost-plus arrangement for such a length of time, because of the difficulty to control costs in the cost-plus model. CMS has also told us that the cost-plus arrangement, which has been in place in Utah since 2002, is typically a short-term solution used before getting a risk contract in place. Prior to September 1, when Molina started their capitated system, 38.5 percent of the total Medicaid population was in a cost-plus arrangement.

Management of Select Access Plan Should Be Reviewed

HCF should review their Select Access plan to ensure adequate cost and utilization controls are in place.

HCF should review the management of the Select Access plan to ensure adequate cost and utilization controls are occurring for this population. Currently, the plan is not designed to provide “managed care” activities. In obtaining more care and contract management for Select Access, HCF should be aware of the administrative costs it pays to ensure additional care and contract management produces an adequate return on investment. Utah Medicaid is currently paying for some basic care management for its pediatric population in Select Access but has not adequately tracked the return on this investment.

HCF has spent about \$300,000 annually for case management but has provided little to no oversight over those providing the case management.

Utah Medicaid Has Not Provided Adequate Oversight Over Select Access Case Management. Utah Medicaid has spent about \$300,000 on case management annually for the last several years but has provided little to no oversight over those providing the pediatric case management. When we asked who provided oversight over the pediatric case management for Select Access, HCF stated that it was IHC SelectHealth’s responsibility because they were IHC employees. However, IHC SelectHealth indicated that it was HCF’s risk pool and SelectHealth was only providing network access. We agree with SelectHealth; based on the contract terms, we believe oversight should come from Utah Medicaid.

As an example of low Select Access pediatric case management, in one month the four Medicaid-paid case managers only reported three interactions with Medicaid clients for the entire month. The average monthly interactions for calendar years 2006 and 2007 were only 22.9 interactions per four case managers, or an average of only .29 interactions per day for each case manager. In 2008, interactions

jumped to a monthly average of 132, which is still only 1.65 interactions per day.

The pediatric case managers reported that they believe there are some data inaccuracies in their database, and interactions are probably higher. Utah Medicaid should have been reviewing these statistics and either correcting data problems or ensuring more productivity. Unfortunately, neither oversight nor corrections occurred.

Medicaid Infrastructure Costs and Management Capacity Should Be Reviewed. Reviewing the current Utah Medicaid infrastructure and management capacity should be part of the decision of whether to return the Select Access population to a managed care organization. Some questions that should be addressed in making this decision include the following:

- **Would Economies of Scale be Lost?** Utah Medicaid has a payment system in place for its rural FFS population and for the Select Access population. Losing the Select Access population may result in the loss of economies of scale.
- **What Staff Savings Potential Is There?** Placing more Medicaid recipients in managed care from Select Access and other rural parts of the state may produce a savings and might result in the reduction of Utah Medicaid staff and other support services.
- **Can Fraud, Waste, and Abuse Avoidance and Recovery Improve?** Our report released in August 2009 found significant problems with Utah Medicaid's ability to prevent, detect, and collect fraud, waste, and abuse. HCF should determine whether managed care is better able to prevent and recover fraud, waste, and abuse.

If the most cost-efficient scenario is to contract the Select Access population to managed care companies, HCF would need to seek out an organization to appropriately and cost-effectively manage the care. We spoke with some local health insurance companies and found there is some interest. Regence BlueCross BlueShield stated,

To date, Regence has had only limited involvement in government programs, such as Medicaid, but it is in the process of taking another look at the issue.

Some questions should be considered when reviewing the current state of the Select Access plan.

We spoke with some local health insurance companies and found there is some interest in managing Medicaid recipients.

IHC SelectHealth said,

SelectHealth would be willing to consider a financially sound and sustainable proposal for Medicaid administration.

Altius Health Care Plans stated,

Under the current funding structure of Medicaid, Altius would not be interested in taking on Medicaid membership on an at-risk basis; however, if the funding or structure of Medicaid in Utah were to change Altius would consider a new Medicaid arrangement.

There are regional and national organizations that may also be interested in doing business in Utah.

Moving more physical health care clients to managed care plans with proven track records in efficiency and effectiveness has a potential to benefit the state. Utah Medicaid would still need to be able to closely monitor any health plan to ensure the plan was providing appropriate benefit to the Medicaid program for the administrative cost paid to the plan.

Expanding Managed Care Into Other Parts of the State Should Be Explored

Utah Medicaid should determine the feasibility of expanding managed care to more areas of the state. The Legislature should provide policy guidance on this decision. However, before an informed decision is made on this topic, HCF must better understand the benefits of managed care. We believe the cost-plus system of managed care has not adequately revealed benefits of risk-based capitated managed care. Figure 2.3 lists the top five rural counties and remaining counties by total medical expenditures, including pharmacy costs. This figure provides a reference for medical costs that could potentially be a part of a managed care contract.

Utah Medicaid should review the feasibility of expanding managed care to more areas of the state.

Figure 2.3 Total Rural County Medicaid Expenditures. This chart shows that about \$209 million in medical services was expended in the rural counties of Utah for calendar year 2008.

	Washington	Cache	Iron	Tooele	Carbon	Remaining 20 Rural Counties
Total Expenditures	\$37.9	\$30.3	\$18.3	\$18.0	\$14.1	\$90.0

Source: Milliman Cost Data
 Note: Dollar amounts in millions

Outside the four Wasatch Front counties, there were just over 53,000 Medicaid recipients who utilized about \$209 million worth of medical and pharmacy services in calendar year 2008. Under the assumption that managed care plans are more cost-effective than FFS, we believe significant savings of medical services could be achieved by expanding managed care to certain rural areas of Utah. Washington and Cache Counties should especially be reviewed for full managed care implementation.

Since managed care is currently in a transition period from cost-plus to capitated, it is difficult to estimate future saving opportunities that could be obtained from managed care. We do not believe the cost-plus contracts are a good benchmark of potential future savings. Utah Medicaid should track this information and provide data to the Legislature for policy guidance.

Other States Have Successfully Implemented Managed Care in Rural Areas

Several other states have implemented managed care in the rural areas. We recognize that each state approaches Medicaid differently, but best practices can still be gleaned from other states’ experiences.

Arizona reports that they have placed about 95 percent of their state’s Medicaid recipients in managed care. Arizona is similar to Utah in that it has a large urban area with vast rural areas. Arizona achieved this implementation rate by paying capitation rates that reflect what health care use should be rather than paying historical use rates. Also, Arizona has contracted separately with managed health plans in each of the state’s 15 counties. This resulted in the development of many small to medium health plans in rural areas that had sufficient enrollees to be financially viable.

About \$209 million in Medicaid expenditures was expended in the rural counties of Utah for CY 2008.

Several other states have implemented managed care in rural areas of their states.

Tennessee and Hawaii have fully implemented capitated managed care statewide. Oregon has been able to achieve managed care in all but two of its smallest counties. Florida and Michigan pay financial incentives to the plans for participating in rural areas, and Florida reports they are looking into tying rural areas to urban areas in contracting by requiring a health plan to service a rural area in exchange for a contract in an urban area. Indiana and Ohio have also reported the implementation of managed care of 70.5 and 95 percent, respectively, of their Medicaid eligibles in rural areas.

A 2005 study of Minnesota's Medicaid program by the National Rural Health Association found that Minnesota achieved cost savings by implementing managed care in rural areas. The study states,

Minnesota's shift from fee-for-service (FFS) Medicaid to MMC [capitated managed care] in its rural counties had little effect on access to health care for either adults or children. Because Minnesota reports that Medicaid costs under MMC are below expected costs under FFS Medicaid, it appears that the primary accomplishment of Minnesota's rural MMC initiative is one of cost savings: MMC provides the same access to care as FFS Medicaid, but at lower cost.

We understand there are potential barriers to extending managed care implementation. A report submitted to CMS in 2004 by the Urban Institute found several barriers can exist for managed care in rural areas:

Among the barriers [states] faced were securing health plan participation, limited provider competition, provider resistance, and local area opposition. The findings suggest that rural programs can work but that states need to make an honest assessment of what MMC model is feasible in their state, given its unique character and circumstances.

To help overcome some of the potential difficulties and concerns of implementing managed care in Utah's rural areas, Utah Medicaid should ensure it has adequate and competent data on the potential benefits of managed care and then seek guidance and policy clarification from the Legislature.

A study of Minnesota's Medicaid program found that Minnesota achieved cost savings by implementing managed care in rural areas.

We understand that some barriers exist to extending managed care that HCF would need to overcome.

HCF Can Achieve Greater Efficiencies In Managed Care Enrollment Process

We believe Utah Medicaid, by making changes to its managed care enrollment process, can create an incentive for its lowest-cost managed care provider and realize efficiencies that could translate into dollar savings.

HCF Should Review Feasibility of Creating an Auto-Assign Process to Incentivize the Lowest-Cost Health Plan. A way of incentivizing health plans to be the lowest-cost provider is to auto-assign new Medicaid recipients to the lowest-cost plan, in the recipients' geographical area, if the new recipient has not chosen a plan during the open enrollment period. Arizona reports doing this and has found it a successful and cost-effective method of assigning Medicaid recipients to health plans if recipients do not choose themselves. We believe Utah Medicaid should seek a waiver from CMS to auto-assign to the lowest-cost provider.

HCF Should Review Streamlining Enrollment Process. Approximately \$193 million in calendar year 2008 was spent in the four urban Wasatch Front counties on all physical health claims before Medicaid recipients were assigned to a health plan. Accordingly, these expenditures were made on the Medicaid fee-for-service fee schedule. To the extent the health plans have favorable contracting agreements, getting recipients into managed care sooner takes advantages of those agreements. Also, the health plans mentioned to us that for some recipients it is important they get the recipient as soon as possible to fully impact and improve the recipients' care. This is especially true in pregnant women. About one-third of all births in Utah are reimbursed by Medicaid.

Federal regulations require Medicaid to cover recipients 90 days prior to their applications. Little could be done to impact this coverage. However, Utah Medicaid can expedite recipients into managed care sooner once eligibility has been determined. The large non-managed care expenditures occur for the following four reasons:

- Federal regulation requires Medicaid coverage 90 days retroactively from the date of application.
- It can take the Department of Workforce Services (DWS) up to 30 days to determine applicant eligibility.

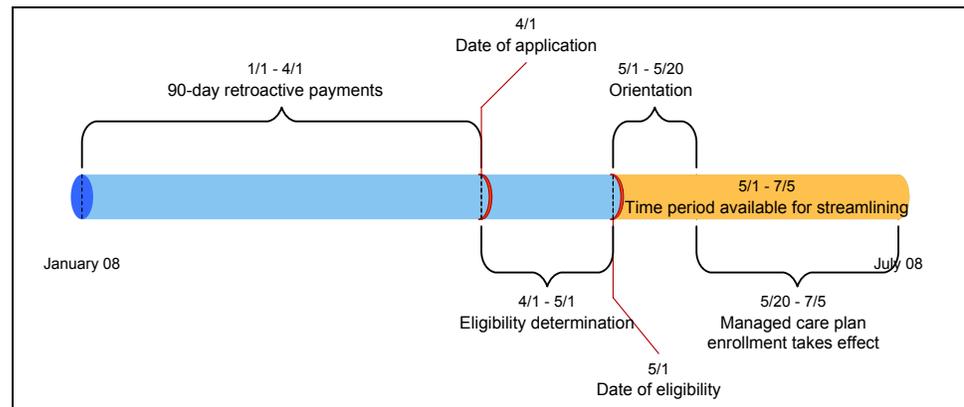
HCF can incentivize the health plans to become the lowest-cost provider by auto-assigning new Medicaid recipients that do not choose a plan.

Utah Medicaid should review ways of enrolling new recipients into managed care sooner after eligibility has been determined.

- Utah Medicaid practice provides recipients a 20-day window to complete a Medicaid orientation and choose a managed care plan before auto-enrollment.
- Managed care plan choice or auto-enrollment can take up to 45 days to take effect, depending on the time of the month plan selection is made.

Figure 2.4 illustrates the possible duration of FFS coverage by new Medicaid recipients in the urban counties.

Figure 2.4 FFS Coverage of New Urban Medicaid Recipients. This shows the possible duration of FFS coverage before managed care enrollment takes effect in urban counties. The yellow shading shows the time span that Utah Medicaid can most likely affect.



Due to federal regulation, it would be difficult, or impossible, to affect a recipient’s medical claims during the 90-day retroactive period. The extent to which DWS can shorten the eligibility determination was not specifically reviewed in the audit, but we understand some of the delays occur due to recipient delays in supplying DWS with required information. While that process may be difficult to affect, HCF can change its assignment process after eligibility is determined.

Specifically, we believe that changes to the orientation and plan enrollment procedures can shorten a recipient’s time under FFS coverage, effectively shifting coverage responsibility to the managed care plan sooner. There are two ways to reduce the duration of FFS coverage.

Medicaid should review policies to streamline managed care enrollment after eligibility has been determined.

Medicaid should review decreasing the open enrollment period and increasing enrollment from once to twice a month.

- Shorten the orientation and plan selection window from 20 to 10 days.
- Increase managed care plan enrollment from once to twice a month.

Utah Medicaid currently only processes plan enrollment once per month. We believe increasing plan enrollment processing to twice per month could be an effective way to reduce the FFS utilization of new recipients. Medicaid should review what, if any, additional administrative support would be needed to accomplish this change.

Recommendations

1. We recommend that Utah Medicaid appropriately incentivize the health plans to reduce utilization and contain costs.
2. We recommend that Utah Medicaid develop a Request for Proposal (RFP) to encourage more managed care organizations to enter the state.
3. We recommend that Utah Medicaid review ways to achieve more cost control in its Select Access plan. This could be achieved by turning the population over to a managed care plan, or through other proven, cost-effective methods.
4. We recommend the Legislature provide policy guidance to Utah Medicaid on appropriate cost control reimbursement methods and require Medicaid to submit progress reports to them on this issue.
5. We recommend that Utah Medicaid review the viability and potential benefits of expanding managed care into more areas of the state. The Legislature should use Utah Medicaid's information to provide policy guidance on this issue.
6. We recommend that Utah Medicaid seek a waiver from Federal Medicaid to develop a method of auto-assigning members to the lowest-cost managed care plan after a recipient's open enrollment period has expired.

7. We recommend that Utah Medicaid review methods of accelerating the process of assigning Medicaid recipients to a managed care plan.

Chapter III

Cost Reduction Opportunities Possible in Managed Care

The Division of Health Care Financing's (HCF or Utah Medicaid) Bureau of Managed Health Care (BMHC) has not provided adequate oversight over the managed health care plans' utilization and costs. We contracted with Milliman Incorporated, a recognized leader in actuarial consulting services in the health industry, to provide risk adjusted calendar year 2008 experience by rate cell for each of Utah's three Medicaid health plans.

Using HCF's data and Milliman's risk-adjusted results for calendar year 2008, we calculated the optimal savings possible if each of the plans could achieve the rates of the current lowest cost provider. These calculations show optimal savings of \$16 to \$20 million for calendar year 2008, of this Milliman believes that \$6 to \$12 million of annual savings can be realized in the future. We concur that \$6 to \$12 million can likely be obtained through utilizing risk-adjusted analysis. However, Milliman indicated that unknown additional savings can be achieved through improved health plan contracts, utilization management efforts, and a review of provider reimbursement levels.

Each of these strategies will require time to implement. Some of the strategies may also require initial budgetary increases for funding either changes to current infrastructure or other associated transition costs. Savings are dependent on the health plans moving away from cost-plus contracts. Further, Milliman's unit cost and benchmarking analysis shows that additional saving opportunities exist in the level of provider reimbursement and better utilization controls by Utah's health plans.

We believe it is Utah Medicaid's oversight responsibility to ensure that the plans are operating at well-managed levels. However, Utah Medicaid's oversight has been insufficient. Strong oversight was especially pertinent in the prior seven years when the plans were on a cost-plus system that rewarded higher utilization which resulted in higher total costs. Had Utah Medicaid's oversight been more focused on cost, it appears costs in Medicaid could have been lower.

Utah Medicaid, or HCF, has not provided adequate oversight over the managed health care plans' utilization and costs.

\$6 to \$12 million of annual savings can be realized in the future.

Improvements to Managed Care Can Reduce Costs

Under the assumption of optimal plan performance and using Milliman's risk-adjustment calculations, we identified approximately \$16 million to \$20 million (about \$4.8 to \$6 million in state dollars) in excess costs in calendar year 2008. Milliman told us that of this optimal performance they believe \$6 million to \$12 million can be realized in annual cost savings. We concur that \$6 to \$12 million can likely be obtained through utilizing risk-adjusted analysis.

Milliman is recognized by many as the leader in health care actuarial cost analysis. Several state Medicaid programs, including Utah, utilize Milliman for Medicaid-specific actuarial analysis. Excess costs in Utah's Medicaid managed care program can be illustrated in the following three ways:

- **Per-Member-Per-Month Costs (PMPM).** The risk-adjusted PMPM combines costs and utilization into one unit. Reviewing PMPMs of both medical costs and medical plus administrative costs shows potential savings opportunities.
- **Cost Analysis.** Looking at PMPM medical costs plus administrative costs reveals the full cost of managed care to the state. This analysis also provides a framework for future cost reduction opportunities.
- **Benchmarking.** Benchmarking Utah's lowest medical cost provider shows some further cost reduction opportunities are obtainable.

Utah Medicaid has not realized potential cost reduction opportunities due to the following three reasons. First, as previously discussed, the cost-plus structure of the contracts over the last seven years did not encourage significant cost and utilization management. Second, Utah Medicaid's oversight of the plans' expenses did not include adequate claim data until recently to determine the relative risk-adjusted costs of the three plans. Third, Utah Medicaid has not deployed enough cost-saving strategies. To obtain all possible savings from excess utilization and costs in future years, Medicaid must develop and implement additional cost-savings strategies.

Actuarial Analysis Shows Cost Reduction Opportunities

Again, for purposes of this audit, we engaged actuaries at Milliman Incorporated, a nationally recognized leader in health care actuarial consulting, to develop a risk-adjusted model that reflects PMPM relative costs that include both utilization rates and unit costs. Risk-adjustment, as described by Milliman, “calculates a health status factor for a population through the assignment of condition categories to individuals based on a review of medical claims and pharmacy data.” In essence, a risk-adjustment adjusts for the health of the plans’ populations so comparative analysis can be completed. Milliman’s full report can be found in Appendix C.

Results of the actuary’s study show a potential for significant cost reduction in future managed care contracts. The actuary states,

The overall risk-adjusted experience differences can reflect opportunities for savings to the State under the potential implementation of a health status-based payment methodology.

Milliman acknowledges some limitations to their analysis, including the fact that the review is a one-year snapshot and that it does not include a review of either administrative expenses or risk margins. The actuary’s analysis focuses only on the cost and utilization of provided physical health care. For purposes of our report, in some instances, we have adjusted for administrative expenses. Even with the stated limitations to the analysis, the actuary believes cost-saving potential exists. The actuary states,

Despite these limitations, the review of risk-adjusted experience between plans provides a strong foundation for identification of opportunities for savings to the state.

We agree that through future, better management of the plans, there is the potential for cost-savings for the state.

Milliman used a risk-adjusted model to calculate relative costs of the health plans.

Milliman study shows cost-saving opportunities are available to the state.

Per-Member-Per-Month (PMPM) Analysis Reveals Cost Reduction Opportunities

Risk-adjusted PMPMs of the health plans reveal the lowest-cost plan.

Reviewing risk-adjusted PMPMs for the three health plans reveals the lowest-cost plan. Looking just at how the plans managed physical health costs and utilization clearly shows that Healthy U is the state's least expensive plan. When including administrative costs, Healthy U is still the lowest-cost plan. However, due to Select Access' lower administrative rates, Select Access is the lowest-cost plan in some instances.

Utah Medicaid does not know the actual medical and administrative costs of the health plans.

Select Access is the plan administered by Utah Medicaid and claims limited managed care activities; administration of the plan is estimated at 2.5 percent of Medicaid program costs. Molina and Healthy U report extensive managed care activities; they were paid a 9 percent administrative rate during the analysis time period. HCF paid the plans this extra rate to compensate for the costs of providing managed care and to provide a profit margin. We find it concerning that HCF never verified Molina's or Healthy U's actual administrative costs.

Further, Utah Medicaid has not conducted an analysis to identify if the plans are producing savings favorable to the administrative costs of the plans. Utah Medicaid has been engaged in a federally required process that determines if the plans' costs were equal or less per service than the predetermined Medicaid rates, called the upper limit test or upper payment limit (UPL). However, the UPL does not take into account utilization and thus has not revealed the plans' performance (discussed more in the next chapter).

We reviewed the plans' PMPMs for medical costs and for medical costs plus administrative rates.

Figure 3.1 shows that by including administrative rates into the plans' PMPM costs (PMPMs factor cost and utilization) in some instances, Medicaid has not been getting a good return on its managed care plan investment. This is not to say that managed care cannot be productive; rather, we believe the analysis shows that the combination of a cost-plus system within a managed care system may not be ideal. This appears particularly true for Molina which, when factoring in the administrative rate paid, shows a rather large cost divide. HCF should conduct careful analysis in the future to ensure the value of managed care is, at a minimum, equal to the administrative load paid to the plans.

Figure 3.1 PMPMs With and Without Admin Cost, CY 2008. This figure shows the best performing plan by rate cell. The plan that achieved the best outcomes by rate cell is referred to as the lowest-cost plan. PMPMs without administrative costs (light blue) and with administrative costs (dark blue).

PMPM Physical Health Costs (Medical Costs)				
Rate Cell	Lowest-Cost Plan	Molina	Select Access	Healthy U
Male Children (1-18)	Healthy U	\$99	\$106	\$94
Male Adults (19-64)	Healthy U	385	320	306
Female Children (1-18)	Healthy U	100	103	92
Female Adults (19-64)	Healthy U	331	314	295
Disabled Male (All Ages)	Healthy U	749	668	663
Disabled Female (All Ages)	Healthy U	755	714	689
Male Babies (Birth to1 yr)	Healthy U	189	197	174
Female Babies (Birth to1 yr)	Healthy U	177	235	157
Pregnancy (All Ages)	Molina	479	485	491
PMPM Physical Health + Administrative Costs (Cost to State)				
Rate Cell	Lowest-Cost Plan	Molina	Select Access	Healthy U
Male Children (1-18)	Healthy U	\$108	109	102
Male Adults (19-64)	Select Access	420	328	334
Female Children (1-18)	Healthy U	109	106	100
Female Adults (19-64)	HU/SA	361	322	322
Disabled Male (All Ages)	Select Access	816	685	723
Disabled Female (All Ages)	Select Access	823	732	751
Male Babies (Birth to1 yr)	Healthy U	206	202	190
Female Babies (Birth to1 yr)	Healthy U	193	241	171
Pregnancy (All Ages)	Select Access	522	497	535

Source: Milliman Incorporated and OLAG analysis of Milliman
 Administrative rates are 9% for Molina and Healthy U and 2.5% for Select Access.

PMPMs shown above reveal costs and utilization for all physical health, including pharmacy costs. The plans do not manage pharmacy costs, but they do manage the physicians who prescribe the pharmacy benefit. Milliman states, “[pharmacy costs] are included in this analysis because member participation in managed care should have a direct impact on prescription drug experience.” To be sure that pharmacy costs did not skew the above analysis, we isolated pharmacy costs out of the PMPMs shown above and found that very little changed.

We believe the cost-plus reimbursement methodology of the last seven years has been a misrepresentation of managed care.

We believe the information in Figure 3.1 does not necessarily indicate that Select Access, or essentially no managed care, is less expensive than managed care. Rather, we believe, it shows that the cost-plus reimbursement methodology of the last seven years is a misrepresentation of managed care. The state has been paying for managed care that was costing considerably more than the program's benefit. Utah Medicaid may have been paying too much for these health plans. Going forward in a capitated managed care environment, rates should decrease and savings should increase with improved contracting and case management. HCF needs to develop and implement a cost-savings vision to fully realize the state's cost reduction opportunities.

Cost Analysis Shows Strong Opportunities To Save Medicaid Funds in Future Contracts

Using Milliman's adjusted PMPM and methodology we were able to determine that significant cost reduction possibilities existed in CY 2008.

Milliman's adjusted PMPM costs by credible rate cell can be used to estimate calendar year 2008 savings and provide a foundation for future cost reduction opportunities. These rates can also be adjusted for administrative rates paid to the health plans to better understand total plan costs. Our estimation of \$16 to \$20 million in optimal cost reduction opportunities for calendar year 2008 includes these administrative rates. Milliman believes realizable savings is \$6 to \$12 million.

We believe this analysis is a good estimate of optimal potential cost reduction opportunities because it shows actual achieved cost and utilization measures by Utah Medicaid health plans. The plan that achieved the best outcomes by rate cell is referred to as the lowest-cost plan. Since the outcomes are comparable through risk-adjustment, it is reasonable to expect that the other plans can and should achieve lowest-cost status. Figure 3.2 shows analysis based on claims data submitted by Medicaid to Milliman. We reviewed portions of Milliman's analysis and found it credible.

Figure 3.2 Managed Care Excess Cost, CY 2008. This figure shows the lowest-cost Utah plan by credible rate cell, including administrative costs. Between \$16 and \$20 million in optimal cost reduction is possible. The \$16 million lower estimate is due to adjusting for the outlier in Select Access' costs of female babies.

Cost Reduction Opportunities				
Rate Cell	Lowest-Cost Plan	Molina	Select Access	Healthy U
Male Children (1-18)	Healthy U	\$565,839	873,886	0
Male Adults (19-64)	Select Access	792,080	0	11,047
Female Children (1-18)	Healthy U	877,976	692,278	0
Female Adults (19-64)	Healthy U	1,724,541	34,239	0
Disabled Male (All Ages)	Select Access	1,982,007	0	355,604
Disabled Female (All Ages)	Select Access	1,921,990	0	479,429
Male Babies (Birth to1 Yr)	Healthy U	931,990	951,178	0
Female Babies (Birth to1 Yr)	Healthy U	1,097,799	5,131,162	0
Pregnancy (All Ages)	Select Access	852,982	0	595,622
Plan Total		\$10,747,203	\$7,682,743	\$1,441,702
Potential Cost Reduction		¹\$19,871,648		
² Percentage of Plan Budget		9.66%	4.27%	1.72%

Source: Auditor analysis based on Milliman methodology

1. As explained below, we estimate potential cost savings between \$16 and \$20 million; the range adjusts for the female baby outlier in Select Access.
2. Percentage of savings is based on credible rate cells in 4 urban Wasatch Front counties.

From the analysis in Figures 3.1 and 3.2, it can be concluded that Utah Medicaid's oversight over utilization and cost has been insufficient. Utah Medicaid, by not being aware of the plans' risk-adjusted relative costs, has not been able to seek after cost reduction opportunities.

Potential savings for female babies in the Select Access plan are significant. A detailed review of claims for calendar year 2008 shows some significant claims for female babies in the Select Access plan. HCF officials told us that it is typical to have a few abnormally expensive babies each year in the Medicaid system. However, even if the costs of female babies were similar to male babies in calendar year 2008, the analysis still provides about \$16 million in excess cost for calendar year 2008 under optimal conditions.

The cost reduction opportunities shown in Figure 3.2 are calculated by taking the difference between the cost of the best-performing plan and the cost of the other plans and then multiplying the difference by the annual-member-month enrollment.

By each of the plans achieving the lowest available cost we estimate that there is potentially \$16 to \$20 million of optimal savings.

Utah Medicaid's oversight over utilization and cost has been insufficient and has cost the state millions of dollars in calendar year 2008.

Understandably, there are certain limitations to this methodology that the actuary identifies, such that an analysis conducted for a different time period may produce different results. Also, we recognize that obtaining full cost savings potential may take some time to achieve. As well, some of the strategies may also require initial budgetary increases for funding either changes to current infrastructure or for other transition costs.

However, we agree with the actuary that the analysis provides a strong foundation that supports significant cost reduction potential in future managed care contracting. However, to achieve this potential savings, Utah Medicaid must improve its oversight.

In addition to lower costs, there may be additional benefits to the state from contracting with managed care plans. For example, managed care plans may offer additional access to care, in that they entice physicians to participate in Medicaid through higher reimbursement than FFS. All potential benefits of managed care should be considered, in context, with any discussion of managed care in the state.

Benchmarks Show Some Improvement Still Possible for Utah's Best Performer

Healthy U, overall, achieved the lowest-cost irrespective of administration costs. We asked Milliman to benchmark Healthy U's performance against best practices of other states' Medicaid plans to understand if Healthy U achieved peak performance. Benchmark results show that more utilization control can be achieved by Healthy U.

Multistate benchmark information in Figure 3.3 shows that, in most areas, Healthy U is an average performer when considered against well to loosely managed plans. Any extent to which Healthy U and Utah's other plans could further reduce cost and utilization may produce additional cost reduction opportunities for the state. HCF should be diligent in its oversight role to ensure that the health plans are operating at acceptable cost and utilization rates.

In addition to cost savings, additional benefits can be derived through managed care plans.

Benchmarking shows that improvements can be achieved by Healthy U, the state's lowest-cost health plan.

Figure 3.3 Healthy U Benchmark. Milliman benchmarked Healthy U's utilization rates in key categories. The benchmark shows some improved utilization control is possible.

Utilization Rates per 1,000 Member Months							
Population	Inpatient Surgical	Inpatient Maternity	Inpatient Hospital	Outpatient ER	Outpatient Surgery	Outpatient Hospital	Office Visit
Benchmark Well-Managed	65	140	415	323	42	743	2,447
Healthy U	93	151	522	433	61	628	2,427
Benchmark Loosely Managed	121	171	636	780	65	1,689	2,719

Source: Milliman Incorporated
 Not all categories are shown. See Appendix C for full results.

According to Milliman, “A loosely managed benchmark is for a Medicaid managed care plan with very few utilization controls. A well-managed benchmark is for a Medicaid managed care plan with several utilization management programs, and may not necessarily be achieved in the most rigorously managed plans.” Utah Medicaid should establish appropriate benchmark goals for the plans and track the plans’ progress in reaching the goals.

HCF Must Ensure Appropriate Cost Reduction Is Realized in Future Contracts

To realize potential cost reduction opportunities in the future, Utah Medicaid should engage in contracting that, where appropriate, establishes costs at lowest-cost levels. In other words, the health plans should be expected to reduce costs and utilization to appropriate lowest-cost levels.

Also, as discussed in the previous chapter, HCF should seek out ways of reducing excess cost and utilization in the Select Access plan, either by contracting with another health plan or through implementing other cost-effective methods to bring medical costs down to lowest-cost levels.

Such cost-saving strategies are used by other states’ Medicaid programs. For example, Arizona regularly compares their plans to

Healthy U appears to be an average plan with some bright spots.

Utah Medicaid should engage in contracting that, where appropriate, establishes contracts at lowest-cost levels.

look for the lowest-cost provider. Arizona then establishes rates with all of its health plans based on the lowest-cost provider. Chapter IV discusses this in more detail.

Some Improvements Possible With Disease Management

Milliman's summary cost analysis of members with chronic illness shows some bright spots and some areas where greater improvement can be achieved by some of Utah Medicaid's health plans. Recent health outcome measures for Molina and Healthy U show both plans are above the national average on 55 percent of the most applicable and measurable standards. Further, Molina has been recognized nationally as one of the top 50 Medicaid health plans in terms of performance quality. We are encouraged by this information and the efforts of the health plans. Our concern is centered on Utah Medicaid's lack of cost oversight. There is little evidence that Medicaid has tracked or targeted costs for health care and disease management services. Utah Medicaid must become more cost control oriented.

Overall PMPMs of Members with Chronic Illness Shows Disparity in Cost

Managed care plans often focus on improving health outcomes of recipients including those with chronic diseases or other health issues. The plans also report an effort to deliver these services at a low cost. Quality outcomes of health care delivery by the plans, as reported in the Healthcare Effectiveness Data and Information Set (HEDIS) measures, appear to be good. Both Molina and Healthy U are above the national average in some key areas. Our concerns are with Utah Medicaid's lack of oversight over costs.

For example, health outcomes for Molina and Healthy U are fairly similar, though costs are substantially different. HCF was unaware of the cost information. Figure 3.4 shows that when rates are risk-adjusted, Molina is more expensive in every rate cell and is substantially more expensive for disabled care.

Recent health outcome measures by the plans are encouraging. Our concern is centered on Utah Medicaid's lack of cost oversight.

Both Molina and Healthy U are above the national average in some key quality measures. However, cost has greatly varied.

Figure 3.4 Chronic Illness Cost Review. This figure shows how the managed care plans are performing in health and disease management. The figure shows the top five diagnoses occurring in each rate cell; see footnote at the end of the figure for the diagnoses by rate cell. PMPMs are risk-adjusted.

Combined Rate Cell	Molina PMPM	Molina PMPM + Admin	SA PMPM	SA PMPM + Admin	HU PMPM	HU PMPM + Admin
¹ Children (1-18)	\$107	\$117	\$102	\$105	\$104	\$113
² Adults (19-64)	377	411	311	319	308	\$336
³ Disabled (all ages)	1,051	1,146	688	705	606	661
⁴ Pregnancy (all ages)	400	436	388	398	347	378
⁵ Babies (birth-1yr)	\$211	\$230	\$179	\$183	\$178	\$194

Source: Milliman Incorporated and OLAG analysis of Milliman

Administrative rates are 9% for Molina and Healthy U and 2.5% for Select Access.

1. Top 5 disease conditions included are psychiatric medium low, pulmonary low, cardiac, gastro low, depression/psychosis/bipolar.
2. Top 5 disease conditions included are gastro low, pulmonary medium, substance abuse low, depression/psychosis/bipolar, pulmonary low.
3. Top 5 disease conditions included are pulmonary very high, depression/psychosis/bipolar, pulmonary medium, CNS high, CNS low.
4. Top 5 health/disease conditions included are pregnancy complete, depression/psychosis/bipolar, gastro low, substance abuse low, pulmonary low.
5. Top 5 disease conditions included are gastro low, pulmonary medium, gastro high, cardiovascular medium, infectious medium.

Factoring in administrative costs, Select Access is the lowest-cost provider for disease management in three of the five categories. From costs shown in Figure 3.4, fluctuations in PMPMs for children and pregnancy are relatively small compared to other categories. This makes it appear that the plans may focus on children and pregnant women.

Costs shown in Figure 3.4 are risk-adjusted. Risk-adjustment takes into account the relative health of each plans' population and adjusts costs accordingly. Milliman's Exhibit 7 shows raw costs for the plans. For example, this exhibit shows that for babies, Molina's raw costs are the lowest; however, so is their risk score. Thus, to make a comparable analysis, each plans' costs are adjusted in accordance with its risk score. In this case, Molina's costs are adjusted higher to account for the relative healthiness of their population. Risk-adjustment is necessary to make accurate comparisons among plans.

Healthy U shows favorable costs for the disabled and for pregnancy. Select Access has favorable costs for children and babies.

Lastly, we recognize that Milliman’s analysis is based on one year of experience and, in some cases, relatively low populations. Consequently, future analysis may produce different results. However, Molina’s current capitated rates are based on the same year’s data, and any possible fluctuations are reflected in their current capitated rates. Further, Milliman’s analysis clearly shows potential for future cost reduction opportunities. Medicaid should seek out these cost reduction opportunities in the future and ensure the appropriate amount is realized.

Disease Management for Children And Pregnancy Appears Encouraging

While there appears to be a disparity in costs for most rate cells, costs are closer aligned for children among the three plans. This may reflect a particular focus the health plans have placed on children. For example, HCF has contracted out for some basic care management in the Select Access plan for children. About 55 percent of Medicaid recipients in managed care are children. Also, the health plans have mentioned that pregnancy is a particular focus of theirs. For example, Molina said, “a robust education program has been implemented for pregnant members called ‘Motherhood Matters.’” Figure 3.5 breaks out the PMPM by service category for children.

Costs are closer aligned for disease management in children and pregnant women.

Figure 3.5 Chronic Conditions for Children 1-18. Milliman reviewed the disease management of children for the top 5 most occurring diagnoses in the population. Results show total PMPM rates for medical costs to be fairly similar.

Service Type	Molina		Select Access		Healthy U	
	PMPM	PMPM + Admin	PMPM	PMPM + Admin	PMPM	PMPM + Admin
Inpatient Medical	\$13	\$14	\$14	\$14	\$19	\$21
Emergency Room	16	17	13	13	13	14
Other OP Hospital	9	10	11	11	5	5
Physician	24	26	17	17	28	31
¹ Total	\$107	\$117	\$102	\$105	\$104	\$113

Source: Milliman Incorporated and OLAG analysis of Milliman Administrative rates are 9% for Molina and Healthy U and 2.5% for Select Access. Utilization numbers are per 1,000 member months. Top 5 disease conditions included are psychiatric medium low, pulmonary low, cardiac, gastro low, depression/psychosis/bipolar.
 1. Total reflects some other costs not shown above. See Milliman's report for full analysis.

It appears that Molina has a favorable utilization and cost mix for inpatient medical costs, while Healthy U has a substantial cost and utilization advantage for other outpatient hospitals. Select Access has a favorable cost advantage in physician costs, which may be due to fairly low reimbursement levels to physicians under the FFS payment schedule. HCF should be aware of all of these potential cost savings and implement measures when appropriate. Up to this point, there seems to have been very little done to ensure the state is receiving the best care for the lowest available cost.

Recommendations

1. We recommend that, in the future, Utah Medicaid better compare Utah managed care plans through risk-adjusted analyses. Utah Medicaid should also benchmark Utah's plans to other well-managed plans.
2. We recommend that Utah Medicaid develop appropriate performance goals, including cost and utilization goals, that can determine if the managed care plans are contributing adequate value to the Utah Medicaid program. Utah Medicaid should then hold the plans accountable to these goals.

Each plan has a favorable cost mix in different service areas, though Select Access's total costs are slightly cheaper than the other plans.

HCF should be aware of the cost-saving potential of the health plans.

3. We recommend that Utah Medicaid help facilitate the sharing of good health management practices between plans.
4. We recommend that the Legislature direct Utah Medicaid to report to them on cost savings obtained through future contracting with the managed care plans.

Chapter IV

Utah Medicaid Should Improve Oversight of Cost and Utilization

The Division of Health Care Financing (HCF or Utah Medicaid) has provided little oversight over costs and utilization of the health plans. Utah Medicaid has chosen to primarily focus on fulfilling federal requirements on quality of care and enrollment data. While quality of care is important, oversight over cost and utilization should also be higher priorities for HCF, especially considering the cost-plus reimbursement structure that has been in place the last seven years that encouraged overutilization. Quality-of-care oversight is discussed in the next chapter.

Utah Medicaid has not established a clear cost reduction strategy. Our contracted actuary, Milliman, did not conduct a detailed analysis in this area, but believes from related experiences that significant cost savings can be achieved through improved health plan contracts, utilization management efforts, and a review of provider reimbursement levels.

Further, HCF has not implemented performance goals that demonstrate a correlation between reported cost control efforts by the health plans and actual outcomes. Instead, Utah Medicaid has focused primarily on mandated federal oversight that was not designed to review utilization trends. Consequently, Utah Medicaid does not know which plan is most cost-effective or which plan has the best controls over utilization of medical services.

Compliance has been the goal of Utah Medicaid in the past; we would like to see a greater proactive response to the plans through increased oversight. We believe Utah Medicaid should have had risk-adjusted costs sooner; this information could have aided the Legislature in funding risk-based capitated contracts sooner.

Utah Medicaid has provided little oversight over the health plans' costs and utilization.

Utah Medicaid does not know which of its plans are most cost-effective or which plans have the best controls over utilization.

Current Oversight Tools Are Insufficient

The current tools used by Utah Medicaid to conduct oversight of cost and utilization of the managed health care plans are ineffective. Consequently, Utah Medicaid has not realized utilization cost savings. Utah Medicaid's current cost controls are basic, minimal oversight functions that are largely focused on compliance with federal standards and are simply not strong enough to provide insightful oversight of the health plans' cost and utilization.

Utah Medicaid must improve this oversight to realize potential cost-saving opportunities discussed in Chapter III. A variety of proven cost control tools are being used by other Medicaid agencies, as well as private insurance, that should be implemented in Utah Medicaid. The next section of this chapter details some of these oversight methods. Below is a list of the current, inadequate oversight tools currently being used by HCF:

- **Upper Limit Test.** This test reviews the health plans to ensure they are not paying any more than what Utah Medicaid would cumulatively pay for the same services. However, it has no utilization measure. So, a health plan might pay the same or less for a procedure but not attempt to control utilization of the service. This test is a minimal oversight tool required by the federal government, yet Utah Medicaid has been out of compliance with this test and was on corrective action until December 2009.
- **Early Periodic Screening Diagnosis and Treatment (EPSDT).** This is another federally required program that is intended to help ensure children are given adequate medical care. Utah Medicaid told us that they use the federal program to track utilization because the federal government requires the tracking of child health evaluations. HCF indicated that evaluations are increasing, but they were not able to correlate this information to actual utilization oversight.
- **Administrative Tools.** When we pressed HCF for cost and utilization oversight activities, they reported the use of several

Utah Medicaid must improve its oversight to realize potential cost-saving opportunities.

administrative tools as cost and utilization oversight and performance measures. However, they were unable to report how the tools are used to track and measure cost and utilization performance. We do not believe these administrative tools are adequate oversight tools.

Upper Limit Test Does Not Review Utilization

The upper limit test or upper payment limit (UPL) is currently the primary cost control used by Utah Medicaid managed care. This test is not, by itself, an adequate cost and utilization control. The upper limit test is a review of claim costs. The test reviews the cost of the health plans' claims against Utah Medicaid's allowed claims costs. The test also ensures the health plans are only reimbursing for services allowed in the contract between HCF and the plan. If the test shows the health plans paid the same or less than what Utah Medicaid would have paid for the same procedure, then the plan passes the test.

The upper limit test does not measure system utilization; therefore, health plans can have excessively high utilization of medical services that goes undetected. Consequently, this test does not get to the heart of what the health plans are paid to do—control utilization and cost. In this instance, Utah Medicaid should develop additional measures to control costs in addition to the federally required upper limit test. The most accurate way to test for cost and utilization control is to risk-adjust plan populations and compare costs to identify relative plan effectiveness. The next section of the report discusses in more detail the changes Utah Medicaid needs to make to its oversight.

Utah Medicaid attempted a risk-adjusted comparison in 2005 but did not have good data from the plans and, therefore, could not rely on the results from the test. Instead, Utah Medicaid has used the upper limit test which, because of unreliable information, was not completed for fiscal years 2003 through 2007. Even though the information was not accepted by the Center for Medicaid and Medicare Services (CMS), Utah Medicaid paid one plan a \$1.5 million dollar bonus under a savings sharing provision. This payment was made after unofficial upper limit test results showed total claims costs plus administration costs were lower than Utah Medicaid's allowed claims costs. CMS has not fully accepted the upper limit test results

The upper limit test by itself is not an adequate cost or utilization control tool.

and put Utah on corrective action for failing to comply with the upper limit requirement between 2003 and 2007.

According to DOH data, preliminary results of a 2007 upper limit test and the 2008 test show the plans passed the upper limit test; however, when the administrative payments are factored in, the plans were more expensive than Utah Medicaid in fiscal year 2007 and cheaper in fiscal year 2008. Consequently, for the last seven years, when Utah Medicaid has been on the cost-plus model, Utah Medicaid has not known which plans have been performing well or poorly and thus has not been able to react to the plans' performance. Had Utah Medicaid understood the plans' costs they could have communicated this information to the Legislature and received policy direction on how to ensure Medicaid funds were adequately safeguarded.

EPSDT Is an Unclear Utilization Measure

Early Periodic Screening Diagnosis and Treatment (EPSDT) is another federally required test. EPSDT tracks the child health evaluation screenings of children based upon a recommended schedule. The BMHC told us that this test is a utilization tool because it tracks certain services provided to children. However, BMHC was not able to adequately demonstrate how it was being used to measure their effort in increasing utilization.

Utah Medicaid tracks early childhood screenings in hopes that the screenings are occurring more frequently over the years. The more children who are screened and receive the needed vaccinations, the higher the utilization for this procedure, and the healthier the children should be. The utilization data provided us does demonstrate that the screenings are taking place at an increasing rate. It also appears that positive outcomes have been achieved for children and their families. It is, however, unclear what is being done beyond tracking to increase the screenings or review utilization trends. The data provided to us focuses on federally required tracking of the evaluations, and not what Utah Medicaid is doing to positively effect the change. Utah Medicaid should better utilize this information to understand the reasoning behind an increasing rate and then use the information to increase plan performance.

For the last seven years, HCF has not known which plans have been performing well or poorly.

Utah Medicaid should better utilize the EPSDT data to develop a strategy to increase screenings.

Administrative Tools Are Not Cost and Utilization Performance Measures

Many performance measures listed by Utah Medicaid are better defined as business statistics. Performance measures are measurable, specific procedures that can measure the effect of increased effort on a specific target. Utah Medicaid reports access to care and membership growth as two performance measures they use and track. While these measures provide important information, they are not measures of output or oversight effort.

Access to Care Is Not a Cost and Utilization Performance Measure. Utah Medicaid is required under federal regulation, 42 CFR part 438.52 to provide and track access and choice of providers to Medicaid clients. This information is federally required to show the state's program meets federal standards; however, the information is not a performance measure. The BMHC claims that access to care does measure performance because managed care organizations, in their opinion, get greater participation from health care providers due to their favorable contracts with the providers. It is, therefore, a valuable resource in increasing Utah Medicaid clientele access. While that information is helpful, it does not demonstrate HCF oversight over cost and utilization. Also, access to care could also be increased with the introduction of more managed care organizations and greater competition among the different groups.

Tracking Membership Growth Is Not a Cost and Utilization Performance Measure. Utah Medicaid tracks membership growth as a standard cost identification practice. However, membership growth is clearly not a performance measure of the success of managed care, as there are numerous reasons for growth in membership. Utah Medicaid management does believe that managed care organizations (MCOs) are better equipped to keep pace with the administrative burden of increasing enrollment. This belief is based on the premise that private organizations are better able to react to changes, whereas HCF must rely on legislative funding.

HCF incorrectly listed business statistics as cost and utilization performance measures.

Utah Medicaid was unaware of cost-saving potential in managed care; consequently they have not sought after it.

To Realize Future Savings, Utah Medicaid Must Implement Better Oversight

As discussed in Chapter III, Milliman estimates that \$6 to \$12 million can be realized in future years utilizing risk-adjustment analysis. Milliman also identified the potential for additional savings through improved health plan contracts, utilization management efforts, and a review of provider reimbursement levels. We also believe that additional cost savings potential exists through improved oversight by Utah Medicaid.

Utah Medicaid has not been fully aware of these cost reduction opportunities and consequently has not captured this savings potential. To realize this savings in the future, Utah Medicaid must have better information for its contract negotiations with the health plans. HCF recently began this process by moving Molina away from a cost-plus contract to a capitated contract. To continue improving its oversight over the plans, Utah Medicaid should do the following:

- **Use Claim Data to Understand Risk-Adjusted Relative Cost of Medical Services.** Utah Medicaid should use claim data to better track utilization and cost trends, thus ensuring the health plans are at appropriate, well-managed levels.
- **Gather Administrative Cost Data:** A key component of managed care oversight is the payment of administrative costs. Utah Medicaid has not calculated their own administrative costs and does not know the administrative costs of the health plans.
- **Utilize Prior Authorization Information:** A key utilization control tool for Utah Medicaid is prior authorization. Utah Medicaid has not conducted adequate oversight over the health plans' prior authorization practices. This lack of oversight may be responsible for some of the high utilization trends.
- **Establish Appropriate Contracts:** Utah Medicaid should implement contracts with the health plans to ensure that adequate cost savings are achieved. HCF should seek appropriate cost savings from all of its contracted plans.

Utah Medicaid Is Not Adequately Using Claim Data to Understand Costs

Utah Medicaid already has one of the most important pieces of information that it needs for oversight—claim cost data. Claim data is submitted to Utah Medicaid monthly by each of the plans and used as the basis for reimbursement. Unfortunately, Utah Medicaid has not adequately used this information to compare the plans for cost and utilization. Consequently, Utah Medicaid has not been able to identify the relative performance of each plan.

The system developed by Utah Medicaid to receive the claim data is called the Medicaid Managed Care System (MMCS). The director of the Bureau of Managed Care explains the MMCS system's use in the following way:

The system is used to make capitation payments, to send the HIPAA[Health Insurance Portability and Accountability Act] 834 eligibility transactions to the health plans, to pay our non-risk contract encounter claims, enroll clients into managed care plans, enroll clients into primary care case management; it holds information for Utah Medicaid providers, Molina providers, and Healthy U providers and provides a means of managing workflow for the health program representatives, etc.

MMCS could also be used to measure utilization of different services among plans to determine if the plans are adequately managing care and keeping utilization at appropriate levels. In the future, this information could also be used to measure whether per-member-per-month (PMPM) rates are appropriate within capitated plans and to compare plans to identify effective cost-saving measures.

Risk-Adjusted Plan Comparison Is an Important Tool That Utah Medicaid Has Not Adequately Utilized. In order to appropriately compare costs and utilizations, risk-adjusted claim data is necessary. Utah Medicaid has not used a risk-adjusted analysis of its cost-plus contracts to determine if the plans were appropriately containing utilization and adequately controlling costs. Until recently, Utah Medicaid did not have good claim data from the two cost-plus health plans. Utah Medicaid attempted such an analysis in 2005, but due to data problems, the analysis could not be used. Consequently, no analysis or plan comparison has been done for at least seven years.

Utah Medicaid has not adequately used claim data to compare plans for cost and utilization.

Utah Medicaid was unable to provide any analysis of relative cost savings between plans.

Utah Medicaid management said that they did not conduct risk-adjustments of the plans because the cost was prohibitive. Utah Medicaid was unable to provide any analysis of relative cost savings between the plans. We believe that the cost of the risk-adjustment is small when compared to the savings generated from better rates derived from better data. A risk-adjusted analysis will likely cost around \$100,000 to \$140,000 (\$50,000 to \$70,000 in state funds) but the potential for savings can be significant. For example, as shown in Chapter III the risk-adjusted analysis we contracted for identified about \$6 to \$12 million in potential savings for future years. Risk-adjusted analysis should be done regularly when comparing plans. Combining a cost comparison analysis with a good utilization monitoring tool would help Utah Medicaid provide better oversight to the health plans.

Some other states use their claim data to provide greater oversight over their health plans.

Some Other States Perform Greater Cost Oversight. Most of these other states use capitated contracts with their health plans. Some of these states use their claim data to provide a significant amount of oversight through further analysis of the data. At least one other state has their plans compete in their cost structures and uses the data to compare plans for cost savings. Competition has kept prices down and driven out those health plans that were not efficient in managing their health care. Utah has been unique in its use of cost-plus contracts. We believe more cost control could occur in the cost-plus contracts than what HCF has been doing, though we recognize capitated contracts are more suited to cost control.

Arizona frequently analyzes claim information, collecting and analyzing monthly claim data to identify best plan practices. The Arizona Medicaid director supports the need for plan oversight, stating:

Sometimes health plans aren't incentivized to look for lowest cost. We have to give them that discipline to look for the lowest cost place to provide the service. If they have no risk they are just going to pass it on to the state. They don't care. The only reason why our plans care is because we look at their data and say, "you can save money here and if you don't we are going to take it out of your rates anyway." So we give the plans ample opportunity to address the issue and then monitor to see if they are addressing the issue appropriately.

Arizona also tracks the profit margin of the care plans through the claim data and caps it at 3 percent. If a plan is making too much profit (over 3 percent), its contract with the health plans can be renegotiated to reflect a smaller profit rate. Additionally, the Arizona Medicaid group will look at specific areas and compare plans to see which plans operation is the most cost-effective. They will then direct the other plans to utilize programs that have been shown by utilization tracking to be successful. If a plan cannot meet the new pricing standard, then it must explain why to the satisfaction of Arizona Medicaid, or its contract is not renewed.

Similar to Utah's program, Tennessee's Medicaid program requires health plans to submit monthly claim data. However, unlike Utah, Tennessee uses this data to conduct a medical loss ratio report, which tracks revenue and losses of their MCO groups. Tennessee's Medicaid program (TennCare) sets annual goals and benchmarks for each of the MCOs which are then held to those standards. The plans are required to explain any goal variances, including payment claim accuracy errors and long payment times. TennCare tracks the various MCOs because they believe that slow payment and denial of payments are symptoms of poor financial management.

Oklahoma tracks their ER utilization through quarterly submitted encounter data to identify frequent users and to look for over- and underutilization of services. Once frequent users are identified, they are assigned to a case management tier based upon their level of ER utilization. These clients are managed until they reach an acceptable level of ER utilization.

Florida performs managed care site visits as a routine part of their oversight. These site visits review all aspects of the managed care plans. Utah Medicaid was performing onsite visits as part of a quality review but eliminated those and allowed the external quality review organization(EQRO) to handle the quality review.

**Similar to Utah,
Tennessee's Medicaid
program requires
health plans to submit
monthly claim data.**

Utah Medicaid is Unaware of Administration Costs For Its Select Access Plan

When asked for the cost analysis done to set the administrative rate, none could be provided by the state Medicaid office.

Utah Medicaid is unable to justify the administrative fee paid to the health plans because they have not been fully aware of their Select Access plan's costs. When we asked for the cost analysis done to set the administrative rate, the Utah Medicaid office could not provide anything. We were told that the 9 percent administrative fee that was in effect for the cost-plus contracts (Molina and Healthy U) from 2002-2008 was agreed upon through negotiation with department heads and health plan directors. The previous risk-based contracts in effect prior to 2002 had a 12 percent administrative fee, so Utah Medicaid felt justified in this negotiation of a lower rate.

Utah Medicaid could not provide any analysis that determined actual administrative costs of its Select Access plan. We asked Utah Medicaid to provide a current analysis of Medicaid program costs associated with administering physical health to Medicaid clients exclusive of Molina and Healthy U for the last five years. Utah Medicaid provided us an analysis, which shows a five-year average of 1.2 percent for its internal administrative expenses for Select Access.

However, this analysis does not appear to include all costs, such as division management costs, contractual services, and maintenance contracts of software systems. In fact, the finance director of Utah Medicaid said he thought their administrative rate was probably between 2 and 4 percent. The Utah Medicaid Director reports that total administrative costs for all programs it administers (including non-physical programs) is about 3 percent. Our calculations estimate that the Utah Medicaid administrative expenses for all activities associated with processing claims is around 2.5 percent.

We believe that Utah Medicaid's lack of understanding of its Select Access plan's administrative costs and that of its managed care plans is problematic.

We believe that Utah Medicaid's lack of understanding of the Select Access administrative costs and that of its managed care plans is problematic. If Utah Medicaid does not understand its own administrative rates, then they cannot adequately assess those of the health plans.

In addition to not identifying administrative costs, Utah Medicaid has not made a determination of acceptable profit margins for the plans. Subtracting Utah Medicaid's estimated administrative rate of

2.5 percent for non-managed care systems from the historical 9 percent given the managed care plans shows that 6.5 percent is paid for managed care activities. Figure 4.1 shows the state’s payment to each plan for providing managed care activities.

Figure 4.1 Health Plan Administration Costs. If Utah Medicaid has a 2.5 percent administrative load, then the managed care plans should have been providing administrative functions worth 6.5 percent (with profit).

Health Plan	FY 2008 6.5% Admin cost
Healthy U	\$5.3 Million
Molina	7.0 Million
Total	\$12.3 Million

The figure identifies that the state paid an additional \$12.3 million in fiscal year 2008 for the third-party managed care administration of the cost-plus system. We recommend Utah Medicaid complete an administrative cost and profit analysis and present it to the Legislature for review. Lack of sufficient cost information continues to be a problem in management of the new capitated system. Since HCF never identified the administrative expense margin from actual expenses, Utah Medicaid does not know where to set the administrative margin. CMS allows up to a 15 percent administrative margin, but expects the administrative rate to be set on actual costs. The upper boundary of the actuary’s analysis was 12 percent, and the state set the capitated administrative cost rate at that value. The administrative rate is one of several factors included in the final capitated rate.

Reviewing Prior Authorization Rates Is an Important Monitoring Tool Not Used by HCF

Utah Medicaid has not been collecting prior authorization data from the health plans. This information can be effectively used as a utilization monitoring tool. The use of prior authorizations in Utah Medicaid is particularly important in that Utah Medicaid, unlike private insurance, cannot control utilization through co-pays and benefit restrictions. We found that Molina’s approval rates were substantially higher than Utah Medicaid’s and Healthy U’s. We believe that this discrepancy demonstrates higher utilization in the Molina plan. This information could have been utilized by Utah

Since HCF does not know the administrative cost of its Select Access plan, they could not set an appropriate capitated rate.

We found that Molina’s approval rates were substantially higher than Medicaid’s and Healthy U’s.

Medicaid to aid in controlling costs through stricter utilization controls.

Utah Medicaid’s five-year-average prior authorization data differs substantially from that provided by Molina and Healthy U. Utah Medicaid’s five-year average is also inconsistent with other data they have provided; therefore, we do not find it credible and decided not to report it. Utah Medicaid’s 2008 calendar year data appears more accurate and is consistent with Healthy U’s approval rate. Figure 4.2 shows the results of Molina’s and Healthy U’s five-year prior authorization averages.

Figure 4.2 Prior Authorization Approval Rates. The following prior authorization approval rates were reported to us by the health plans. Molina’s rates appear abnormally high. Utah Medicaid should have been investigating these rates to ensure appropriate utilization trends.

Health Plan	5-Year-Average Prior Authorization Approval Rate ¹
Molina	98.63%
Healthy U	90.20%

Source: Molina and Healthy U

1. Molina’s five-year average is from FY 05 to FY 09. Healthy U provided information from FY 04 to FY 08.

Had Utah Medicaid been tracking approval rates, they could have been alerted to potential high utilization.

Healthy U’s average is consistent with Utah Medicaid’s calendar year 2008 approval rate of 88 percent that was previously reported to us. However, Molina’s approval rate appears high. Had BMHC been tracking Molina’s approval rates, they would have been alerted to and would have addressed the higher utilization occurring in Molina. Unfortunately, Utah Medicaid conducted no such oversight.

Health Plans Have Approved Restricted Procedures.

Insufficient policies and criteria led to Utah Medicaid approving questionable procedures to the detriment of cost avoidance or utilization control. The health plans have also approved many procedures that are restricted pursuant to Utah Medicaid policy. We did not determine if these procedures were appropriate and medically necessary, but due to the concerns we found in our last audit, we feel Utah Medicaid should be more involved in oversight over these approvals. Figure 4.3 shows that both plans have approved restricted procedures.

Figure 4.3 Health Plans' Approval of Restricted Procedures. The health plans have a high approval rate of restricted procedures.

	Restricted Procedures	
	Sleep Studies	Circumcision
Molina	Approved 97%	Approved 86%
Healthy U	Approved 98%	Approved 52%

Both health plans have a high approval rate of restricted procedures. We believe Utah Medicaid should be more involved to understand if the approvals have been appropriate.

Utah Medicaid Should Improve Contracts To Realize Potential Savings

The theory behind managed care is that there should be cost savings through contractual discounts and health management of Utah Medicaid recipients. It is concerning that Utah Medicaid, thus far, has been unable to quantify the value of managed care in Utah. This lack is due in part to the health plans' contracts not focusing on either the quantitative or the qualitative value of the health plans. Going forward HCF should look for ways of realizing cost savings in all of its health plans, regardless of the contract arrangement.

It appears Utah Medicaid's past negotiations with the health plans lacked complete risk-adjusted relative cost and utilization analysis and instead focused on setting contracts to available budgets. While setting a contract within budget is essential, Utah Medicaid should be more proactive in seeking after cost-saving opportunities in their contract negotiations. During Utah Medicaid's recent capitated negotiations with Molina, HCF appears to have based their rate decision on the amount they had in their budget. We are also concerned that the recent negotiations were based on high cost and utilization data and inaccurate administrative rate information.

Recent Contract with Molina Appears to Be Based on Inflated Cost. The recent Molina contract negotiations are based on costs and utilization that are actuarially shown to be the highest of the three plans. During rate negotiations, the actuary conducted sufficient analysis to determine utilization was high and recommended a cost-savings strategy based on improved health care management. Specifically, the actuary identified that an aggregate rate reduction of

It is concerning that Utah Medicaid has been unable to quantify the value of managed care in Utah.

In the most recent contract negotiations Utah Medicaid settled for 3% instead of the recommended 5.4% in management savings.

5.4 percent for health management improvements was appropriate. Utah Medicaid settled for a 3 percent reduction that did not capture the full cost-savings potential. Figure 3.2 in Chapter III estimates that for calendar year 2008, Molina had about \$11 million in cost reduction opportunities. For the next contract with Molina, Utah Medicaid should carefully review and implement an appropriate rate based on cost reduction opportunities.

Utah Medicaid Negotiated a Previous Cost-Plus Contract That Gives Savings Back to a Health Plan and Leaves Little for the State. The previous Molina contract gave most of any savings to Molina. The savings sharing provision states:

Profit sharing occurs if MHU's [Molina] costs plus 9% administration fee are less than MHU's revenues under this contract. Revenues are defined as the amount the DEPARTMENT would have paid had this contract remained a risk contract as described in 42 CFR 447.361. MHU may retain the savings as follows: if the difference between MHU's costs plus 9% administration and total revenues is 5% or less of total revenues, MHU may retain the entire amount. The portion of savings greater than 5% shall be shared 50/50 with the DEPARTMENT.

This provision means that the state only shares in savings if Molina's costs and administrative fees are 95 percent or lower of what the state would have paid, and then those savings are shared 50/50. For Molina, this means that as long as they stay under the upper payment limit (UPL), they will receive both a 9 percent administrative fee and the value of savings. Our calculation based on preliminary data shows that this payment could be in excess of \$4.3 million for fiscal year 2008. None of that potential savings would be shared with the state.

In the future, we believe that Utah Medicaid should tighten the contract rates and expect the plans, where appropriate, to reduce costs and utilization. We suggest the rates be reduced to, at a minimum, best-in-class Utah performer levels, and preferably, where appropriate, to national comparable benchmarks. Further, Utah Medicaid should establish a clear profit margin rate and manage the contracts with the health plans accordingly. It is important that the plans achieve an

In the future, we expect Utah Medicaid to establish contracts based on appropriate lowest-cost potential.

acceptable profit margin to maintain their viability and presence in the state.

Recommendations

1. We recommend that Utah Medicaid apply risk-adjusted relative costs to their analysis of health plans to gain potential cost savings.
2. We recommend Utah Medicaid determine an acceptable cost-level for the plans and hold the plans to that level.
3. We recommend Utah Medicaid determine the actual amount and rate of administering the Select Access plan, managing claims, overseeing the health plans, and other cost centers so that it can be used in further analysis.
4. We recommend that Utah Medicaid incorporate prior authorization data in their monitoring of the health plans.
5. We recommend that the Legislature direct Utah Medicaid to report to them on cost-savings obtained through improved managed care contracting, and follow-up to ensure that the fullest, appropriate, cost-savings potential is realized.

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Chapter V

Quality-of-Care Oversight Is Good, But Some Improvements Still Needed

The primary aim of the Division of Health Care Financing (HCF or Utah Medicaid program) is compliance with federal requirements. As a result, we believe management has spent little time developing and implementing best practices for good management. While adherence to federal requirements is essential, HCF is also given the authority to customize the Medicaid program. We believe that the Bureau of Managed Health Care (BMHC) within HCF can provide more meaningful oversight to improve care delivery.

We are encouraged with the level of oversight given to quality of care issues. Unlike cost and utilization, discussed in the previous chapter, where very little oversight is occurring, BMHC has required some accountability over the managed care plans' quality of care. However, the quality of care oversight has largely been driven by the federal government and is implemented differently among the health plans. BMHC needs to better utilize and organize its federally mandated external quality review (EQR) process and take a more active role in the validation and standardization of its quality improvement report information. This improvement should, in turn, create a better program.

External Quality Review Process Provides Valuable Quality Information

Quality health care can be defined as care that is easily accessible and cost-effective, is based on best evidence methods, and provides optimal health outcomes. The BMHC indicated one of its goals is to provide quality health care to Medicaid recipients, and they indicated this is accomplished through the EQR process, which reports on health care quality, outcomes, timeliness, and access. Each of these components is an important aspect of administrative oversight over the managed care plans. Two of Utah's managed care plans, Healthy U and Molina, take part in this annual report. However, Select Access

Bureau of Managed Health Care (BMHC) quality oversight has been largely driven by federal regulations and is implemented differently among the plans.

Healthy U and Molina take part in the external quality review. However, Select Access does not.

is a federally defined primary care case management (PCCM) system and, therefore, is not required to submit to an external quality review.

Health Care Excel (HCE) QualityQuest is the external quality review organization (EQRO) currently contracted with HCF to conduct the annual EQR. As one of three main parts of the EQR process, a compliance review is conducted every three years to see if the two plans fully adhere to the state’s managed care quality strategy and plan contract agreements, as well as federal requirements. The state’s quality strategy is based on fulfilling federal regulations, and the BMHC is currently revising the quality strategy from the last update in 2003. The EQRO is responsible for assessing Molina and Healthy U’s compliance to 71 standards that cover three general areas:

- Access to care
- Structure and operations
- Measurement and improvement

Figure 5.1 shows the 2008 EQR compliance review results for both Molina and Healthy U.

Figure 5.1 EQR Compliance Review Results. Utah managed care plans Molina and Healthy U are each 79% fully compliant with BMHC quality strategy standards.

Healthy U and Molina are both 79 percent fully compliant with Utah Medicaid standards.

Plan	# of Standards Met	# of Standards Substantially Met	# of Standards Partially Met	# of Standards Not Met	Total # of Standards
Healthy U	56	8	5	2	71
Molina	56	9	3	3	71
Average % of Standards	79%	12%	6%	3%	100%

Source: Utah 2008 Annual External Quality Review Report for Prepaid Inpatient Health Plans

Healthy U and Molina are both 79 percent fully compliant with Utah Medicaid standards. The standards indicated as “not met” pertain to the plans’ individual provider recredentialing processes and plan oversight of responsibilities delegated to third parties. BMHC should ensure plan provider recredentialing and third party oversight is occurring and is compliant with the required standards.

Along with the compliance review, there are two other main parts of the EQR process that provide beneficial insight into the quality of health care. These two other parts are a review of performance measures and performance improvement projects.

- **HEDIS Measures Provide Valuable Insight to the National Standing of Managed Care Plans.** The Healthcare Effectiveness Data and Information Set (HEDIS), designed by the National Committee for Quality Assurance, is a nationally recognized standard of health care quality measurement. HEDIS provides national benchmarking of plans across eight areas of care and is HCF’s chosen quality benchmark for both Healthy U and Molina. The EQR summary of HEDIS measurements is derived from the Utah Office of Health Care Statistics’ annual performance report. The EQRO does not independently validate the HEDIS results, which scored Utah’s two plans above the national average for 55 percent of HEDIS measures. HEDIS measures are neither gathered nor reported for Select Access.
- **Performance Improvement Projects (PIPs) Provide Health Outcomes and Member Satisfaction Measures.** In 2005, Utah Medicaid directed Molina and Healthy U to participate in performance improvement projects aimed at improving the communication and coordination of Medicaid physical and mental health care. PIPs are 10-step projects; however, neither plan has yet completed the final two steps of measuring and reporting the level of real progress achieved and sustained. However, for the steps completed, Molina was rated as 93 percent compliant, and Healthy U was rated as 100 percent compliant with PIP process standards provided by the Centers for Medicare and Medicaid Services (CMS).

Utah Medicaid Can Improve Its Use Of External Quality Review Information

Utah Medicaid’s BMHC can better use the quality of care information it receives through the federally mandated external quality review process. While we are encouraged at the efforts of Utah Medicaid in fulfilling federal requirements, we believe they can better

HEDIS measures benchmark managed care plans nationally.

BMHC can improve program operations by utilizing external quality review results more effectively.

use the external quality review process to improve health plan performance by taking the following measures:

- **Collecting Quality Review Information on All Health Plans.** BMHC currently requires an external quality review of two of its plans, as required by federal regulations. Utah Medicaid's third plan is not subject to this regulation, so no review is required. HCF should review the cost/benefit of collecting health care quality information from all plans. Without complete information, HCF cannot adequately compare information across all plans.
- **Better Defining Performance Goals.** Utah Medicaid has not set a general performance goal. They simply require Molina and Healthy U to report their HEDIS performance measures. To improve performance, BHMC should tailor specific program goals to address Utah's unique needs as is done in other states. For example, Arizona and Florida Medicaid programs have created additional quality benchmarks and goals.
- **Complete Documenting of Corrective Action Plans.** BMHC should ensure that corrective action plans identified by the EQRO are clear, include detailed explanations of the deficiencies, are updated annually with plan improvement efforts and results, and are included in the comprehensive EQR report. This will help ensure the EQR report is meaningful from one year to the next and that the plans track and maintain quality improvement over time.

Medicaid Should Consider Collecting Similar Quality Information for Its Select Access Program

Currently, Utah Medicaid is not collecting the full breadth of quality of care information for the Select Access plan because it is not required by the federal government. HCF should review the cost/benefit of collecting health care quality information from the Select Access plan. Having this information would help Medicaid in comparing quality outcomes across all plans and better identifying performance. BMHC stated:

Utah Medicaid is not collecting all quality of care information for Select Access because it is not required by the federal government.

It is not a managed care BBA [Balanced Budget Act] requirement that PCCMs such as Select Access submit performance measurement data. None of the Measurement and Improvement Standards . . . are required of PCCMs.

Arizona Medicaid has an extensive list of health plan contractors who are all subject to EQR participation and requirements. We believe having multiple plans of the same contract type to compare against one another is an effective way to ensure that all plans receive the same level of oversight, allowing for more meaningful and accurate quality comparisons among all plans.

In the future, BMHC should conduct a cost/benefit analysis of collecting similar quality of care information from all their health plans so they may develop meaningful universal performance goals. If all the health plans were moved to a capitated (comprehensive risk) arrangement, CMS would require Utah Medicaid to collect similar quality information on all the plans because they would all be federally defined as managed care organizations (MCOs).

Performance Goals Can Be Better Defined and More Meaningful

HCF could establish more defined oversight performance goals over quality of care that are more meaningful and help provide better program guidance. We believe Utah Medicaid's current performance goals are vague and provide little direction to quality of care efforts. For example, Molina and Healthy U report that they are only required to track and report HEDIS measures; BMHC has not established performance goals or targets for these measures. We believe BMHC should go beyond simply tracking performance measures. Instead, they should closely review reported measures, identify areas of weak plan performance, set specific performance goals, and require corrective action to meet those goals. BMHC currently lists the following quality of care performance goals:

- Meet federal requirements.
- Provide access to high-quality care and services.
- Ensure plans meet contractual requirements.
- Ensure 80 percent of Medicaid children receive medical screenings as required by federal standards.
- Track consumer survey results.

BMHC should determine the feasibility of requiring all plans to participate in the external quality review.

BMHC should find more effective ways to utilize the information it gathers and tracks.

- Track membership information.
- Track HEDIS performance measures.
- Track percentage of consumer assessment measures that meet or exceed target of 90 percent (consumer satisfaction measurement).

While we are encouraged by BMHC's tracking of some performance-related measures, we believe they should provide a more involved level of oversight and determine effective ways to utilize the information being tracked. Some other states have identified performance goals related to quality of care and have implemented more meaningful benchmarks and information tracking mechanisms.

For example, Arizona Medicaid has implemented a state-level quality improvement committee. Annually, this committee meets with staff from Arizona's contracted plans to discuss quality outcomes as reported in the EQR. Areas of concern are identified, and the plans have the opportunity to explain where barriers exist in meeting benchmarks. Through this process, Arizona reports they are able to determine if requiring their plans to meet national HEDIS averages is adequate or if they should set higher, Arizona-specific, quality standards. Also, Florida has set a higher standard for their plans than the national average, requiring each plan to meet a national 75th percentile benchmark. If Florida plans fail to meet this benchmark, the plans are subject to corrective action measures.

Other states have implemented additional performance benchmarks.

We believe that, like Arizona and Florida, Utah Medicaid should be more involved in setting specific performance goals and benchmarks. Clear and understandable goals and benchmarks will allow Utah Medicaid to easily identify poor plan performance and provide a greater level of direction in corrective action planning.

Corrective Action Plan Reporting Can Be Improved

The Utah Medicaid program can improve its corrective action process to make it more clear, understandable, and available. Improving this process will create more meaningful corrective action plans (CAPs) that will clearly delineate year-to-year improvements or deficiencies in plan performance.

The Medicaid program utilizes the EQRO to request and monitor CAPs from the managed care plans, which are required in response to compliance shortcomings found during the EQR process. BMHC originally provided us with the *2008 Annual External Quality Review (EQR) Report for Prepaid Inpatient Health Plans*, which details results for all of Utah's physical and mental health Medicaid plans. The external review agent reported in this report:

UDOH works collaboratively with [QualityQuest] to determine if CAPs are acceptable and where to focus group or individual technical guidance sessions.

We reviewed the 2008 comprehensive EQR and could not find evidence that CAPs were requested, created, or implemented. However, after further discussion, BMHC was able to provide documentation regarding the 2008 CAPs for Molina and Healthy U. BMHC only included the CAPs in individual EQR reports specific to each plan.

However, BMHC indicated that the individual EQR reports are not required by the federal government and that the comprehensive report is the only requirement. Therefore, for the purpose of tracking, monitoring, and verifying successful completion of the corrective action plans, BMHC should ensure the annual comprehensive EQR report provides a clear summary of all information found in the individual reports. Also, federal regulation states that the EQR report be available to all interested parties upon request; therefore, the annual comprehensive EQR report should contain all review results, including CAPs.

BMHC-Required Quality Improvement Reports Need Development

In an effort to further monitor quality, BMHC has required Molina and Healthy U to provide additional quality improvement reports. BMHC reports that they gain valuable insight from these reports, but we were unable to determine exactly how these reports are used to improve program quality. The reports are not independently validated by BMHC, and the reporting format is not being consistently followed. BMHC should take a more active role

The 2008 external quality review (EQR) was missing Molina and Healthy U's corrective action plans (CAPs).

validating these reports through sampling and ensuring the proper format is followed.

Reports Should Be Validated by Sampling and Formatted Correctly

BMHC requires Healthy U and Molina to submit self-reported annual quality improvement reports. Best management practices suggest that BMHC should take an active role in the oversight of the plans' quality improvement initiatives and provide independent validation of quality outcomes through sampling. Also, BMHC should ensure all managed care plans construct their reports in the required format to aid in comparisons among plans.

Quality Improvement Is Self-Reported by the Managed Care Plans. Molina and Healthy U are required by BMHC to self-report three quality improvement documents annually. We believe it is important as a management best practice for BMHC to independently validate (through sampling) and require evidence of reported outcomes contained in the following three reports:

- **Quality Improvement Description (QID).** Through the QID, the plans report to the BMHC what quality improvement efforts they will carry out in the coming year.
- **Quality Improvement Work Plan (QIP).** The QIP is used by the plans to explain how they will carry out the efforts contained in the QID.
- **Work Plan Evaluation (WPE).** The WPE is a report of the results of the quality improvement efforts from the preceding year.

Strict Standardization of Reporting Format Would Aid in Quality Oversight. BMHC provides a basic format of the information that is reported in the quality improvement reports. However, the formatting requirements are not being consistently followed; organization, depth, and information topics reported varied between the two plans. Healthy U provided the 2009 reports in the required format, but Molina needed to be reminded of the proper

BMHC requires additional quality improvement reporting. However, the information is self-reported by the plans.

format. Arizona's Medicaid director told us standardized reports are essential. He said:

[The] reason why we have a lot of standardized reports is because we use them in terms of our analysis. We have come to understand what you have to look for to create your benchmark reports that help you analyze whether you are getting good cost and quality management from your health plans. Standardized reports are used by our staff as part of our analytical tools and then as part of our discussion with our health plans. . . . If [you] don't have standard reports that your management team is using that is a problem. That is a symptom of not using your data to be able to analyze the effectiveness of your health plans.

Due to formatting conflicts of reports submitted by managed care plans, comparing the plans using their quality improvement reports is difficult. BMHC should ensure the standardized reporting requirements are followed and should set forth the type, depth, and order of the information to be included. This will enable the plans' quality improvement efforts to be more easily and accurately compared, thus identifying problem areas. We believe that making these changes would increase the value of these reports and provide results that could increase the efficiency of the plans.

Formatting conflicts found in the quality improvement reports make quality comparisons among plans difficult.

Recommendations

1. We recommend that the Bureau of Managed Health Care conduct a cost/benefit analysis of collecting similar health quality information, including HEDIS measures, for the Select Access plan.
2. We recommend that the Bureau of Managed Health Care should establish a standard for quality of care appropriate for Utah.
3. We recommend that the Bureau of Managed Health Care require the *Annual External Quality Review Report for Prepaid Inpatient Health Plans* to include a full summary of all results of the corrective action plans.

4. We recommend that the Bureau of Managed Health Care independently validate, through sampling, some of the information contained within the quality improvement reports (plan description, work plan, and work plan evaluation).
5. We recommend, for comparison purposes, that the Bureau of Managed Health Care ensure that the managed care plans adhere to their required format for quality improvement reporting.

Chapter VI

Medicaid Should Implement More Cost-Saving Options

The Division of Health Care Financing (HCF or Utah Medicaid program) can reduce expenditures by focusing on cost-saving options that reduce utilization of services while maintaining a healthy Medicaid population. Cost-saving options can be implemented and strengthened across the Medicaid program. We found several areas where savings can occur. For example, HCF had been overpaying emergency room claims. By correcting this payment error, HCF can recover about \$7.1 million in overpayments for fiscal year 2009, and should save approximately \$7 million during the current fiscal year. Also, by instituting ER programs to redirect non-emergent use of the ER, HCF should be able to reduce expenditures.

We also identified several best practices in other states' Medicaid programs. Some other states have realized substantial cost savings from targeted recipient-care management. By comparing best practices found nationwide, HCF may be able to further reduce Medicaid expenditures.

Utah Medicaid Should Focus on Implementing Proven Cost-Saving Options

Cost reduction opportunities are available in several areas. Utah Medicaid should review these opportunities and seek ways of implementing them. This section of the report focuses on three specific cost reduction opportunities:

- Utah Medicaid should ensure proper payment of non-emergent ER claims.
- Utah Medicaid should further seek opportunities to redirect non-emergent ER visits to urgent care and physicians' offices.
- Utah Medicaid should review ways of minimizing barriers that hinder the use of lower-cost surgical centers.

Utah Medicaid can reduce expenditures by focusing on cost-saving options that reduce utilization of services.

Cost reduction opportunities are available in several areas.

Correct Payment of ER Visits Should Save About \$7 Million in Current Fiscal Year

Due to a payment error by HCF that has now been corrected, Utah Medicaid is realizing a cost savings in the current fiscal year of approximately \$7 million. We believe there will be ongoing savings from this correction. Specifically, this cost savings is due to inaccurate payments by HCF to hospitals for ER visits. It appears hospitals have been submitting claims correctly. The error occurred with how Utah Medicaid reimbursed the hospitals.

HCF Error Overpaid Non-Emergent ER Claims. During fiscal year 2009, the state’s Medicaid payment system inadvertently used any diagnosis to determine if the claim was a valid emergency code, in which case the claim was reimbursed at 98 percent of billed charges. However, according to the Utah Medicaid State plan, “The ‘emergency’ designation is based on the principal diagnosis.” For non-emergent claims, the claim should only be reimbursed at 40 percent of charges for urban claims and 65 percent for rural claims. Those claims that were wrongfully paid as emergent were overpaid by 58 percent in urban hospitals and 33 percent in rural hospitals.

For fiscal year 2010, the system was corrected to determine if the visit was an emergency by looking only at the principal diagnosis. Figure 6.1 shows that we estimate this error to have cost about \$7.1 million in fiscal year 2009.

Figure 6.1 Overpayment of ER Claims. Due to a state error, ER claims were reimbursed as an emergency based on any diagnosis, rather than the first-listed diagnosis. This resulted in overpayments of almost \$7.1 million.

ER Claims	99,864
Claims Paid as Emergent	53,106
Number of Claims Incorrectly Paid as Emergent*	16,419
Total Overpayments (Approximate)	\$7,082,716

*60.2% urban claims overpaid by 58%, and 39.8% rural claims were overpaid by 33%.

Because the payment system has now been corrected, immediate savings should be realized this year as more ER claims are reimbursed at 40 or 65 percent rather than 98 percent. With this change, it is crucial that the Utah Department of Health (DOH) monitor ER

Non-emergent ER claims were overpaid by as much as 58 percent.

Because HCF corrected the payment system, the Medicaid program should save about \$7 million this fiscal year.

claims to ensure hospitals continue to code correctly and the proper reimbursement is paid.

The Utah Medicaid director said that they would recover payments back to April 2009, when they notified providers of their error and that it would be changed. The Medicaid director said they would evaluate the extent of the mistake for fiscal year 2009 and review the possibility of recovering the remainder of those funds. We believe Utah Medicaid does have the necessary information to recover the funds for all of fiscal year 2009.

Providers should be assigning primary diagnosis according to *ICD-9-CM Official Guidelines for Coding and Reporting* as required by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA was passed in part to improve the Medicaid program “by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.” Violations of HIPAA are punishable by a fine as set in the law. According to the guidelines, the first-listed diagnosis should be the one that was “chiefly responsible for the services provided.” The method or amount of reimbursement should not determine how the provider diagnoses and bills an ER claim.

Hospitals Have Been Correctly Coding ER Claims Based on Established Coding Rules. We asked the newly established Office of Internal Audit Service (OIAS), which now encompasses the office formerly known as the Bureau of Program Integrity (BPI), to review a sample of ER claims to determine if they were being coded correctly. They evaluated 25 records, and 23 were properly coded; the two incorrectly coded claims did not result in overpayments as they did not cause a non-emergent claim to be billed as emergent. While we do feel that the reimbursement method could be improved (as discussed later in this chapter), it does appear as though the hospitals understand and follow the coding requirements necessary for the current reimbursement method.

Greater Attempts to Redirect Non-Emergent Visits Should Be Made

Medicaid should continue to seek out ways of redirecting non-emergent visits to the ER. Even at 40 percent of charges, an ER visit

OIAS found that hospitals have been coding ER claims correctly.

Non-emergent claims cost \$463 more in an ER than in a physician's office.

costs substantially more than a visit to a primary care physician or an urgent care facility. Based on Figure 6.1 and an analysis done by the Bureau of Coverage and Reimbursement, the average non-emergent ER claim for urban areas costs \$589, while a visit to a primary care physician or urgent care facility averages \$126, a \$463 difference. Figure 6.2 shows the potential savings that could be realized in urban areas if non-emergent claims were moved to a physician's office or an urgent care facility, although some level of non-emergent ER usage will always be present.

Figure 6.2 Savings Exist Through Reduced ER Visits. The difference in reimbursement rates between an emergency room and a physician or urgent care facility is \$463. This presents significant savings if non-emergent uses of the ER can be reduced, although some non-emergent use of the ER will always be present.

ER Claims	99,864
Non-Emergent Claims	63,177
Cost in Emergency Room	\$37,211,253
Cost at Physician Office/ Urgent Care	\$7,960,302
Percent Savings	78.6%
Maximum Total Dollar Savings	\$29,250,951

HCF should continue focusing on reducing non-emergent ER visits. Doing so should provide a cost savings.

Because of the disparity in reimbursement rates between emergency rooms and primary care visits, it is crucial that non-emergent uses of emergency rooms be reduced. While it is unreasonable to think that all non-emergent visits to the ER could be eliminated, we believe that HCF can reduce a portion of these claims and achieve cost savings.

Some Efforts Have Been Made To Reduce Non-Emergent ER Use, But More Can Be Done. Centers for Medicare and Medicaid Services (CMS) recognized this need and, in April 2008, awarded \$50 million in grants to 20 states (including Utah) to improve access to primary care and reduce unnecessary ER visits. According to CMS, the funds will be used for the following purposes:

- Establishing new community health centers
- Extending the hours of operation at existing clinics
- Educating beneficiaries about new services
- Providing for electronic health information exchange between facilities for better coordination of care

The Emergency Medical Treatment & Labor Act (EMTALA), passed by Congress in 1986, requires emergency rooms to provide screening of anyone who requests it. Therefore, even if the condition is not emergent, the ER cannot turn the patient away. Because of this requirement, other means of redirecting non-emergent cases away from the ER must be utilized. Utah's program focuses on contacting non-emergent users of the ER, educating them on their options for care, and finding them primary care physicians.

Preliminary results of the grant show that Utah Medicaid has had good success reducing non-emergent ER use. Compared to the control group (who were not contacted), individuals who were contacted after one non-emergent visit had 82 percent less recidivism. These results are very encouraging because they show that education of Medicaid recipients is an effective tactic for stopping non-emergent ER use. However, we believe more can be done.

This tactic does nothing to impact the initial non-emergent claims. While there is some education of proper ER use in the orientation process, by increasing upfront education and emphasis on proper use of emergency rooms, Utah Medicaid could reduce initial instances of non-emergent use. Additionally, other states have incorporated further cost-saving methods through the grants that could be applied to Utah. These methods can actively remove non-emergent cases to lower cost alternatives without jeopardizing health care quality.

Tennessee's ER diversion grant set up health clinics in direct proximity to the hospital emergency room. If a patient is screened and found not to be in an emergent state, a community access facilitator offers the patient the option of being treated immediately at the clinic rather than waiting at the emergency room. At most, one person per month has decided to stay in the ER. After the visit, the clinic sends the treatment and follow-up information to the patient's primary care physician, and the managed care organization (MCO) contacts the patient to discuss why the visit to the ER was made and educates him or her about the appropriate uses of the ER. Similar programs are run in other states.

Providing an easy-access, no-wait clinic can shift much of the burden away from emergency rooms to more appropriate facilities. The most visited emergency room for Medicaid recipients is McKay-

ER-use education has resulted in 82 percent less recidivism of improper use.

Tennessee has been able to shift non-emergent ER patients to clinics.

Dee Hospital in Ogden. A pediatric urgent care center is also located at the hospital. It is likely a similar program could be set up and be successful. The five most utilized emergency rooms are shown in Figure 6.3. Two of these facilities have urgent care facilities at the same location as the hospital.

Figure 6.3 Urgent Care Facilities Could Be Used for Triage Recipients. The close proximity of urgent care facilities in two of the five most commonly used emergency rooms provides the opportunity to triage patients to a less-costly facility for treatment, resulting in \$4 million in potential savings.

Hospital	Urgent Care at Facility	ER Claims	Eligible to Triage ²	Approx Maximum Savings ³
McKay-Dee Hospital	Yes ¹	10,068	4,071	\$1.9 million
Intermountain Medical	No	7,988		
Utah Valley Regional Medical Center	Yes	7,041	4,450	\$2.1 million
Jordan Valley Hospital	No	5,338		
Primary Children's	No	5,282		

¹Pediatric urgent care facility

²Based on 63.2% of ER claims not meeting emergent criteria (See Figure 6.1). McKay-Dee only shows children's claims (approx 64% of population).

³Does not include cost of initial screening by ER.

The ability to achieve the savings shown depends on several factors, such as the hours of operation of the clinic, the cost of the initial ER screening, and the number of patients agreeing to go to the urgent care facility. However, large savings are clearly available, and programs at the two locations shown could be implemented fairly simply.

The absence of an urgent care facility would not necessarily mean that a similar triage program could not work. Many hospitals have clinics in close proximity that may be an option for patients with transportation. This may also be an opportunity for additional urgent care facilities, or as is the case in other states, use of existing facilities during the night and weekends.

In addition to the education component and use of onsite triage to reduce non-emergent ER utilization, there are many other methods that HCF should consider, such as:

Additional hospitals could have clinics set up to handle non-emergent ER patients.

- Utilizing telehealth technology
- Setting up relationships with chronic care patients and primary care physicians
- Starting mobile medicine programs

Some other states have instituted programs using telehealth technology. This has been found to be an effective way of home monitoring patients to get them primary care as well as receiving care in their home clinic after hours. One doctor can be used to reach recipients in many locations. The clinic will staff a nurse only, and the doctor will be contacted once the nurse is able to see the patient. These programs have been effective in expanding physician reach, especially in rural settings. By providing additional access to care, ER visits can be reduced.

In addition to educating clients, many grants have emphasized setting up relationships between clients and primary care physicians as a means of avoiding emergency room use except in cases of true emergencies. This practice can be especially effective for those with chronic conditions who need ongoing care.

Complete results from ER grants are not readily available at this point. Once grants expire in 2010, it is expected that more evidence will be available regarding the success of these programs. HCF should monitor these results and determine which programs are feasible in Utah.

Private companies have also instituted methods of cost avoidance that could be applied in Medicaid. Microsoft has instituted a “mobile medicine” program that involves doctors traveling to employees’ homes instead of employees going to emergency rooms for non-emergent situations. According to Microsoft’s director of benefits, they save over \$200 per claim. A similar program may work in the managed care plans.

Other states’ ER grants can give Utah ideas of how to decrease improper ER use.

Microsoft saves over \$200 per claim by having doctors visit patients in lieu of ER visits.

Business Barriers Prevent Possible Surgical Cost Savings

Ambulatory surgical centers (ASCs) often have lower costs than hospitals, but contracting barriers that the health plans encounter prevents their widespread use. However, the plans do have contracts with some ASCs. Since 1982, Medicare has utilized ASCs as an alternative to hospitals for some outpatient procedures. In 2006, the Government Accountability Office (GAO) conducted an audit to compare the costs of performing procedures in hospital outpatient departments and ASCs. According to their study, “The cost of procedures in ASCs is substantially lower than the corresponding cost in hospital outpatient departments.” In 2008, CMS allowed an additional 800 outpatient procedures, bringing the total to over 3,500.

Surgical centers are used extensively in Medicare as a cost-saving measure.

Surgical Centers Have Lower Reimbursement Rates. CMS, which sets rates for the Medicare program, pays for outpatient surgical procedures on different payment schedules. These schedules are reflective of the lower costs at surgical centers; therefore, surgical centers are paid at a lower rate than hospital outpatient departments (HOPDs). In Utah, Medicaid pays for most outpatient surgeries on a percentage of charges (although 16 procedures do have set reimbursement rates). Surgeries in physician’s offices or ASCs result in lower average payments than procedures in hospitals, as shown in Figure 6.4. We were also able to obtain private industry reimbursement rates. While the rates were not directly comparable to Medicaid, they also clearly showed that cost savings are often present in ASCs compared to hospitals.

Surgical centers typically cost Medicaid less than hospitals.

Figure 6.4 Reimbursement Rates Are High at Hospitals. Medicare has set rates for surgeries done in HOPDs and ASCs, while Medicaid pays a percentage of billed charges. In both circumstances, the procedures were generally less costly when done outside of a hospital. Medicaid charges shown are the average for fiscal year 2009.

Procedure	Medicare Hospital	Medicare Ambulatory	Medicaid Hospital	Medicaid Ambulatory*
Cataract Surgery	\$1,605	\$965	\$1,511	\$792
Upper GI Endoscopy, Biopsy	572	392	825	367
Diagnostic Colonoscopy	594	399	658	457
Colonoscopy and Biopsy	594	399	744	463
After Cataract Laser Surgery	348	259	274	293
Fetal Non-Stress Test	\$94	\$15	\$174	\$36

*Includes ASCs and physician offices

Cost savings are typically available by utilizing surgical centers. Additional cost-savings may be realized by further utilization of ASCs, although there are barriers to this occurring on a large-scale basis. As discussed in Chapter II, all Medicaid recipients along the Wasatch Front must join one of three health plans. Molina, Healthy U, and IHC (Select Access has a network lease with IHC) engage in their own contracting with hospitals. These contracts provide a discount on inpatient services in exchange for the volume that the provider can supply. Because of this, the hospitals can discourage plans from contracting with competitors, such as ASCs. Medicaid’s Select Access plan rents the IHC panel of providers, and Medicaid recipients go to those providers.

While savings could be realized from contracts with ASCs, savings through inpatient procedures may be lost if the hospital no longer agrees to reduce rates. Molina is not directly associated with a specific provider network, so any provider can be contracted with to provide services. However, Molina reports saving approximately \$58 million on inpatient procedures over the past five years. To match this savings through outpatient procedures, they would need to save 37 percent on outpatient procedures. Even with the contracting of surgical centers, it is unlikely that savings in this area could match inpatient savings.

Health plans get a discount on inpatient services in exchange for sending volume to the hospital.

One of Arizona's plans focuses on contracting with surgical centers as a means of reducing costs.

For the University of Utah's Healthy U program, the plans have an incentive to move surgeries to their own lower-cost facilities. For Select Access, all providers are part of the IHC panel. Molina and Healthy U have contracted with some ASCs to expand the reach of their network. Any services performed by IHC are paid on the Medicaid fee schedule, so HCF can control reimbursement for these services, but the procedures would still be limited to IHC facilities.

One method of increasing the use of surgical centers and realizing the cost-savings that may be available is through increased competition among managed care plans. It is not uncommon in other states to have four or more plans competing for Medicaid clients. In Arizona, one of their 15 MCOs focuses much of their contracting on surgical centers as a way of keeping costs low. This may be especially effective for certain segments of the Medicaid population that may not need as much inpatient care.

HCF Has Been Paying Some Surgical Procedures Incorrectly.

The Bureau of Coverage and Reimbursement within Utah Medicaid has set specific rates for 16 surgical procedures. This was done as a method of cost containment for procedures that saw a sudden spike in charges as well as a means of attracting additional providers by enhancing rates. However, the system was not correctly programmed to pay these rates. Incorrectly set payment rates for the 12 procedures that were performed were lower than the actual payments. For the 4,200 claims affected, the overpayment was over \$196,000. Only 1 of the 12 procedures appeared to have consistently paid the correct amount, although correct payments were not made every time. The Bureau of Coverage and Reimbursement should correct these payments and consider adding to the list of procedures with set reimbursement rates. This will be discussed in greater detail later in the chapter.

Surgical procedures have been overpaid by \$196,000.

National Best Practices Reveal Programs That Utah Medicaid Should Consider

In a survey of other state Medicaid programs, we found that some of them have found it necessary to be innovative in their efforts to decrease utilization and reduce costs. Some of these Medicaid programs have realized significant cost savings from targeted recipient

care management. We found that some areas where savings have been realized include the following:

- Establishing set reimbursement rates
- Implementing health management programs
- Utilizing cost-saving programs

Utah's Medicaid-administered programs (Select Access and fee-for-service) have done little to control costs using these methods. We believe Utah Medicaid should review best practices from other states and implement the best programs. Specifically, HCF should consider methods where other states have realized cost savings and determine if similar methods could be successful in Utah.

Legislature and Medicaid Should Reexamine Reimbursement Method

HCF and the Legislature should review changing Utah Medicaid's reimbursement method to more fixed rates and fees. We believe that this area has greater cost-savings potential and is deserving of more in-depth review.

Medicaid Should Examine Flat-Fee Reimbursement

Methodology. Utah Medicaid could do more in setting reimbursement rates to control costs. Reimbursement rates in Utah are different than in other states we reviewed. For example, 88 percent of states we received feedback from used fixed fee schedules. Utah reimburses both outpatient procedures and ER visits on a percentage of billed charges. This creates an incentive for the providers to bill as much as possible, and extra supplies, consultations, or procedures could be a result of this type of arrangement. By reimbursing on the diagnosis or procedure code as other states do, Medicaid could reduce this incentive and keep costs in check.

In HCF's September 2009 report to the Health and Human Services Appropriations Subcommittee, HCF recommended a revenue-code fee schedule be implemented in response to the Legislature's request to investigate changing "outpatient hospital reimbursement to a fee-for-service system." Under a revenue-code fee schedule, claims would be reimbursed on a set fee schedule. The report points out that the fee schedule would not necessarily bring about cost savings but could be used to easily reduce reimbursements

HCF should review best practices from other states and implement the best practices.

Changing to a fee schedule reimbursement could help control costs.

and control inflation. With a revenue-code fee schedule, the Legislature can set rates in a cost-saving or a cost-neutral way, but even a cost-neutral fee schedule would reduce provider incentives to bill higher to increase their reimbursement amounts.

Other Medicaid Programs Have Implemented Health Management Programs

Utah Medicaid should review health management programs used by other states. Focusing on a small number of patients with chronic conditions could lead to substantial savings. Two general ways other states have implemented health management programs include utilizing medical homes and targeting chronic behaviors.

Medical homes offer recipients greater access to primary care.

Some States Have Developed “Medical Homes” to Reduce Costs and Improve Health. The concept of a medical home focuses on physicians who have ongoing relationships with enrollees along with coordinated care between providers. Some also offer expanded coverage hours, giving recipients a location other than the emergency room in which they can get care outside of normal office hours. Medical homes and similar approaches were often cited in the CMS Medicaid emergency room diversion grants as a way of increasing primary care and reducing more-costly options.

Other states and private insurances have started disease management programs.

Targeting Chronic Diseases Can Reduce Medical Costs and Improve Health of Recipients. Targeting and managing care of specific chronic diseases has been effective in some other states and plans as a cost control. Diabetes, asthma, chronic obstructive pulmonary disease, and congestive heart failure programs have been used by other states and plans to provide primary care and avoid expensive procedures. Examples of those proactive programs are found in North Carolina’s and Florida’s Medicaid programs and in Utah’s IHC SelectHealth.

- North Carolina claims that their asthma program has led to a 40 percent reduction in inpatient admission rates and a 16.6 percent decrease in ER visits for patients with an asthma diagnosis. A study of North Carolina’s asthma and diabetes programs showed savings of \$6.4 million from 2000-2002. Some people have questioned this savings.

- Florida realized \$42.2 million in savings over five years through their disease management programs.
- IHC's SelectHealth private insurance plan has shown cost-savings through their asthma and congestive heart failure programs. Additionally, they have also shown improved clinical outcomes through other programs. Their diabetes management program has resulted in improved glucose and blood lipid control.

Overall, the Community Care of North Carolina program, which focuses on medical homes and disease management, saved over \$150 million over the past two years. While these programs take additional money upfront, the cost savings can be substantial. The use of such programs is limited in state-run Select Access and fee-for-service plans, which make up 61.5 percent of the Medicaid population. As discussed in Chapter II, Select Access does provide some case management for pediatric care, but it is very limited and there is nothing targeted at the adult Medicaid population.

Other states' MCOs have been successful in asthma disease management programs. An asthma program in Kansas City, Missouri was able to reduce asthma-related ER visits by 45 percent, hospitalizations by 50 percent, and treatment costs by 35 percent. A New York plan decreased inpatient utilization by about 300 percent and pediatric asthma ER visits by over 400 percent. New York's MCO reports savings in childhood asthma of \$10 for every \$1 spent.

In 2008, Molina, Select Access, and Healthy U averaged over 8,500 recipients with pulmonary-related diagnosis and 2,100 diabetic patients. These two populations alone account for almost 10 percent of Medicaid recipients so any cost savings that could be realized through disease management could be substantial.

Other Means of Cost Containment Should Be Considered

Several methods of achieving cost savings, which are used in other states' Medicaid programs, may be possible in Utah as well. Due to the rising costs of health care, states have implemented a variety of cost containment methods that include the following:

North Carolina has saved \$150 million through primary care and disease management programs.

Diabetic patients and patients with pulmonary-related problems account for 10 percent of the Medicaid population.

HOAs allow Medicaid recipients to be more aware of their medical costs.

- Utilizing health opportunity accounts
- Introducing competition between managed care plans
- Starting health insurance premium programs

Health Opportunity Accounts Could Offer Cost Savings. The Deficit Reduction Act of 2005 (DRA) allowed states to implement health opportunity accounts (HOAs). These accounts work like a traditional health savings account (HSA); money is deposited into an account from which a Medicaid recipient can pay for medical services. HOAs make recipients more aware of health care costs, and a portion of any unspent funds may be kept by recipients for qualifying expenses. The program is only allowed for healthy children and adults who are not as likely to need a high amount of services.

The HOA program was started in 2007 with little initial participation, but studies have shown that health savings accounts can save money. A GAO study found that HSA enrollees incurred lower annual costs than traditional plan enrollees using low-to-moderate amounts of health care. The insurance company Aetna conducted a study released in March 2009 that showed HSAs provided cost savings of \$21 million per 10,000 members. The study also said,

The results also show that Aetna HealthFund members are seeking increased levels of chronic and preventive care, using generic drugs more often and accessing online tools and information at higher rates than PPO members, while experiencing lower annualized medical cost increases. Importantly, this year's results also show that Aetna HealthFund members had lower emergency room use than PPO members, suggesting that members are becoming better informed about where to access health care.

HCF prepared a report to the Utah Legislature in September 2009 entitled *Consumer-Driven Health Care in Medicaid*, which discussed the implementation options of a HOA program. The report discussed the two methods of implementation, either a state plan amendment or a 1115 demonstration waiver. The State Plan Amendment would give existing Medicaid recipients the option of choosing the HOA model, while the 1115 Demonstration Waiver would be used to expand services to populations not currently on Medicaid.

HCF's recommendation was to use an 1115 Demonstration Waiver in part due to the lack of success seen in the one state that has used the State Plan Amendment. However, the lack of success in another state does not necessarily translate to Utah. The introduction of an HOA program in Utah combined with education of members of the benefits of the programs (specifically in regards to the benefit of being able to keep unused portions for qualifying expenses) may be effective and would not require expanding services to additional populations.

Competition Among Plans Reduces Costs, Increases Available Services. Competition among plans has also been an effective cost reduction tool. In Arizona, MCO claims data is carefully tracked and reviewed. The profits, financial data, and utilization of each plan are analyzed each year. Plans that cannot contain costs to the same degree as others have their rates reduced to be in line with the low-cost plans.

Another benefit of competing plans is the opportunity to allow additional services to Medicaid members. In Florida, for example, the Medicaid program has obtained a 1915(b)(3) waiver from CMS allowing its MCOs to utilize some of their cost savings to provide additional services to recipients that are not covered under the state plan. This is used as an incentive to get enrollees into their plan, but the costs of the extra procedures are not included in the capitation rates.

Cost Savings Through Health Insurance Premium Payment (HIPP) Programs May Be Possible. These programs allow Medicaid to pay for premiums, deductibles, and co-insurance for enrollees' employer-based health plans. For healthy populations, significant savings are being realized. A study by the South Carolina Legislative Audit Council found that a HIPP program could save over \$1,300 per recipient. Utah Medicaid has implemented a similar program for about 200 individuals and should evaluate the cost savings of this program.

Arizona tracks plan profits and expenses to manage costs.

HIPP programs in South Carolina have been shown to save \$1,300 per recipient.

Recommendations

1. The Department of Health should frequently review emergent ER claims to verify the appropriate diagnosis is used to help ensure expected cost savings are realized.
2. Utah Medicaid should monitor results of ER utilization grants to determine which grants could feasibly transfer to Utah hospitals.
3. Utah Medicaid should ensure that surgical center rates are being paid correctly and should consider adding to the list of defined reimbursement procedures as a way of controlling costs.
4. The Legislature and Utah Medicaid should consider moving away from a percent of charges to a revenue-code fee schedule.
5. Utah Medicaid should consider using more preventive care and case management through cost-saving programs such as medical homes and disease management.
6. Utah Medicaid should determine potential cost savings that could be realized through HOAs, HIPP, and other programs, and implement or expand them if savings are shown.

Appendices

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Appendix A

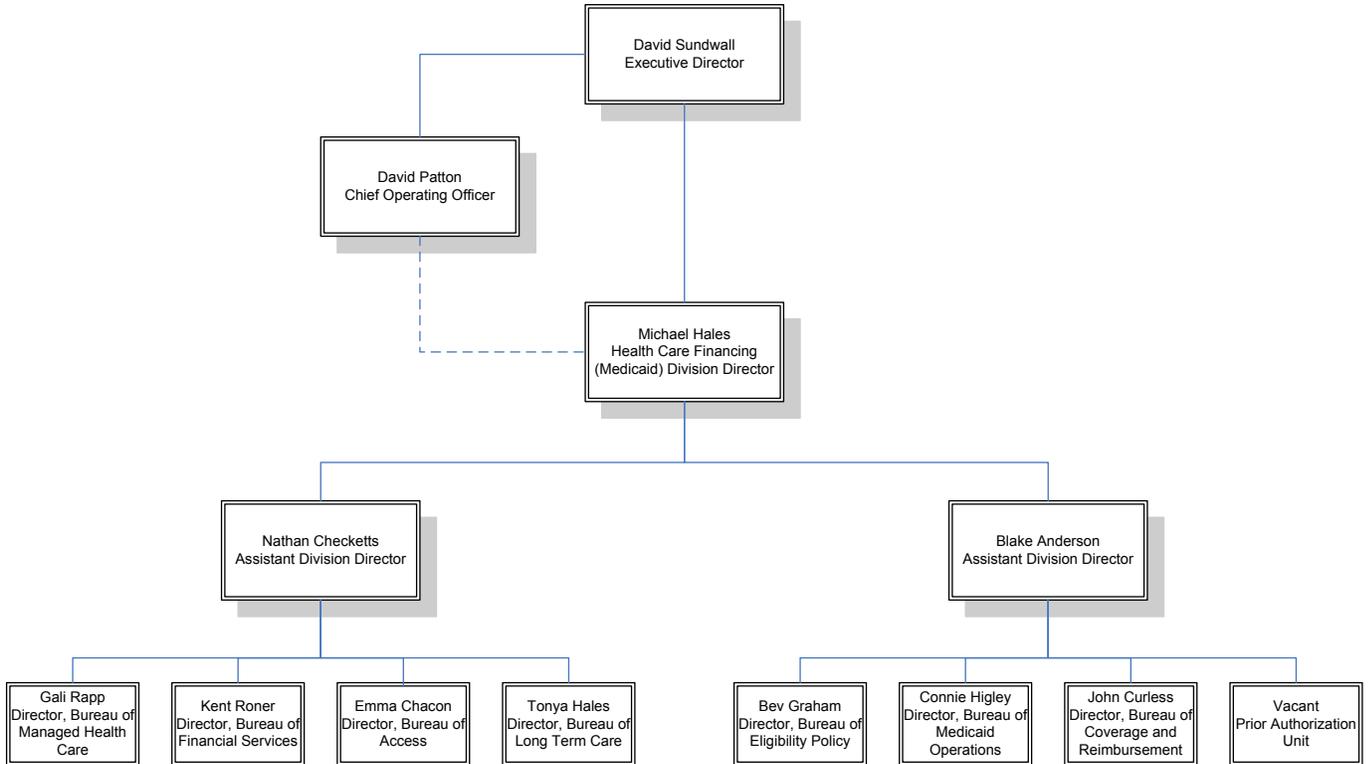
History of Utah Medicaid Managed Care. The following timeline shows benchmark dates of the history of Utah managed care.

Year	Description
3/23/1982	Utah's DOH DHCF receives approval of a 1915(b) Freedom of Choice waiver for its waiver program called the Choice of Health Care Delivery Program.
1982	Utah's first Medicaid managed care plan was FHP (Family Health Plan). This plan became PacifiCare in 1997 and Altius in 1998.
1994	Governor Leavitt releases HealthPrint 1994, a blueprint for market oriented health care reform for both commercial and government health plans. Managed care and capitation were endorsed as cost containment tools in Medicaid.
1994	House Bill 226: Health Care Reform I established the Utah Health Policy Commission to carry out the goals of HealthPrint.
1994	House Bill 126 established that Utah's Freedom of Choice waiver was to be amended to provide that all Medicaid urban clients must be cared for under capitated managed care by 7/1/1996.
5/1/1994	The state contracted with United under a capitated arrangement.
7/1/1994	Senate Bill 158: phase I of HB 126 implementation. By 7/1/1994, 40 percent of urban Medicaid clients would be cared for under capitated managed care plans. The state surpassed this goal and achieved 88 percent enrollment by this date.
1/1/1995	The state contracted with IHC Access under a capitated agreement.
7/1/1995	Senate Bill 158: phase II of HB 126 implementation. By 7/1/1995, 65 percent of urban Medicaid clients would be cared for under capitated managed care plans. The state surpassed this goal and achieved 90 percent enrollment by this date.
10/1/1995	1915(b)(1) Freedom of Choice waiver is modified from a voluntary program by requiring new Medicaid clients in urban counties to enroll in capitated managed care.
7/1/1996	Senate Bill 158: phase III of HB 126 implementation. By 7/1/1996, once enrolled, 100 percent of urban Medicaid clients would be cared for under capitated managed care plans.
1/1/1997	The state contracted with Molina (formerly American Family Care) under a capitated payment plan.

Up until	All Medicaid contracted health plans were HMOs licensed by the Department of Insurance.
1/1/1998	
1/1/1998	The State contracted with Healthy U under a capitated payment plan.
2000	Altius drops out of Utah's Medicaid program.
2002	United drops out of Utah's Medicaid program.
7/1/2002	Molina & Healthy U are changed from capitated to cost-plus contracts and are federally defined as PIHPs. The state sets an administrative fee of 9 percent that is paid through 12/31/2008.
10/1/2002	IHC Access (now called Select Access) became a Preferred Provider Network and a federally defined PCCM system.
7/1/2004	Modification to the 1915(b)(1) waiver allowed the state to require Medicaid clients to stay with the same health plan for up to 12 months.
1/1/2009	On and after this date, Molina and Healthy U claims are paid a cost-plus administrative fee of 8 percent by the State.
7/1/2009	Molina is paid a cost-plus administrative fee of 6.5 percent from July to August 2009.
9/1/2009	Molina returns to a capitated payment contract with an actuarially certified admin rate of 12 percent and is now federally defined as a MCO. Healthy U remains under a cost-plus contract as a PIHP. Select Access continues as a non-risk PCCM, paying IHC a \$0.695 PMPM.

Appendix B

Utah Medicaid Program Organization Chart 2009. This organization chart shows the line of authority over the Medicaid program from the executive director of the Department of Health down to the Medicaid bureau level.



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Appendix C
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Consulting Actuaries

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Utah Medicaid Managed Care Risk Adjusted Experience Review

A Report sponsored by the Office of the
Legislative Auditor General summarizing risk
adjusted experience of the Medicaid Managed
Care Plans for the Utah Department of Health.

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TABLE OF CONTENTS

EXECUTIVE OVERVIEW	3
CAVEATS AND DISCLAIMERS	5
RESULT	5
BACKGROUND	7
DATA DESCRIPTION	9
RISK ADJUSTMENT METHODOLOGY	11
Risk Adjustment Model Selection	11
Risk Adjustment Model Application	11
RISK STRATIFICATION	11
BENCHMARKING TO OTHER STATES AND MILLIMAN GUIDELINES	13
APPENDICIES	14

EXECUTIVE OVERVIEW

The office of the Legislative Auditor General (Auditor) requested Milliman provide technical Actuarial analysis and risk adjustment of experience data in relation to the audit of the Department of Health's (Department) management of Medicaid Managed Care program. There are limitations to a risk adjusted experience review of the Medicaid Managed Care program, this study focuses on the variation in the utilization rates between plans, and does not account for variation in the average cost per service. The overall risk adjusted experience differences can reflect opportunities for savings to the State under the potential implementation of a health status based payment methodology.

Differences in risk adjusted experience between Plans can reflect opportunities for savings to the State.

The Medicaid Managed Care program consists of three plans: Molina, Select Access, and HealthyU; (Plans) Milliman serves as the actuarial consultant to the Department, and most recently provided the Actuarial Certification of capitation rates in the conversion of the Molina plan from a cost plus approach to a pre-paid monthly capitation arrangement. Through this engagement Milliman developed the baseline data which supports the in-depth review of historical experience being requested by the Auditor.

It is our understanding this request has Department support and aims to provide the Auditor with a review of the relative efficiency of plan performance during calendar year 2008. Furthermore, this report is not a recommendation of a future strategy in regards to the management of the Department's expenditures or procurement strategy. Any expectations of savings derived from this review need to consider the impact of changes in cost management as the program shifts expenditures from the current cost-plus reimbursement structure to a pre-paid capitation payment.

The relative efficiency of plan performance in this review is a measurement of overall risk adjusted cost per member per month. Risk adjustment only considers the average effect of disease on utilization rates, and not average cost per service. The risk adjusted per member per month (PMPM) expenditure is comparable to the medical and pharmacy benefit cost component of a monthly health-status based capitation rate. Additional considerations for administrative expense rates, risk margin, differences in average cost per service experienced by the Plans, and county specific practice patterns by category of service, including Pharmacy, are beyond the scope of review.

The majority of the report focuses on a comparison between each of the Plans in a thorough risk adjustment review of the medical and pharmacy experience and three methods of risk stratification. Even though the Department does not anticipate entering into capitation arrangements that include pharmacy claims, those costs are included in this analysis because member participation in managed care should have a direct impact on prescription drug experience. Other service categories such as nursing home stays are much less impacted by managed medical care. This report also includes comparisons of utilization rates from other states, and the Milliman Medicaid *Health Cost Guidelines*. There are advantages and disadvantage to each of these relative benchmarks.

The comparison of risk adjusted experience between Plans reflects a limited number of lives in the State's Medicaid Managed Care program and do not adjust for any outliers of plan specific experience. The advantage is that most of the State's medical expenditures are through the Medicaid Managed Care program. This comparison does not address the fact that replacing one Managed Care plan with another in the same market with the same population will not achieve the same historical results. This review consists of a single scenario for a range of possible outcomes and strategies relating to the structure of a Medicaid Managed Care program. Despite the robust application of risk adjustment to the cost experience, this analysis is not intended to set benchmark targets for future capitation rate negotiations or structure of a health based capitation payment.

In addition to reviewing the overall risk adjusted cost comparison between plans, condition specific cohorts are identified at three different levels:

- Rate Cell – Individual Condition,
- Rate Cell – Top Five Conditions, and
- Major Condition Categories – Combining All Rate cells.

Each of these comparisons provides additional risk stratification for consideration of the validity of the overall conclusions drawn from the historical experience review. The relativity of the risk adjusted expenditures for the Top Five Conditions is not always the same as the overall experience.

The evaluation of experience relative to an independent benchmark or outside state has the advantage of covering more lives, and reducing the effect of outliers. The main disadvantage lies within the inherent flexibility that the Centers for Medicare and Medicaid Services (CMS) provide in the specification of eligibility criteria and program structure.

Despite these limitations, the review of risk adjusted experience between plans provides a strong foundation for identification of opportunities for savings to the State. More analysis is needed to develop and realize a strategy for the Department to maximize the potential of a health status based payment methodology.

CAVEATS AND DISCLAIMERS

The information contained in this report has been prepared for the Office of the Legislative Auditor General under the terms and conditions of the contract with the State of Utah Department of Health. It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this report is provided to third parties, it should be distributed in its entirety. Any user of this information should possess a certain level of expertise in health care modeling and projections so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties beyond the Office of the Legislative Auditor General or the Department of Health. Likewise, third parties are instructed that they are to place no reliance upon this report that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the Department of Health's management of the Medicaid Managed Care program.

Milliman has reviewed the data used in this report for reasonableness, but has not performed a comprehensive audit of the data. To the extent that the inputs are incomplete or in error, the actuarial analysis contained in this report may be inaccurate and erroneous.

RESULTS

The total medical and pharmacy expenditures by the Department in calendar year 2008 for the population under consideration in this study are approximately \$796 Million, with \$405 Million of this expenditure enrolled through the Plans. Of this total, approximately \$588 Million is considered from the geographic area of interest, and \$355 Million is enrolled within the rate cells of interest for risk adjustment. Of the approximately \$588 Million considered from the geographic area pertaining to this review, \$170 Million is for beneficiary expenditures occurring before enrollment in a Managed Care Plan.

Through risk adjusting the calendar year 2008 medical and pharmacy experience, comparisons can be made of the relative efficiency through which each of the Plans delivers care to select cohorts. On the next page, Table 1 summarizes risk adjusted modeled cost by rate cell for each Plan. The risk adjusted cost reflects the expected cost if the plan enrolled a population mix with average age, gender, morbidity and geographic distribution. For example, a Plan serving a high cost cohort based on their actual case mix would have their actual cost reduced to reflect their expected cost for an average population.

For calendar year 2008, HealthyU consistently demonstrated the lowest risk adjusted expenditure by rate cell with the exception of Pregnant Women, where Molina is the lowest. While admittedly an oversimplification, which is discussed in more detail below, differences in risk adjusted experience between Plans can reflect opportunities for improvement in care management or provider contracting that could lead to material savings for the State. Note that the risk adjustment factors used in Table 1 differ by rate cell. Therefore comparison of adjusted rates between rate cells is inappropriate.

Rate Cell	Least Cost Plan	Molina		Select Access		HealthyU	
		Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
A	HealthyU	\$92.90	\$99.36	\$115.42	\$105.57	\$91.90	\$94.47
B	HealthyU	\$401.16	\$384.58	\$332.44	\$319.52	\$264.93	\$305.74
C	HealthyU	\$90.46	\$100.44	\$98.37	\$102.97	\$85.42	\$92.32
D	HealthyU	\$396.89	\$330.94	\$406.14	\$313.98	\$366.08	\$294.69
G	HealthyU	\$776.42	\$748.82	\$945.89	\$667.66	\$996.94	\$662.56
H	HealthyU	\$913.84	\$754.64	\$1,043.27	\$714.16	\$1,093.13	\$688.89
K	HealthyU	\$435.40	\$189.35	\$444.82	\$196.74	\$441.23	\$174.44
L	HealthyU	\$369.22	\$176.91	\$509.48	\$235.27	\$338.24	\$157.01
P	Molina	\$916.50	\$478.95	\$899.50	\$485.47	\$968.84	\$490.89

As noted above, it is an oversimplification to assume that each plan should perform at the level of the best performer. Similarly, it may not be feasible for even the best performer to achieve comparable results if they enrolled the entire population. As an illustration, consider the essential aspect of network adequacy. Expecting a single Plan to serve the entire population would likely necessitate an expansion of their provider network. This expansion would require working with and contracting with many of the same providers in the networks of the other Plans today. It may be overly optimistic to assume that a new Plan could achieve any different outcomes with the same set of providers. At the same time, these comparisons do show real potential for improvements. Such benchmarking can and should be used by the Department prospectively to negotiate contractual terms that incentivize and anticipate the most efficient use of State resources as possible.

The attached Exhibit 1 provides the member months, historical expenditures per member per month (PMPM), risk scores and risk adjusted PMPMs by Plan and by rate cell (which tie to the figures in Table 1). In addition, the exhibit separates results for all counties and for the Top 4 counties. Exhibits 2a and 2b further break down the differences in total expenditure between risk adjusted utilization and average cost per service by plan and rate cell.

Exhibits 3, 4, and 5 provide different risk stratification summaries. Exhibit 3 compares experience for groupings of rate cells highlighting the performance of specific conditions categories identified through the risk adjustment mechanism. Exhibit 4 compares experience for the same groupings of rate cells but summarizes the risk adjusted performance for the top five conditions affecting each rate cell. Exhibit 5 compares the experience for all the rate cells combined for a particular condition category. The risk adjustment section below describes the different conditions and categories in more detail.

The review of the risk stratification results demonstrates that the overall comparison can shift with the analysis of subgroups for relative performance of each plan. For example, with Rate Cells A & C, in Exhibit 7 covering the top five condition categories the Select Access Adjusted PMPM is \$5.61 higher than the HealthyU. The composite adjusted difference for all condition categories in Table 1 for Select Access Rate Cell A is \$11.09 higher than HealthyU, and for Rate Cell C is \$10.64 higher than HealthyU. This implies that for the individuals with the most severe and frequently occurring conditions are closer in risk adjusted cost for Select Access and HealthyU.

BACKGROUND

Milliman's contract with the Utah Department of Health (Department), effective August 1, 2007 is to provide actuarial consulting services including evaluation of the cost effectiveness of the health plan expenditures. In the fall of 2008, the Department began to supply data to Milliman for various analyses. The data includes eligibility and expenditures for members participating through any of the three delivery options, or managed care plans: Molina, Select Access, and HealthyU. The primary purpose of the data analysis has been the computation of pre-paid, full risk capitation rates.

As such, the data includes only services under consideration for coverage through this type of arrangement for the eligibility periods where the member is assigned to one of the Plans. Fee-For Service (FFS) expenditures before plan enrollment or for service categories outside the scope of Plans covered services are generally excluded from the data and the analysis. The Department decision on what services to consider for coverage in a capitation arrangement is beyond the scope of this review. It is our understanding that the primary category of service excluded from consideration is skilled nursing facility expenditures.

This report is a result of the Auditor engaging Milliman to provide a more robust, risk adjusted review and comparison of the plan performance in the same structure as the Actuarial Certification of the Molina rate development. The Department of Health authorized this actuarial report with independent oversight by the Office of the Legislative Auditor General. Of particular interest in this analysis is an extension of the risk adjustment performed as part of the actuarial soundness certification. The Department and Milliman relied on a risk adjustment process as a mechanism to equitably compare Plan results, which ultimately lead to conclusions regarding the potential for additional managed care savings.

The Chronic Illness and Disability Payment System (CDPS) developed by the University of California San Diego, is a diagnostic classification system that Medicaid programs often use to make health-based capitated payments. The latest version of CDPS in combination with the CDPS MedicaidRx, a pharmacy based risk adjustment enhancement, calculates a risk score for every beneficiary with at least five months of enrollment in a Medicaid Managed Care plan. The risk score reflects the age and gender of the beneficiary, as well as their health status based upon the identification of chronic condition categories identified through their claim data. The aggregate risk scores of any cohort reflect an average weighted by the number of months of enrollment for each member.

Department of Health authorized this Actuarial report with independent oversight by the Office of the Legislative Auditor General.

The Department eligibility data classifies beneficiaries into rate cells. An enrollees' rate cell assignment is made at the time of plan enrollment. The rate cell also corresponds to the CMS funding authorization and review. CMS regulations provide each state with some flexibility in the structure of their Medicaid programs. This creates challenges in benchmarking data from other states. For example, states differ in the specific income thresholds for which populations qualify for benefits. In addition, states vary in how they segregate populations. For example, Utah is somewhat unique in the number of categories into which the Temporary Aid to Needy Families (TANF) and pregnant women split. While this level of definition facilitates the effective comparison of different delivery options with the State, it complicates comparisons to other states.

Through the application of risk adjustment and segregation by rate cell, effective comparisons between Plans can begin to be made. However, each of the Plans also has a different composition to their service area. Therefore, experience for the enrollee' county of residence is also considered in an area adjustment factor for the utilization and expenditures. Given that all Plans are available and 96 percent of the managed care membership resides in the Wasatch front counties of Salt Lake, Weber, Davis and Utah, these four counties are the area of interest for the review.

DATA DESCRIPTION

The Department provided data for all of the Plans, originally for the purpose of actuarial certification of rate range calculations provided to CMS. The expenditures are summarized on a date of service or incurred basis for all claims paid through September 30, 2009. The medical and pharmacy expenditures were also provided for all FFS expenditures by county. With nine months of run-out, the CY 2008 data is determined to be sufficiently complete and the expenditures do not include any reserve for claims incurred but not paid. In general, the expenditures also only reflect categories of service under consideration by the Department for inclusion in a monthly capitated payment, although pharmacy claims have been included. The expenditure data is also matched to specific eligibility records, requiring that an individual's eligibility history match the reported eligibility period.

All medical claim and pharmacy data is processed through the Milliman *Health Cost Guidelines* grouper for comparable analysis and review. This algorithm processes details of each claim and assigns a category of service consistent with the Milliman *Health Cost Guidelines* while grouping individual claims into common units of utilization. Appendix 1 contains summarized cost models for all rate cells reflecting this first step of data processing.

At the direction of the Department, not all Medicaid expenditures are included in this analysis. For example, long-term care costs were excluded. At the same time, the expenditures considered in the study contain more than just managed care covered services, most notably prescription drugs. The reason for including the pharmacy claims in the analysis is that the member participation in managed care should have a direct impact on prescription drug experience, while other service categories such as nursing home stays are much less impacted by managed medical care.

Table 2 over the next two pages first summarizes by county those expenditures considered as part of the study. The table then summarizes the subset of those expenditures for months of member enrollment in managed care. Costs in the considered category but not in the enrolled category primarily reflect months where members are not assigned to a plan, but are in the fee-for-service program. While managed care enrollment is mandatory in four counties (Salt Lake, Weber, Davis and Utah), members in those counties often have some time in fee-for-service prior to plan enrollment. In addition, it should be noted that in Table 2 some Considered Expenditures are assigned to counties based on the place of service, while Enrolled Expenditures are all assigned to counties based on the enrollee residence. Molina is the only Managed Care Plan to operate outside of the four largest counties, which are all voluntary.

County	Considered Expenditure	Enrolled Expenditure
SALT LAKE	\$327,424,434	\$210,400,812
UTAH	126,977,862	87,111,761
WEBER	72,544,880	53,736,776
DAVIS	60,831,090	43,222,919
Subtotal	\$587,778,265	\$394,472,268

Table 2: Expenditures by County (Voluntary)

County	Considered Expenditure	Enrolled Expenditure
WASHINGTON	37,852,494	3,954,028
CACHE	30,345,075	156,939
IRON	18,316,559	2,679,748
TOOELE	17,967,060	2,833,071
CARBON	14,072,108	-
BOX ELDER	12,406,469	273,732
SANPETE	10,858,184	11,572
SEVIER	10,643,110	18,900
UINTAH	8,834,859	-
DUCHESNE	7,096,169	772
SAN JUAN	6,224,332	908
GRAND	5,691,478	71,077
JUAB	4,223,923	2,987
MILLARD	4,197,592	-
SUMMIT	4,270,715	119,086
EMERY	4,106,123	-
WASATCH	3,741,092	-
BEAVER	2,541,437	63,627
KANE	1,420,446	19,418
GARFIELD	1,037,397	2,187
PIUTE	747,126	156
WAYNE	705,324	560
MORGAN	716,347	168,133
RICH	467,833	-
DAGGETT	104,854	-
OUT OF STATE	112,878	-
Grand Total	\$796,479,249	\$404,849,168

In order to assign risk scores to a member, we established the enrollment threshold for the calculation of credible risk scores at a minimum of five months of eligibility within any of the Plans. We also excluded periods of dual-eligibility with Medicare as Medicaid claim data is often incomplete for these members. Any enrollee who is not dual-eligible for Medicare but enrolled within a rate cell for less than five months is assigned the plan average risk score for that rate cell. Table 3, below summarizes the expenditures as segregated during the risk adjustment process.

Table 3: Managed Care Medical and Pharmacy Expenditures by Plan

	Molina	Select Access	HealthyU	Total
Considered Totals by Plan	\$117,700,556	\$195,665,556	\$91,483,055	\$404,849,168
Percentage of Grand Total	9%	14%	7%	29%
Rate Cells of Interest, Top 4 Counties	\$102,101,577	\$175,570,923	\$76,945,693	\$354,618,194
Percentage of Plan Total	87%	90%	84%	88%
Percentage of Grand Total	7%	13%	6%	26%

RISK ADJUSTMENT METHODOLOGY

A risk adjustment model calculates a health status factor for a population through the assignment of condition categories to individuals based on a review of medical claims and pharmacy data. Health status factors are calculated for the risk concurrent with the data period, or prospectively in advance of the data period. A concurrent risk adjustment calculation will assess the relative management of conditions within the population, while prospective risk adjustment is used to establishing projected expenditure targets normally associated with risk based payments. The concurrent model has been used for this analysis. An aggregate risk score for any cohort is the average of each individual's risk score weighted by the number of enrollment months for that individual. As noted above, members with less than five months of enrollment do not contribute to the computation of the aggregate risk score. Risk score based adjustments are intended to reflect the per member per month relative expected cost, which includes both utilization rates and expected unit costs. This analysis applies adjustments for risk scores to the utilization rates per 1000, and makes no modifications to the average cost per unit of service

Risk Adjustment Model Selection

There are several risk adjustment models available. This study utilizes the University of San Diego's Chronic Illness and Disability Payment System (CDPS) developed specifically for use by Medicaid agencies. The 5.1 version of CDPS, the medical diagnosis based model, is combined with a new pharmacy based risk adjustment model, MedicaidRx, to calculate CDPS-Rx based risk scores. The vast majority of states implementing risk adjustment in some manner for their Medicaid populations rely upon the CDPS tool.

Risk Adjustment Model Application

All dual-eligible enrollees are excluded from risk adjustment. Individuals that are not dual-eligible for risk adjustment are considered credible if they have more than five months of enrollment. For each combination of Plan - County - Rate Cell under evaluation there needed to be at least 240 credible member months for the average credible risk score to be extended to the rest of the risk adjustment eligible population. If a plan - county - Rate Cell did not have 240 credible member months then the Plan - Rate Cell average credible risk score was extended over the rest of the risk adjustment eligible population. The effects of this methodology are demonstrated in the differences between Exhibit 1 Section 2 and Exhibit 1 Section 3. All Rate Cells with less than 6,000 member months were also excluded in the step between these sections due to the low contribution to the overall adjusted comparison.

RISK STRATIFICATION

The comparison of risk adjusted expenditures by Plan and rate cell is the primary result of this experience review. In addition to this overall comparison, the experience for different sub-groupings of rate cells and health conditions is discussed in Exhibits 3 through 8. These various cohorts can provide additional points of discussion in regard to the management of health conditions between plans. Exhibits 3, 4, and 5 have been normalized for the relative risk adjustment between plans, while Exhibits 6, 7 and 8 are only adjusted for differences in geographic service areas.

The sub-groupings summarized in Exhibits 3 and 6 include the following combinations of rate cells and specific conditions of high prevalence:

- A & C – Traditional Children Ages 1 through 18
with Pulmonary Medium Condition
- A & C – Traditional Children Ages 1 through 18
with Cardiac Pharmacy Condition
- A & C – Traditional Children Ages 1 through 18
with a Depression/Psychosis/Bipolar Pharmacy Condition
- B & D – Traditional Adults Ages 19 through 64
with Pulmonary Medium Condition
- B & D – Traditional Adults Ages 19 through 64
with a Depression/Psychosis/Bipolar Pharmacy Condition
- D & P – Traditional Female Adults and Pregnant Women
with a Completed Pregnancy Condition
- G & H – Disabled Enrollees All Ages
with a Pulmonary Very High Condition
- G & H – Disabled Enrollees All Ages
with a Depression/Psychosis/Bipolar Pharmacy Condition
- G & H – Disabled Enrollees All Ages
with a Pulmonary Medium Condition
- K & L – Traditional Children Ages Up to 1 year
with a Pulmonary Medium Condition
- K & L – Traditional Children Ages Up to 1 year
with a Gastrointestinal High Condition
- K & L – Traditional Children Ages Up to 1 year
with a Cardiovascular Medium Condition

For Exhibit 3 the plan results are adjusted for the relative risk scores within the sub-group to reflect the variation in co-morbid conditions between the Plans without removing the overall diagnosis risk. Exhibit 6 does not make this normative adjustment and reports the risk scores as calculated in the model, adjusted only for geographic area.

Exhibits 4 and 7 are for the same combinations of similar rate cells, but summarize the combined experience for the top five conditions for each rate cell combination. The stratification of risk in this manner generates more member months and adds to the credibility of each sample. However, this increases the diversity within each cohort by adding to the mix of co-morbid conditions, as well as the relative composition of the top five conditions within a plan. The conditions were selected from the total of all plans for each of the rate cell groupings. Exhibit 4 normalizes for risk score mix across the plans, while Exhibit 7 summarizes the experience only adjusted for geographic variation.

The final risk stratification is by condition category, combined for all rate cells of interest and is contained in Exhibits 5 and 8. The top four condition categories were selected along with diabetes. Exhibit 5 normalizes for the mix of risk scores by plans within the condition category. This method contains the similar deficiency as the previous method where plan specific mix of the intensity of patients complicates the comparison.

BENCHMARKING TO OTHER STATES AND MILLIMAN GUIDELINES

Each state is granted flexibility by CMS in the structure of eligibility classes and rate cells. Utah's separate rate cell for pregnant women apart from other female adults and children is somewhat unique. Adjusting for the age and gender mix is critical in developing a benchmark without accounting for this significant driver of utilization patterns, benchmarks lose their relevance. In addition, the classification of data into Milliman service categories is dependent upon the quality of data submitted by each of the three plans serving the State of Utah. The development of the Milliman Guidelines is also dependent on the quality of data available for study and research. Milliman is unable to audit the data underlying these benchmarks, but has adjusted them where appropriate and reviewed them for reasonability.

Exhibit 9 summarizes key utilization statistics from comparable populations in Washington and Nevada. The comparable populations between the three states are Rate Cells, A & C comparable to Children Ages 2 through 18; Rate Cell B comparable to Adult Males Ages 19 through 64; and Rate Cells K & L comparable to Infant Children Ages Up to 2 years; For Washington we are also able to provide FFS utilization statistics for Disabled individuals of all Ages, comparable to Rate Cells G&H.

Exhibit 10 includes benchmarking comparisons to Milliman's AFDC – TANF *Health Cost Guidelines* (Guidelines). The Guidelines present benchmarks of utilization on a spectrum from Loosely Managed to Well Managed. A Loosely Managed benchmark is for a Medicaid Managed Care plan with very few utilization management controls. A Well Managed benchmark is for a Medicaid Managed Care plan with several utilization management programs, and may not necessarily be achieved in the most rigorously managed plans.

This version of the Guidelines is adjusted for the Utah specific age gender composition and rate of deliveries per composite AFDC – TANF Medicaid enrollee. The rate cells that are considered to best correlate with the Guidelines are Rate Cells A, B, C, D, and P. The basis for determining the rate of deliveries per 1000 is based upon the Risk Adjustment methodology in assignment of the category PRGCMP, or Pregnancy Complete. Since this assignment requires at least 6 months of enrollment the same delivery rate per 1000 for each age band was applied to the entire population in a manner consistent with the handling of risk adjustment. We have shown the benchmarks for All Plans and the lowest cost plan HealthyU.

APPENDICIES

After the Exhibits there are several appendices attached to summarize the various supporting cost model summaries. Appendix 1 contains the unadjusted cost models in support of Exhibit 1 – Section 1. Appendix 2 contains the risk and area adjusted cost models in support of Exhibit 1 – Section 4 as well as Exhibits 2a and 2b. Appendix 3 contains the area adjusted cost model summaries in support of Risk Stratification Method 1, Exhibits 3 and 6. This Appendix is not normalized for the relative risk scores for each rate cell combination, and does not adjust for the overall diagnosis burden. Appendix 4 contains the risk and area adjusted cost models in support of Risk Stratification Method 2, Exhibits 4 and 7. Appendix 5 contains the risk and area adjusted cost models in support of Risk Stratification Method 3, Exhibits 5 and 8.

Exhibit 1: Progression of Data Analysis and Comparison of Plan Relativities
 CY 2008 Data: Claims Incured January 1, 2009 through December 31, 2008; Paid Through September 1, 2009

Section 1														
Total Cost - Managed Care Plans														
All Rate Cells, All Counties, All Members														
	Molina			Select Access			Healthy U			Total				
	Member Months	Raw PMPM	Total Cost	Member Months	Raw PMPM	Total Cost	Member Months	Raw PMPM	Total Cost	Member Months	Raw PMPM	Total Cost		
A - Male (1 through 18 years)	127,718	91.89	11,735,869	152,888	115.42	17,647,012	78,400	93.79	7,352,798	359,006	102.33	36,735,679		
B - Non-Traditional Male (19 through 64 years)	8,893	385.40	3,427,334	13,391	334.07	4,473,523	6,543	261.45	1,710,646	28,827	333.42	9,611,503		
C - Female (1 through 18 years)	123,906	87.89	10,889,485	147,603	98.36	14,518,865	74,909	85.95	6,446,455	346,508	91.93	31,854,805		
D - Non-Traditional Female (19 through 64 years)	38,428	395.64	15,203,465	43,618	406.76	17,742,131	21,355	363.96	7,754,107	103,351	393.80	40,699,702		
E - Aged (65 years and older)	20,902	130.54	2,728,651	25,994	149.92	3,896,922	19,651	197.00	3,871,271	66,547	157.74	10,496,844		
F - Tech. Dependent Waiver	98	4,824.47	472,798	703	8,500.69	5,975,985	294	7,869.37	2,313,596	1,095	8,002.17	8,762,379		
G - Disabled Male (all ages)	27,135	466.22	12,650,866	50,776	613.43	31,147,745	33,238	582.05	19,346,097	111,149	568.11	63,144,708		
H - Disabled Female (all ages)	34,230	538.91	18,447,043	59,091	651.10	38,473,937	32,665	668.60	21,839,846	125,986	625.16	78,760,826		
I - Medically Needy Child (0 through 18 years)	1,372	102.88	141,151	1,616	130.39	210,711	602	371.96	223,917	3,590	160.38	575,779		
J - Medically Needy Adults (19 years and older)	9	39.25	353	7	100.25	702	8	957.48	7,660	24	363.12	8,715		
K - Male (birth up to 1 year)	27,227	432.33	11,771,053	36,534	444.82	16,250,880	13,730	442.82	6,079,856	77,491	440.07	34,101,788		
L - Female (birth up to 1 year)	26,369	375.74	9,908,007	33,845	509.45	17,242,375	13,890	335.08	4,654,276	74,104	429.19	31,804,659		
N - Breast/Cervical Cancer (all ages)	350	1,599.44	559,805	953	1,924.93	1,834,462	266	1,376.84	366,240	1,569	1,759.41	2,760,507		
P - Pregnant Woman (all ages)	20,098	914.36	18,376,752	26,476	898.66	23,792,936	8,397	990.32	8,315,691	54,971	918.40	50,485,379		
Q - Non-Traditional Restriction	305	1,365.36	416,433	455	1,803.72	820,691	211	760.03	160,366	971	1,439.23	1,397,491		
R - Traditional Restriction	605	1,513.92	915,923	1,011	1,617.47	1,635,264	412	1,775.00	731,301	2,028	1,618.58	3,282,488		
S - Male Refugee (all ages)	161	200.74	32,318	22	54.84	1,206	767	261.47	200,546	950	246.39	234,071		
T - Female Refugee (all ages)	66	352.25	23,248	8	26.08	209	394	275.09	108,387	468	281.72	131,844		
Total	457,872	257.06	117,700,556	594,991	328.85	195,665,556	305,772	299.19	91,483,055	1,358,635	297.98	404,849,168		
Composite based on Total Membership		271.13			314.21			295.21						

Section 2																
Risk Score Population Adjusted Cost																
All Rate Cells, All Counties, Credible for Risk Scores																
	Molina				Select Access				Healthy U				Total			
	Member Months	Raw PMPM	Risk Score	Adjusted PMPM	Member Months	Raw PMPM	Risk Score	Adjusted PMPM	Member Months	Raw PMPM	Risk Score	Adjusted PMPM	Member Months	Raw PMPM	Risk Score	Adjusted PMPM
A - Male (1 through 18 years)	111,549	94.02	0.929	101.20	135,097	118.38	1.094	108.23	69,155	95.00	0.986	96.33	315,801	104.66	1.015	103.14
B - Non-Traditional Male (19 through 64 years)	6,658	395.37	1.023	386.54	10,605	336.60	1.046	321.94	5,255	271.28	0.864	313.87	22,518	338.73	0.999	339.16
C - Female (1 through 18 years)	108,167	89.35	0.889	100.54	130,550	99.30	0.954	104.06	65,973	86.54	0.923	93.75	304,690	93.00	0.925	100.58
D - Non-Traditional Female (19 through 64 years)	32,149	402.73	1.193	337.61	36,977	416.43	1.293	322.02	18,208	362.97	1.237	293.35	87,334	400.24	1.244	321.78
E - Aged (65 years and older)	210	1,126.85	1.139	989.32	216	608.86	1.203	506.29	701	964.35	0.960	1,004.47	1,127	926.50	1.022	906.17
F - Tech. Dependent Waiver	98	4,824.47	7.030	686.24	694	8,591.37	8.601	998.88	292	7,921.94	10.256	772.44	1,084	8,070.50	8.872	909.62
G - Disabled Male (all ages)	14,632	701.71	1.038	676.03	28,510	895.73	1.413	634.00	16,031	976.02	1.503	649.53	59,173	869.50	1.341	648.60
H - Disabled Female (all ages)	17,277	873.16	1.206	723.98	31,824	1,027.48	1.455	706.23	16,721	1,053.33	1.573	669.52	65,822	993.54	1.416	701.57
I - Medically Needy Child (0 through 18 years)	1,197	104.38	0.587	177.78	1,394	138.89	0.813	170.92	520	398.23	0.977	407.41	3,111	168.96	0.793	213.09
J - Medically Needy Adults (19 years and older)	8	30.29	4.909	6.17	3	-	1.000	-	7	1,094.27	1.727	633.50	18	439.01	1.762	249.10
K - Male (birth up to 1 year)	21,463	387.13	2.276	170.08	29,313	371.98	2.274	163.56	10,779	377.42	2.590	145.70	61,555	378.22	2.325	162.71
L - Female (birth up to 1 year)	20,815	286.32	2.115	135.35	26,966	446.86	2.194	203.64	11,171	286.56	2.153	133.10	58,952	359.80	2.165	166.16
N - Breast/Cervical Cancer (all ages)	308	1,606.49	1.462	1,098.94	842	1,609.92	1.709	941.80	222	1,423.42	1.791	794.84	1,372	1,578.97	1.656	953.30
P - Pregnant Woman (all ages)	12,447	943.06	1.900	496.28	16,734	921.63	1.868	493.31	5,499	1,000.28	1.961	510.11	34,680	941.79	1.895	497.04
Q - Non-Traditional Restriction	287	1,333.68	1.431	932.14	430	1,893.27	1.684	1,124.35	187	805.26	1.306	616.45	904	1,490.55	1.555	958.26
R - Traditional Restriction	507	1,692.55	1.729	978.80	883	1,772.31	2.009	882.30	378	1,794.75	1.991	901.48	1,768	1,754.23	1.919	914.07
S - Male Refugee (all ages)	43	576.31	0.522	1,103.41	6	13.95	0.073	191.46	257	526.17	0.831	633.36	306	523.17	0.757	690.75
T - Female Refugee (all ages)	8	592.57	0.279	2,123.89	0	-	1.000	-	158	438.71	1.287	340.90	166	446.12	1.045	426.83
Total	347,823	257.87	1.241	207.84	451,044	342.67	1.462	234.38	221,514	320.05	1.438	222.57	1,020,381	308.85	1.386	222.77
Composite based on Total Membership		281.17	1.240	226.66		324.30	1.435	225.95		306.85	1.453	211.12				

Exhibit 1: Progression of Data Analysis and Comparison of Plan Relativities
 CY 2008 Data: Claims Incured January 1, 2009 through December 31, 2008; Paid Through September 1, 2009

Section 3																
Rate Cells of Interest, All Counties																
Average Risk Score Applied																
	Molina				Select Access				Healthy U				Total			
	Member Months	Raw PMPM	Risk Score	Adjusted PMPM	Member Months	Raw PMPM	Risk Score	Adjusted PMPM	Member Months	Raw PMPM	Risk Score	Adjusted PMPM	Member Months	Raw PMPM	Risk Score	Adjusted PMPM
A - Male (1 through 18 years)	127,718	91.89	0.928	99.00	152,888	115.42	1.093	105.57	78,399	93.79	0.986	95.15	359,005	102.33	1.014	100.96
B - Non-Traditional Male (19 through 64 years)	8,874	385.43	1.031	373.75	13,365	332.44	1.046	317.91	6,540	261.39	0.862	303.13	28,779	332.63	1.003	331.77
C - Female (1 through 18 years)	123,896	87.89	0.888	98.96	147,591	98.37	0.954	103.08	74,999	85.95	0.925	92.96	346,486	91.94	0.925	99.42
D - Non-Traditional Female (19 through 64 years)	38,386	395.50	1.194	331.37	43,552	406.14	1.293	314.19	21,268	363.82	1.237	294.00	103,206	393.46	1.243	316.42
G - Disabled Male (all ages)	15,705	750.85	1.034	726.03	30,452	945.89	1.412	669.83	17,221	996.09	1.502	662.97	63,378	911.20	1.336	681.89
H - Disabled Female (all ages)	18,468	906.50	1.204	753.04	33,734	1,043.27	1.455	717.20	17,803	1,090.73	1.575	692.65	70,005	1,019.26	1.415	720.41
K - Male (birth up to 1 year)	27,227	432.33	2.272	190.29	36,534	444.82	2.277	195.34	13,730	442.82	2.534	174.75	77,491	440.07	2.317	189.92
L - Female (birth up to 1 year)	26,369	375.74	2.117	177.45	33,845	509.45	2.181	233.64	13,890	335.08	2.157	155.36	74,104	429.19	2.157	198.97
P - Pregnant Woman (all ages)	20,089	914.21	1.902	480.63	26,440	899.50	1.864	482.63	8,386	990.97	1.966	504.08	54,915	918.85	1.894	485.18
Total	406,732	269.97	1.280	210.87	518,401	338.68	1.443	234.73	252,236	312.65	1.429	218.84	1,177,369	309.37	1.387	223.08
Composite based on Total Membership		287.04	1.262	227.46		324.12	1.430	226.61		307.10	1.454	211.21				

Section 4																
Rate Cells of Interest, Top 4 Counties																
Average Risk Score Applied to All																
	Molina				Select Access				Healthy U				Total			
	Member Months	Risk Score	Area Factor	Adjusted PMPM	Member Months	Risk Score	Area Factor	Adjusted PMPM	Member Months	Risk Score	Area Factor	Adjusted PMPM	Member Months	Risk Score	Area Factor	Adjusted PMPM
A - Male (1 through 18 years)	113,727	0.937	0.998	99.36	152,888	1.093	1.000	105.57	76,707	0.971	1.002	94.47	343,322	1.017	1.000	101.03
B - Non-Traditional Male (19 through 64 years)	8,282	1.046	0.998	384.58	13,365	1.046	0.995	319.52	6,384	0.866	1.000	305.74	28,031	1.008	0.997	335.60
C - Female (1 through 18 years)	110,218	0.903	0.998	100.44	147,591	0.954	1.001	102.97	73,473	0.923	1.002	92.32	331,282	0.931	1.000	99.76
D - Non-Traditional Female (19 through 64 years)	36,398	1.202	0.998	330.94	43,552	1.293	1.001	313.98	20,759	1.242	1.001	294.69	100,709	1.249	0.999	316.13
G - Disabled Male (all ages)	14,496	1.035	1.002	748.82	30,452	1.412	1.003	667.66	17,007	1.502	1.002	662.56	61,955	1.339	1.003	685.25
H - Disabled Female (all ages)	17,528	1.215	0.997	754.64	33,734	1.455	1.004	714.16	17,545	1.581	1.004	688.89	68,807	1.422	1.002	718.03
K - Male (birth up to 1 year)	24,942	2.289	1.005	189.35	36,534	2.277	0.993	196.74	13,257	2.525	1.002	174.44	74,733	2.322	0.998	190.32
L - Female (birth up to 1 year)	24,246	2.092	0.998	176.91	33,843	2.181	0.993	235.27	13,426	2.155	1.000	157.01	71,515	2.150	0.995	200.79
P - Pregnant Woman (all ages)	18,236	1.915	0.999	478.95	26,440	1.864	0.994	485.47	8,056	1.975	0.999	490.89	52,732	1.899	0.997	484.05
Total	368,073	1.287	0.999	215.80	518,399	1.443	1.000	234.74	246,614	1.427	1.002	218.27	1,133,086	1.391	1.000	225.00
Composite based on Total Membership		1.277	0.999	231.11		1.426	1.000	228.19		1.455	1.002	211.70				

Exhibit 2a
Comparison of CY 2008 Utilization per 1,000 for Exhibit 1 - Section 4 Risk Adjusted

Plan	Rate Cell	Member Months	Annual Utilization per 1,000								
			Inpatient Medical	Inpatient Surgical	Inpatient Maternity	Inpatient Hospital	Outpatient ER	Outpatient Surgery	Outpatient Hospital	Office Visits	Pharmacy
Molina	A - Male (1 through 18 years)	113,727	36.8	25.2	-	62.3	409.6	50.5	496.8	2,310.3	5,123.5
Select Access	A - Male (1 through 18 years)	152,888	28.6	32.7	-	61.8	363.7	102.5	650.9	2,111.2	4,972.6
HealthyU	A - Male (1 through 18 years)	76,707	49.4	27.8	-	78.4	266.4	38.9	348.5	1,758.9	4,369.3
Molina	B - Non-Traditional Male (19 through 64 years)	8,282	264.7	126.0	-	396.7	887.8	147.3	1,139.7	3,416.1	14,520.7
Select Access	B - Non-Traditional Male (19 through 64 years)	13,365	125.7	89.7	-	241.9	951.4	194.1	1,583.1	3,484.8	14,588.5
HealthyU	B - Non-Traditional Male (19 through 64 years)	6,384	153.4	83.3	-	277.4	608.7	198.9	943.4	3,607.2	12,445.4
Molina	C - Female (1 through 18 years)	110,218	40.5	16.1	18.2	77.1	415.7	56.7	539.8	2,544.8	5,023.7
Select Access	C - Female (1 through 18 years)	147,591	37.5	18.0	17.2	74.3	404.4	107.4	756.9	2,517.6	5,048.8
HealthyU	C - Female (1 through 18 years)	73,473	49.5	18.0	17.4	87.8	296.8	37.9	395.8	2,035.7	4,441.7
Molina	D - Non-Traditional Female (19 through 64 years)	36,398	111.3	82.1	5.7	214.6	1,053.2	175.5	1,371.9	4,159.8	16,403.7
Select Access	D - Non-Traditional Female (19 through 64 years)	43,552	101.9	86.9	3.0	212.6	1,132.0	203.1	1,965.2	4,086.1	17,366.8
HealthyU	D - Non-Traditional Female (19 through 64 years)	20,759	120.5	111.8	26.2	271.5	863.6	169.7	1,318.7	3,802.6	13,924.7
Molina	G - Disabled Male (all ages)	14,496	625.8	297.1	-	935.3	680.2	229.5	1,113.1	3,647.7	31,663.6
Select Access	G - Disabled Male (all ages)	30,452	445.2	320.5	-	779.6	576.0	234.4	1,697.0	2,829.6	23,676.7
HealthyU	G - Disabled Male (all ages)	17,007	568.7	265.1	-	879.4	385.1	188.7	761.4	2,657.8	23,095.8
Molina	H - Disabled Female (all ages)	17,528	516.5	280.8	53.0	860.0	885.3	293.1	1,496.3	5,075.6	42,798.9
Select Access	H - Disabled Female (all ages)	33,734	425.5	219.3	10.8	682.0	866.4	284.8	2,225.1	4,211.1	35,492.7
HealthyU	H - Disabled Female (all ages)	17,545	626.3	245.9	14.4	909.9	591.1	232.4	1,145.8	3,797.1	34,454.6
Molina	K - Male (birth up to 1 year)	24,942	124.3	85.6	-	1,123.6	355.9	39.3	441.2	2,132.3	2,317.0
Select Access	K - Male (birth up to 1 year)	36,534	140.4	38.4	-	1,026.0	316.4	37.3	630.2	2,217.3	2,287.1
HealthyU	K - Male (birth up to 1 year)	13,257	130.0	112.5	-	888.9	224.4	29.8	289.2	1,658.0	2,004.8
Molina	L - Female (birth up to 1 year)	24,246	121.3	62.0	-	1,131.3	351.8	29.3	426.3	2,222.7	2,273.6
Select Access	L - Female (birth up to 1 year)	33,843	112.3	133.7	-	1,206.7	302.6	29.3	588.4	2,099.7	2,028.7
HealthyU	L - Female (birth up to 1 year)	13,426	143.4	22.2	-	928.5	247.6	9.7	286.3	1,672.4	1,960.6
Molina	P - Pregnant Woman (all ages)	18,236	22.1	10.0	1,907.1	2,073.3	520.7	67.4	1,535.5	1,335.6	8,278.4
Select Access	P - Pregnant Woman (all ages)	26,440	7.5	14.9	1,780.7	1,908.7	454.9	250.1	2,354.2	1,254.1	7,704.1
HealthyU	P - Pregnant Woman (all ages)	8,056	21.0	12.2	1,860.0	2,066.6	645.5	50.5	1,326.6	1,262.8	7,685.1

Exhibit 2b
Comparison of CY 2008 Average Cost Per Service Exhibit 1 - Section 4

Plan	Rate Cell	Member Months	Annual Average Cost Per Service								
			Inpatient Medical	Inpatient Surgical	Inpatient Maternity	Inpatient Hospital	Outpatient ER	Outpatient Surgery	Outpatient Hospital	Office Visits	Pharmacy
Molina	A - Male (1 through 18 years)	113,727	\$1,795.93	\$3,189.38	\$0.00	\$2,361.65	\$533.50	\$2,028.46	\$683.25	\$47.77	\$66.16
Select Access	A - Male (1 through 18 years)	152,888	\$1,809.58	\$3,596.84	\$0.00	\$2,752.27	\$523.22	\$1,505.91	\$590.58	\$45.09	\$79.93
HealthyU	A - Male (1 through 18 years)	76,707	\$1,825.85	\$2,862.00	\$0.00	\$2,177.36	\$585.65	\$1,452.82	\$687.02	\$50.86	\$67.53
Molina	B - Non-Traditional Male (19 through 64 years)	8,282	\$1,886.51	\$5,518.51	\$0.00	\$3,061.31	\$861.49	\$4,051.07	\$1,251.50	\$51.66	\$71.13
Select Access	B - Non-Traditional Male (19 through 64 years)	13,365	\$2,717.86	\$4,974.32	\$0.00	\$3,395.69	\$718.12	\$2,623.34	\$822.60	\$49.03	\$71.87
HealthyU	B - Non-Traditional Male (19 through 64 years)	6,384	\$2,539.17	\$3,660.21	\$0.00	\$2,722.07	\$721.24	\$1,660.14	\$890.04	\$54.44	\$76.67
Molina	C - Female (1 through 18 years)	110,218	\$2,054.35	\$2,609.69	\$1,190.91	\$1,946.31	\$558.44	\$1,954.79	\$682.23	\$47.83	\$51.68
Select Access	C - Female (1 through 18 years)	147,591	\$1,888.73	\$4,248.69	\$1,468.65	\$2,358.11	\$526.69	\$1,355.99	\$528.87	\$44.97	\$57.62
HealthyU	C - Female (1 through 18 years)	73,473	\$1,920.32	\$3,023.52	\$1,296.90	\$2,027.80	\$560.32	\$1,498.48	\$606.58	\$51.47	\$46.61
Molina	D - Non-Traditional Female (19 through 64 years)	36,398	\$2,003.37	\$3,746.16	\$1,348.00	\$2,698.67	\$842.80	\$2,926.38	\$1,075.05	\$50.36	\$53.81
Select Access	D - Non-Traditional Female (19 through 64 years)	43,552	\$2,441.31	\$3,556.22	\$1,390.53	\$2,770.71	\$764.47	\$2,291.90	\$732.95	\$48.33	\$58.04
HealthyU	D - Non-Traditional Female (19 through 64 years)	20,759	\$2,796.14	\$3,473.04	\$1,137.89	\$2,876.44	\$743.83	\$1,698.32	\$752.20	\$51.71	\$54.63
Molina	G - Disabled Male (all ages)	14,496	\$2,283.07	\$3,831.91	\$0.00	\$2,769.33	\$927.02	\$3,053.81	\$1,483.51	\$49.68	\$103.75
Select Access	G - Disabled Male (all ages)	30,452	\$2,715.97	\$3,678.33	\$0.00	\$3,086.39	\$814.34	\$2,082.64	\$822.05	\$47.66	\$113.94
HealthyU	G - Disabled Male (all ages)	17,007	\$2,293.25	\$3,545.50	\$0.00	\$2,608.79	\$779.98	\$1,927.96	\$1,081.38	\$53.88	\$134.97
Molina	H - Disabled Female (all ages)	17,528	\$1,666.29	\$3,804.28	\$1,009.24	\$2,323.04	\$940.99	\$2,554.65	\$1,220.71	\$50.50	\$81.44
Select Access	H - Disabled Female (all ages)	33,734	\$2,519.37	\$3,793.33	\$1,634.32	\$2,873.74	\$864.18	\$2,203.62	\$759.17	\$48.63	\$89.92
HealthyU	H - Disabled Female (all ages)	17,545	\$1,885.61	\$3,720.99	\$1,446.62	\$2,348.46	\$835.72	\$1,596.23	\$1,031.14	\$54.25	\$87.60
Molina	K - Male (birth up to 1 year)	24,942	\$1,779.79	\$3,161.55	\$0.00	\$1,231.81	\$462.84	\$1,363.31	\$534.18	\$46.84	\$26.66
Select Access	K - Male (birth up to 1 year)	36,534	\$1,802.95	\$3,225.19	\$0.00	\$1,395.11	\$421.16	\$1,306.37	\$336.41	\$43.85	\$28.17
HealthyU	K - Male (birth up to 1 year)	13,257	\$1,764.07	\$2,648.03	\$0.00	\$1,344.09	\$518.55	\$1,718.37	\$629.42	\$48.28	\$22.75
Molina	L - Female (birth up to 1 year)	24,246	\$1,652.69	\$3,178.75	\$0.00	\$1,096.57	\$457.08	\$1,138.24	\$500.62	\$46.58	\$27.24
Select Access	L - Female (birth up to 1 year)	33,843	\$1,602.97	\$3,473.88	\$0.00	\$1,568.41	\$421.89	\$1,289.25	\$337.60	\$43.90	\$28.50
HealthyU	L - Female (birth up to 1 year)	13,426	\$1,624.36	\$3,462.62	\$0.00	\$1,117.66	\$523.72	\$1,494.50	\$544.53	\$47.72	\$19.74
Molina	P - Pregnant Woman (all ages)	18,236	\$2,048.62	\$3,998.43	\$1,151.09	\$1,211.01	\$822.66	\$2,562.90	\$599.67	\$49.67	\$29.08
Select Access	P - Pregnant Woman (all ages)	26,440	\$1,675.56	\$4,126.86	\$1,453.32	\$1,502.77	\$714.39	\$1,080.28	\$411.43	\$45.60	\$31.66
HealthyU	P - Pregnant Woman (all ages)	8,056	\$1,529.94	\$5,212.52	\$1,357.72	\$1,434.58	\$634.77	\$2,405.73	\$543.80	\$46.69	\$28.74

Exhibit 2c
Comparison of CY 2008 Data
By Rate Cell Grouping and Plan
Risk and Area Adjusted, Not Normalized for Rate Cell Specific Scores

Rate Cell:	A&C Traditional Children (1 through 18 years)									
	Molina			Select Access			HealthyU			
Member Months	223,945			Member Months	300,479			Member Months	150,180	
Risk Score	0.920			Risk Score	1.026			Risk Score	0.948	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
IP Medical	38.6	1,929.19	\$6.21	32.96	1,853.79	\$5.09	49.47	1,872.15	\$7.72	
IP Surgical	20.7	2,968.12	\$5.12	25.49	3,823.46	\$8.12	23.03	2,923.88	\$5.61	
IP Maternity	8.9	1,190.91	\$0.89	8.44	1,468.65	\$1.03	8.53	1,296.90	\$0.92	
IP Hospital	69.6	2,135.10	\$12.38	67.93	2,540.55	\$14.38	83.03	2,099.95	\$14.53	
OP ER	412.6	545.87	\$18.77	383.67	525.02	\$16.79	281.29	572.57	\$13.42	
OP Surgery	53.5	1,990.06	\$8.88	104.91	1,430.55	\$12.51	38.44	1,474.86	\$4.72	
OP Hospital	518.0	682.73	\$29.47	702.95	557.95	\$32.68	371.63	645.11	\$19.98	
Office Visits Physician	2,425.7	47.80	\$9.66	2,310.81	45.02	\$8.67	1,894.32	51.18	\$8.08	
			\$32.54			\$26.16			\$35.92	
Pharmacy Other	5,074.4	59.10	\$24.99	5,010.03	68.88	\$28.76	4,404.71	57.21	\$21.00	
			\$25.49			\$31.07			\$22.99	
Total			\$99.89			\$104.29			\$93.42	

Rate Cell:	B&D Non-Traditional Adults (19 though 64 years)									
	Molina			Select Access			HealthyU			
Member Months	44,680			Member Months	56,917			Member Months	27,143	
Risk Score	1.169			Risk Score	1.234			Risk Score	1.151	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
IP Medical	139.8	1,962.34	\$22.85	107.49	2,517.23	\$22.55	128.23	2,723.84	\$29.11	
IP Surgical	90.2	4,204.90	\$31.62	87.52	3,897.39	\$28.42	105.11	3,507.94	\$30.73	
IP Maternity	4.6	1,348.00	\$0.52	2.30	1,390.53	\$0.27	20.01	1,137.89	\$1.90	
IP Hospital	248.4	2,806.02	\$58.08	219.47	2,932.46	\$53.63	272.87	2,839.52	\$64.57	
OP ER	1,022.6	845.81	\$72.07	1,089.62	754.97	\$68.55	803.66	739.81	\$49.55	
OP Surgery	170.3	3,106.76	\$44.08	201.00	2,367.06	\$39.65	176.58	1,688.21	\$24.84	
OP Hospital	1,328.8	1,103.10	\$122.15	1,875.47	750.72	\$117.33	1,230.45	777.06	\$79.68	
Office Visits Physician	4,022.0	50.57	\$16.95	3,944.88	48.48	\$15.94	3,756.63	52.33	\$16.38	
			\$83.07			\$56.02			\$81.85	
Pharmacy Other	16,054.7	56.71	\$75.87	16,714.45	60.88	\$84.80	13,576.76	59.38	\$67.19	
			\$77.58			\$88.29			\$71.20	
Total			\$340.88			\$315.28			\$297.29	

Exhibit 2c
Comparison of CY 2008 Data
By Rate Cell Grouping and Plan
Risk and Area Adjusted, Not Normalized for Rate Cell Specific Scores

Rate Cell:	G&H Disabled Enrollees (All Ages)								
	Molina			Select Access			HealthyU		
	Member Months	32,024		Member Months	64,186		Member Months	34,552	
	Risk Score	1.133		Risk Score	1.435		Risk Score	1.543	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
IP Medical	565.9	1,974.99	\$93.14	434.88	2,614.86	\$94.76	597.98	2,076.44	\$103.47
IP Surgical	288.2	3,817.17	\$91.68	267.34	3,727.92	\$83.05	255.37	3,631.31	\$77.28
IP Maternity	29.0	1,009.24	\$2.44	5.66	1,634.32	\$0.77	7.30	1,446.62	\$0.88
IP Hospital	894.1	2,534.38	\$188.83	728.34	2,981.73	\$180.98	894.88	2,474.38	\$184.52
OP ER	792.5	935.56	\$61.78	728.64	845.49	\$51.34	489.74	814.14	\$33.23
OP Surgery	264.3	2,750.82	\$60.58	260.86	2,152.05	\$46.78	210.92	1,742.32	\$30.62
OP Hospital	1,322.9	1,320.82	\$145.60	1,974.55	784.81	\$129.14	956.56	1,050.82	\$83.76
Office Visits Physician	4,429.2	50.19	\$18.53	3,555.65	48.26	\$14.30	3,236.31	54.10	\$14.59
			\$125.45			\$79.72			\$110.77
Pharmacy	37,758.4	89.91	\$282.91	29,886.78	98.95	\$246.44	28,863.63	106.26	\$255.59
Other			\$292.13			\$302.27			\$296.88
Total			\$752.01			\$692.10			\$675.93

Rate Cell:	D&P Pregnant Females Adults								
	Molina			Select Access			HealthyU		
	Member Months	54,634		Member Months	69,992		Member Months	28,815	
	Risk Score	1.502		Risk Score	1.568		Risk Score	1.529	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
IP Medical	81.6	2,007.46	\$13.64	66.25	2,408.47	\$13.30	92.69	2,715.76	\$20.98
IP Surgical	58.0	3,760.73	\$18.19	59.66	3,609.93	\$17.95	83.95	3,543.56	\$24.79
IP Maternity	640.3	1,152.25	\$61.49	674.54	1,453.15	\$81.68	538.87	1,350.03	\$60.62
IP Hospital	835.0	1,465.77	\$102.00	853.31	1,699.33	\$120.84	773.36	1,799.21	\$115.95
OP ER	875.5	838.81	\$61.20	876.24	754.65	\$55.10	802.64	719.31	\$48.11
OP Surgery	139.4	2,867.69	\$33.32	220.85	1,773.65	\$32.64	136.39	1,771.62	\$20.14
OP Hospital	1,426.5	904.25	\$107.49	2,112.12	597.57	\$105.18	1,320.93	693.69	\$76.36
Office Visits Physician	3,217.1	50.27	\$13.48	3,016.27	47.90	\$12.04	3,092.54	51.14	\$13.18
			\$114.17			\$90.06			\$103.59
Pharmacy	13,691.6	48.82	\$55.70	13,716.68	52.45	\$59.95	12,180.24	50.07	\$50.82
Other			\$56.69			\$62.69			\$53.64
Total			\$380.34			\$378.76			\$349.55

Exhibit 2c
Comparison of CY 2008 Data
By Rate Cell Grouping and Plan
Risk and Area Adjusted, Not Normalized for Rate Cell Specific Scores

Rate Cell:	K&L Traditional Children (Birth up to 1 year)								
	Molina			Select Access			HealthyU		
	Member Months	49,188		Member Months	70,377		Member Months	26,683	
	Risk Score	2.196		Risk Score	2.226		Risk Score	2.349	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
IP Medical	122.8	1,717.91	\$17.58	126.88	1,717.81	\$18.16	136.74	1,690.32	\$19.26
IP Surgical	74.0	3,168.65	\$19.54	84.22	3,415.04	\$23.97	67.09	2,783.95	\$15.56
IP Maternity	-	-	\$0.00	-	-	\$0.00	-	-	\$0.00
IP Hospital	1,127.4	1,164.91	\$109.44	1,112.87	1,485.47	\$137.76	908.82	1,227.69	\$92.98
OP ER	353.9	460.02	\$13.57	309.78	421.51	\$10.88	236.09	521.28	\$10.26
OP Surgery	34.3	1,268.71	\$3.63	33.43	1,299.16	\$3.62	19.70	1,662.97	\$2.73
OP Hospital	433.8	517.93	\$18.72	610.09	336.96	\$17.13	287.71	586.92	\$14.07
Office Visits Physician	2,176.9	46.70	\$8.47	2,160.71	43.87	\$7.90	1,665.24	48.00	\$6.66
			\$48.98			\$50.34			\$52.14
Pharmacy Other	2,295.6	26.94	\$5.15	2,162.85	28.32	\$5.10	1,982.56	21.25	\$3.51
			\$6.07			\$10.03			\$6.48
Total			\$183.22			\$215.27			\$165.67

Exhibit 3

Risk Stratification Method 1

CY 2008 Combined Rate Cells by Plan and Condition

Area Adjusted, Each Plan is Normalized for Average Cell Specific Risk Score without Removing Overall Diagnosis Risk

Rate Cell:	A&C		Traditional Children (1 through 18 years)						
Diagnosis:	PulM		Pulmonary, medium						
	Molina			Select Access			HealthyU		
	Member Months		782	Member Months		1,093	Member Months		528
	Risk Normalization Adj.		1.068	Risk Normalization Adj.		0.986	Risk Normalization Adj.		0.925
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	3,890.14	\$3,141.40	\$1,018.38	4,191.98	\$3,590.64	\$1,254.32	2,739.85	\$2,306.72	\$526.67
Emergency Room	1,373.70	\$817.29	\$93.56	1,560.64	\$752.55	\$97.87	817.84	\$781.40	\$53.26
Other OP Hospital			\$49.77			\$145.43			\$34.23
Physician			\$189.40			\$191.12			\$213.82
Prescription Drugs	13,430.50	\$52.05	\$58.26	14,136.06	\$69.81	\$82.23	16,259.73	\$59.57	\$80.71
Other			\$5.61			\$63.84			\$78.72
Total			\$1,414.97			\$1,834.82			\$987.41

Rate Cell:	A&C		Traditional Children (1 through 18 years)						
Diagnosis:	MRX2		Cardiac						
	Molina			Select Access			HealthyU		
	Member Months		2,058	Member Months		4,396	Member Months		1,376
	Risk Normalization Adj.		1.030	Risk Normalization Adj.		1.007	Risk Normalization Adj.		0.935
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	164.82	\$2,504.60	\$34.40	256.50	\$2,333.82	\$49.89	242.75	\$2,262.40	\$45.77
Emergency Room	595.71	\$625.38	\$31.05	497.98	\$589.95	\$24.48	323.18	\$461.06	\$12.42
Other OP Hospital			\$12.34			\$30.86			\$10.49
Physician			\$51.00			\$44.13			\$58.99
Prescription Drugs	32,944.05	\$87.78	\$241.00	33,208.95	\$106.84	\$295.66	28,720.44	\$95.45	\$228.45
Other			\$1.35			\$7.03			\$14.43
Total			\$371.13			\$452.05			\$370.54

Rate Cell:	A&C		Traditional Children (1 through 18 years)						
Diagnosis:	MRX3		Depression/Psychosis/Bipolar						
	Molina			Select Access			HealthyU		
	Member Months		5,943	Member Months		10,813	Member Months		3,662
	Risk Normalization Adj.		1.118	Risk Normalization Adj.		0.975	Risk Normalization Adj.		0.907
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	133.57	\$1,517.78	\$16.89	106.43	\$1,890.40	\$16.77	73.69	\$2,994.49	\$18.39
Emergency Room	474.85	\$662.70	\$26.22	359.70	\$500.00	\$14.99	294.60	\$573.30	\$14.07
Other OP Hospital			\$14.36			\$18.53			\$10.72
Physician			\$48.68			\$29.32			\$48.85
Prescription Drugs	26,306.18	\$97.98	\$214.78	24,886.79	\$115.99	\$240.55	21,894.91	\$103.70	\$189.20
Other			\$0.91			\$4.77			\$8.80
Total			\$321.85			\$324.92			\$290.04

Exhibit 3

Risk Stratification Method 1

CY 2008 Combined Rate Cells by Plan and Condition

Area Adjusted, Each Plan is Normalized for Average Cell Specific Risk Score without Removing Overall Diagnosis Risk

Rate Cell:	B&D		Non-Traditional Adults (19 though 64 years)						
Diagnosis:	PULM		Pulmonary, medium						
	Molina			Select Access			HealthyU		
	Member Months	299		Member Months	575		Member Months	359	
	Risk Normalization Adj.	1.135		Risk Normalization Adj.	0.877		Risk Normalization Adj.	1.154	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	5,923.14	\$2,897.26	\$1,430.07	5,432.03	\$3,084.79	\$1,396.39	5,266.97	\$3,612.28	\$1,585.48
Emergency Room	4,135.26	\$1,105.63	\$381.01	5,748.53	\$1,081.59	\$518.13	2,161.60	\$905.52	\$163.12
Other OP Hospital			\$209.98			\$194.44			\$137.77
Physician			\$483.93			\$342.21			\$446.01
Prescription Drugs	59,153.62	\$55.61	\$274.14	47,246.17	\$67.06	\$264.02	43,768.02	\$53.59	\$195.48
Other			\$3.32			\$41.72			\$12.64
Total			\$2,782.44			\$2,756.91			\$2,540.50

Rate Cell:	B&D		Non-Traditional Adults (19 though 64 years)						
Diagnosis:	MRX3		Depression/Psychosis/Bipolar						
	Molina			Select Access			HealthyU		
	Member Months	6,661		Member Months	9,092		Member Months	3,803	
	Risk Normalization Adj.	0.980		Risk Normalization Adj.	1.040		Risk Normalization Adj.	0.950	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	392.48	\$2,609.58	\$85.35	192.78	\$2,472.83	\$39.73	317.50	\$2,128.39	\$56.31
Emergency Room	1,321.43	\$898.92	\$98.99	1,381.56	\$782.73	\$90.12	1,112.36	\$810.20	\$75.10
Other OP Hospital			\$85.74			\$60.44			\$45.76
Physician			\$122.96			\$78.41			\$107.77
Prescription Drugs	31,772.41	\$64.27	\$170.18	37,090.64	\$67.14	\$207.52	30,280.92	\$62.73	\$158.29
Other			\$3.20			\$5.11			\$6.26
Total			\$566.42			\$481.32			\$449.49

Rate Cell:	D&P		Pregnant Females Adults						
Diagnosis:	PrgCMP		Pregnancy, complete						
	Molina			Select Access			HealthyU		
	Member Months	12,918		Member Months	18,135		Member Months	6,550	
	Risk Normalization Adj.	1.000		Risk Normalization Adj.	1.011		Risk Normalization Adj.	0.967	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	3,388.63	\$1,256.71	\$354.88	3,302.56	\$1,506.85	\$414.70	3,309.77	\$1,390.84	\$383.61
Emergency Room	1,221.38	\$904.51	\$92.06	1,220.91	\$742.19	\$75.51	1,406.07	\$713.37	\$83.59
Other OP Hospital			\$81.01			\$107.17			\$52.22
Physician			\$307.48			\$260.26			\$275.74
Prescription Drugs	16,489.26	\$32.34	\$44.44	15,824.09	\$35.28	\$46.52	14,310.96	\$31.26	\$37.28
Other			\$1.06			\$3.23			\$5.99
Total			\$880.92			\$907.40			\$838.44

Exhibit 3
Risk Stratification Method 1
CY 2008 Combined Rate Cells by Plan and Condition
Area Adjusted, Each Plan is Normalized for Average Cell Specific Risk Score without Removing Overall Diagnosis Risk

Rate Cell:	G&H		Disabled Enrollees (All Ages)						
Diagnosis:	PulVH		Pulmonary, very high						
	Molina			Select Access			HealthyU		
	Member Months		235	Member Months		1,390	Member Months		600
	Risk Normalization Adj.		1.182	Risk Normalization Adj.		0.977	Risk Normalization Adj.		0.998
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	9,155.50	\$2,439.29	\$1,861.08	7,542.34	\$3,193.99	\$2,007.52	10,440.95	\$2,279.61	\$1,983.44
Emergency Room	2,753.79	\$997.60	\$228.93	1,859.95	\$1,152.90	\$178.69	1,307.01	\$901.93	\$98.24
Other OP Hospital			\$91.97			\$387.70			\$266.97
Physician			\$385.42			\$286.41			\$613.90
Prescription Drugs	104,207.32	\$113.92	\$989.31	66,161.80	\$119.47	\$658.68	75,923.83	\$156.15	\$987.96
Other			\$69.46			\$478.19			\$561.56
Total			\$3,626.17			\$3,997.20			\$4,512.08

Rate Cell:	G&H		Disabled Enrollees (All Ages)						
Diagnosis:	MRX3		Depression/Psychosis/Bipolar						
	Molina			Select Access			HealthyU		
	Member Months		8,416	Member Months		17,923	Member Months		8,680
	Risk Normalization Adj.		1.138	Risk Normalization Adj.		0.987	Risk Normalization Adj.		0.894
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	879.73	\$2,720.34	\$199.43	724.79	\$2,906.13	\$175.53	873.47	\$2,315.68	\$168.56
Emergency Room	909.84	\$1,010.95	\$76.65	663.16	\$840.62	\$46.46	527.43	\$770.32	\$33.86
Other OP Hospital			\$112.06			\$94.68			\$55.17
Physician			\$171.99			\$89.31			\$148.89
Prescription Drugs	70,987.97	\$95.01	\$562.04	56,361.65	\$105.99	\$497.82	54,399.52	\$96.87	\$439.16
Other			\$9.63			\$74.91			\$61.05
Total			\$1,131.80			\$978.71			\$906.69

Rate Cell:	G&H		Disabled Enrollees (All Ages)						
Diagnosis:	PulM		Pulmonary, medium						
	Molina			Select Access			HealthyU		
	Member Months		745	Member Months		2,286	Member Months		1,347
	Risk Normalization Adj.		1.080	Risk Normalization Adj.		0.990	Risk Normalization Adj.		0.978
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	8,529.37	\$2,757.69	\$1,960.11	8,486.59	\$3,224.45	\$2,280.39	8,298.11	\$2,536.88	\$1,754.27
Emergency Room	2,023.64	\$1,523.97	\$257.00	2,301.74	\$1,052.01	\$201.79	1,774.44	\$935.97	\$138.40
Other OP Hospital			\$273.28			\$457.43			\$271.10
Physician			\$516.29			\$453.61			\$480.08
Prescription Drugs	98,969.98	\$68.64	\$566.12	78,458.67	\$88.38	\$577.86	66,345.59	\$84.13	\$465.16
Other			\$38.81			\$275.51			\$187.72
Total			\$3,611.61			\$4,246.59			\$3,296.73

Exhibit 3
Risk Stratification Method 1
CY 2008 Combined Rate Cells by Plan and Condition
Area Adjusted, Each Plan is Normalized for Average Cell Specific Risk Score without Removing Overall Diagnosis Risk

Rate Cell:	K&L		Traditional Children (Birth up to 1 year)						
Diagnosis:	PulM		Pulmonary, medium						
	Molina			Select Access			HealthyU		
	Member Months	852		Member Months	1,379		Member Months	597	
	Risk Normalization Adj.	1.063		Risk Normalization Adj.	0.895		Risk Normalization Adj.	1.155	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	13,656.84	\$1,958.45	\$2,228.86	8,186.99	\$2,139.59	\$1,459.73	8,264.54	\$2,083.83	\$1,435.16
Emergency Room	2,303.78	\$718.81	\$138.00	1,440.84	\$528.39	\$63.44	1,844.06	\$492.49	\$75.68
Other OP Hospital			\$45.82			\$99.44			\$74.30
Physician			\$467.15			\$306.08			\$477.47
Prescription Drugs	13,870.91	\$38.29	\$44.26	9,498.00	\$50.27	\$39.79	13,420.99	\$34.96	\$39.10
Other			\$1.83			\$50.96			\$50.69
Total			\$2,925.92			\$2,019.45			\$2,152.40

Rate Cell:	K&L		Traditional Children (Birth up to 1 year)						
Diagnosis:	GIH		Gastro, high						
	Molina			Select Access			HealthyU		
	Member Months	122		Member Months	207		Member Months	91	
	Risk Normalization Adj.	1.228		Risk Normalization Adj.	0.927		Risk Normalization Adj.	1.187	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	36,775.77	\$2,868.56	\$8,791.13	69,794.94	\$2,983.95	\$17,355.38	13,368.31	\$1,911.40	\$2,129.35
Emergency Room	3,318.42	\$896.14	\$247.82	2,656.22	\$631.14	\$139.70	2,653.58	\$496.84	\$109.87
Other OP Hospital			\$169.98			\$129.18			\$366.52
Physician			\$1,197.38			\$1,947.72			\$2,407.17
Prescription Drugs	32,862.45	\$38.03	\$104.15	27,846.93	\$37.64	\$87.35	37,776.36	\$40.38	\$127.11
Other			\$78.47			\$700.02			\$732.08
Total			\$10,588.93			\$20,359.35			\$5,872.10

Rate Cell:	K&L		Traditional Children (Birth up to 1 year)						
Diagnosis:	CarM		Cardiovascular, medium						
	Molina			Select Access			HealthyU		
	Member Months	470		Member Months	661		Member Months	286	
	Risk Normalization Adj.	1.072		Risk Normalization Adj.	0.963		Risk Normalization Adj.	1.067	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	9,727.11	\$1,962.18	\$1,590.53	14,286.89	\$2,551.63	\$3,037.90	5,917.19	\$1,263.95	\$623.25
Emergency Room	2,891.48	\$611.18	\$147.27	1,937.10	\$670.75	\$108.28	2,589.08	\$662.60	\$142.96
Other OP Hospital			\$90.42			\$88.49			\$98.15
Physician			\$475.82			\$546.67			\$413.30
Prescription Drugs	16,734.91	\$33.33	\$46.48	17,955.25	\$32.35	\$48.41	13,135.62	\$30.76	\$33.67
Other			\$7.69			\$132.79			\$152.36
Total			\$2,358.21			\$3,962.54			\$1,463.70

Exhibit 4
Risk Stratification Method 2
CY 2008 Combined Rate Cells by Plan for the Top 5 Conditions
Area Adjusted, Each Plan is Normalized for Average Cell Specific Risk Score And Adjusted for Overall Diagnosis Risk

Rate Cell:	A&C								
Diagnoses:	PSYML Psychiatric, medium low PULL Pulmonary, low MRX2 Cardiac GIL Gastro, low MRX3 Depression/Psychosis/Bipolar								
	Molina			Select Access			HealthyU		
Member Months	36,159			55,409			21,178		
Risk Normalization Adj.	1.058			0.958			1.029		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	80.67	\$1,981.71	\$13.32	71.39	\$2,427.08	\$14.44	111.35	\$2,044.62	\$18.97
Emergency Room	320.06	\$614.68	\$16.39	263.90	\$581.65	\$12.79	252.99	\$605.22	\$12.76
Other OP Hospital			\$9.01			\$11.04			\$5.23
Physician			\$24.25			\$16.84			\$27.56
Prescription Drugs	6,554.56	\$79.23	\$43.28	5,949.17	\$91.11	\$45.17	6,044.87	\$74.79	\$37.67
Other			\$0.50			\$2.02			\$1.90
Total			\$106.76			\$102.31			\$104.10

Rate Cell:	B&D								
Diagnoses:	GIL Gastro, low PULM Pulmonary, medium SUBL Substance abuse, low MRX3 Depression/Psychosis/Bipolar PULL Pulmonary, low								
	Molina			Select Access			HealthyU		
Member Months	15,592			21,355			9,593		
Risk Normalization Adj.	1.057			0.952			1.017		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	275.69	\$2,767.99	\$63.59	208.84	\$2,735.32	\$47.60	284.68	\$2,623.79	\$62.24
Emergency Room	1,041.28	\$910.23	\$78.98	1,008.11	\$808.93	\$67.96	808.70	\$806.33	\$54.34
Other OP Hospital			\$52.67			\$43.13			\$31.63
Physician			\$84.47			\$48.91			\$74.63
Prescription Drugs	18,570.52	\$61.97	\$95.91	18,524.93	\$64.45	\$99.50	16,339.03	\$59.89	\$81.55
Other			\$1.74			\$3.77			\$3.17
Total			\$377.36			\$310.88			\$307.56

Rate Cell:	D&P								
Diagnoses:	PRGCMP Pregnancy, complete MRX3 Depression/Psychosis/Bipolar GIL Gastro, low SUBL Substance abuse, low PULL Pulmonary, low								
	Molina			Select Access			HealthyU		
Member Months	29,602			39,610			15,834		
Risk Normalization Adj.	1.024			0.988			0.984		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	1,012.77	\$1,396.70	\$117.88	979.34	\$1,660.91	\$135.55	942.89	\$1,534.86	\$120.60
Emergency Room	811.67	\$899.59	\$60.85	793.79	\$771.64	\$51.04	776.77	\$740.43	\$47.93
Other OP Hospital			\$46.31			\$49.49			\$27.66
Physician			\$119.31			\$91.23			\$101.14
Prescription Drugs	12,947.21	\$50.89	\$54.91	13,101.75	\$53.19	\$58.07	11,665.22	\$48.64	\$47.28
Other			\$1.01			\$2.62			\$2.20
Total			\$400.27			\$388.00			\$346.80

Exhibit 4
Risk Stratification Method 2
CY 2008 Combined Rate Cells by Plan for the Top 5 Conditions
Area Adjusted, Each Plan is Normalized for Average Cell Specific Risk Score And Adjusted for Overall Diagnosis Risk

Rate Cell:	G&H								
Diagnoses:	PULVH Pulmonary, very high MRX3 Depression/Psychosis/Bipolar PULM Pulmonary, medium CNSH CNS, high CNSL CNS, low								
	Molina			Select Access			HealthyU		
Member Months	14,023			31,911			16,834		
Risk Normalization Adj.	1.291			0.946			0.901		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	1,122.48	\$2,586.26	\$241.92	674.95	\$3,100.70	\$174.40	742.23	\$2,411.52	\$149.16
Emergency Room	870.29	\$1,020.55	\$74.01	531.21	\$886.03	\$39.22	401.91	\$775.29	\$25.97
Other OP Hospital			\$110.43			\$68.76			\$38.83
Physician			\$158.72			\$64.76			\$102.45
Prescription Drugs	58,752.41	\$92.95	\$455.10	32,698.94	\$105.00	\$286.13	30,359.93	\$97.13	\$245.73
Other			\$10.63			\$54.93			\$43.85
Total			\$1,050.81			\$688.20			\$605.97

Rate Cell:	K&L								
Diagnoses:	GIL Gastro, low PULM Pulmonary, medium GIH Gastro, high CARM Cardiovascular, medium INFM Infectious, medium								
	Molina			Select Access			HealthyU		
Member Months	6,443			9,440			3,140		
Risk Normalization Adj.	1.167			0.894			1.125		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	1,086.91	\$1,577.96	\$142.93	851.20	\$1,724.07	\$122.29	861.80	\$1,522.92	\$109.37
Emergency Room	276.86	\$530.54	\$12.24	177.18	\$494.89	\$7.31	190.96	\$528.51	\$8.41
Other OP Hospital			\$6.09			\$6.11			\$5.25
Physician			\$42.19			\$34.07			\$45.72
Prescription Drugs	1,967.21	\$38.65	\$6.34	1,426.21	\$35.93	\$4.27	1,586.16	\$28.95	\$3.83
Other			\$0.85			\$4.61			\$4.99
Total			\$210.64			\$178.66			\$177.57

Exhibit 5
Risk Stratification Method 3
CY 2008 All Rate Cells of Interest Combined by Plan for Condition Category
Area Adjusted, Each Plan is Normalized for Average Cell Specific Risk Score And Adjusted for Overall Diagnosis Risk

Rate Cell:	Gastro								
	Molina			Select Access			HealthyU		
Member Months	19,784			32,011			15,580		
Risk Normalization Adj.	1.141			0.920			1.044		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	712.39	\$2,029.82	\$120.50	661.72	\$2,621.63	\$144.57	680.12	\$2,372.89	\$134.49
Emergency Room	638.27	\$941.06	\$50.05	502.87	\$873.09	\$36.59	452.33	\$817.24	\$30.81
Other OP Hospital			\$52.12			\$42.14			\$31.74
Physician			\$81.40			\$48.20			\$76.89
Prescription Drugs	15,157.69	\$74.29	\$93.83	10,803.62	\$80.88	\$72.82	13,682.02	\$76.35	\$87.05
Other			\$4.37			\$21.55			\$23.89
Total			\$402.28			\$365.87			\$384.86

Rate Cell:	Psychiatric								
	Molina			Select Access			HealthyU		
Member Months	49,188			84,690			35,833		
Risk Normalization Adj.	1.029			0.997			0.974		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	455.81	\$2,232.11	\$84.78	416.19	\$2,744.13	\$95.17	515.50	\$2,346.67	\$100.81
Emergency Room	677.62	\$909.75	\$51.37	683.41	\$792.92	\$45.16	519.28	\$794.47	\$34.38
Other OP Hospital			\$43.30			\$46.04			\$30.15
Physician			\$81.15			\$53.75			\$80.92
Prescription Drugs	23,803.61	\$85.30	\$169.20	22,930.86	\$95.02	\$181.57	24,292.92	\$92.81	\$187.88
Other			\$2.87			\$18.34			\$19.23
Total			\$432.67			\$440.03			\$453.37

Rate Cell:	Pulmonary								
	Molina			Select Access			HealthyU		
Member Months	31,940			47,921			22,317		
Risk Normalization Adj.	1.127			0.944			0.991		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	566.38	\$2,337.39	\$110.32	506.56	\$2,801.08	\$118.24	573.66	\$2,386.73	\$114.10
Emergency Room	582.86	\$827.78	\$40.21	501.79	\$796.99	\$33.33	414.19	\$743.09	\$25.65
Other OP Hospital			\$29.33			\$33.47			\$22.47
Physician			\$59.52			\$40.71			\$60.05
Prescription Drugs	11,719.87	\$67.91	\$66.32	9,592.82	\$78.23	\$62.54	10,516.28	\$77.78	\$68.17
Other			\$2.80			\$16.90			\$17.48
Total			\$308.50			\$305.19			\$307.92

Exhibit 5
Risk Stratification Method 3
CY 2008 All Rate Cells of Interest Combined by Plan for Condition Category
Area Adjusted, Each Plan is Normalized for Average Cell Specific Risk Score And Adjusted for Overall Diagnosis Risk

Rate Cell:	Cardiovascular								
	Molina			Select Access			HealthyU		
	Member Months	22,913		Member Months	42,118		Member Months	19,689	
	Risk Normalization Adj.	1.083		Risk Normalization Adj.	0.947		Risk Normalization Adj.	1.030	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	798.93	\$2,399.00	\$159.72	681.65	\$2,897.24	\$164.58	752.05	\$2,558.07	\$160.32
Emergency Room	626.15	\$1,046.32	\$54.60	545.78	\$920.07	\$41.85	457.15	\$866.02	\$32.99
Other OP Hospital			\$62.84			\$54.63			\$46.22
Physician			\$97.95			\$57.86			\$92.75
Prescription Drugs	26,229.43	\$74.45	\$162.73	19,568.55	\$80.92	\$131.96	23,297.35	\$83.47	\$162.06
Other			\$6.02			\$22.86			\$27.06
Total			\$543.86			\$473.73			\$521.40

Rate Cell:	Diabetes								
	Molina			Select Access			HealthyU		
	Member Months	7,096		Member Months	12,172		Member Months	5,977	
	Risk Normalization Adj.	1.043		Risk Normalization Adj.	0.966		Risk Normalization Adj.	1.024	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	1,004.66	\$2,300.69	\$192.62	806.29	\$2,929.62	\$196.84	828.11	\$2,776.11	\$191.58
Emergency Room	697.73	\$1,127.25	\$65.54	687.66	\$1,007.80	\$57.75	524.52	\$823.81	\$36.01
Other OP Hospital			\$62.47			\$64.35			\$42.54
Physician			\$115.39			\$71.73			\$105.25
Prescription Drugs	36,171.54	\$70.16	\$211.49	30,151.64	\$76.18	\$191.41	36,739.85	\$75.81	\$232.11
Other			\$9.26			\$29.54			\$36.97
Total			\$656.76			\$611.63			\$644.45

Exhibit 6
Risk Stratification Method 1
CY 2008 Combined Rate Cells by Plan and Condition
Area Adjusted, Not Normalized or Adjusted for Overall Diagnosis Risk

Rate Cell:	A&C		Traditional Children (1 through 18 years)							
Diagnosis:	PulM		Pulmonary, medium							
	Molina			Select Access			HealthyU			
Member Months	782			Member Months	1,093			Member Months	528	
Risk Score	11.747			Risk Score	12.719			Risk Score	13.561	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	3,643.25	\$3,141.40	\$953.74	4,250.62	\$3,590.64	\$1,271.87	2,962.20	\$2,306.72	\$569.41	
Emergency Room	1,286.51	\$817.29	\$87.62	1,582.47	\$752.55	\$99.24	884.21	\$781.40	\$57.58	
Other OP Hospital			\$46.61			\$147.46			\$37.01	
Physician			\$177.38			\$193.79			\$231.17	
Prescription Drugs	12,578.11	\$52.05	\$54.56	14,333.80	\$69.81	\$83.38	17,579.27	\$59.57	\$87.26	
Other			\$5.25			\$64.74			\$85.11	
Total			\$1,325.17			\$1,860.49			\$1,067.55	

Rate Cell:	A&C		Traditional Children (1 through 18 years)							
Diagnosis:	MRX2		Cardiac							
	Molina			Select Access			HealthyU			
Member Months	2,058			Member Months	4,396			Member Months	1,376	
Risk Score	4.990			Risk Score	5.101			Risk Score	5.493	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	160.10	\$2,504.60	\$33.41	254.71	\$2,333.82	\$49.54	259.56	\$2,262.40	\$48.94	
Emergency Room	578.62	\$625.38	\$30.15	494.51	\$589.95	\$24.31	345.56	\$461.06	\$13.28	
Other OP Hospital			\$11.98			\$30.64			\$11.21	
Physician			\$49.54			\$43.83			\$63.08	
Prescription Drugs	31,999.16	\$87.78	\$234.09	32,977.60	\$106.84	\$293.60	30,709.78	\$95.45	\$244.28	
Other			\$1.31			\$6.98			\$15.43	
Total			\$360.49			\$448.90			\$396.21	

Rate Cell:	A&C		Traditional Children (1 through 18 years)							
Diagnosis:	MRX3		Depression/Psychosis/Bipolar							
	Molina			Select Access			HealthyU			
Member Months	5,943			Member Months	10,813			Member Months	3,662	
Risk Score	2.303			Risk Score	2.642			Risk Score	2.839	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	119.46	\$1,517.78	\$15.11	109.18	\$1,890.40	\$17.20	81.23	\$2,994.49	\$20.27	
Emergency Room	424.69	\$662.70	\$23.45	368.99	\$500.00	\$15.37	324.72	\$573.30	\$15.51	
Other OP Hospital			\$12.84			\$19.01			\$11.82	
Physician			\$43.54			\$30.08			\$53.85	
Prescription Drugs	23,527.42	\$97.98	\$192.09	25,529.36	\$115.99	\$246.76	24,133.44	\$103.70	\$208.55	
Other			\$0.82			\$4.90			\$9.70	
Total			\$287.85			\$333.31			\$319.70	

Exhibit 6
Risk Stratification Method 1
CY 2008 Combined Rate Cells by Plan and Condition
Area Adjusted, Not Normalized or Adjusted for Overall Diagnosis Risk

Rate Cell:	B&D		Non-Traditional Adults (19 though 64 years)						
Diagnosis:	PULM		Pulmonary, medium						
	Molina			Select Access			HealthyU		
	Member Months	299		Member Months	575		Member Months	359	
	Risk Score	6.333		Risk Score	8.190		Risk Score	6.228	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	5,219.41	\$2,897.26	\$1,260.16	6,190.52	\$3,084.79	\$1,591.37	4,564.74	\$3,612.28	\$1,374.09
Emergency Room	3,643.94	\$1,105.63	\$335.74	6,551.22	\$1,081.59	\$590.48	1,873.40	\$905.52	\$141.37
Other OP Hospital			\$185.03			\$221.59			\$119.40
Physician			\$426.43			\$389.99			\$386.55
Prescription Drugs	52,125.52	\$55.61	\$241.57	53,843.33	\$67.06	\$300.89	37,932.57	\$53.59	\$169.42
Other			\$2.93			\$47.54			\$10.96
Total			\$2,451.86			\$3,141.87			\$2,201.78

Rate Cell:	B&D		Non-Traditional Adults (19 though 64 years)						
Diagnosis:	MRX3		Depression/Psychosis/Bipolar						
	Molina			Select Access			HealthyU		
	Member Months	6,661		Member Months	9,092		Member Months	3,803	
	Risk Score	1.609		Risk Score	1.517		Risk Score	1.661	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	400.39	\$2,609.58	\$87.07	185.44	\$2,472.83	\$38.21	334.35	\$2,128.39	\$59.30
Emergency Room	1,348.05	\$898.92	\$100.98	1,328.95	\$782.73	\$86.68	1,171.38	\$810.20	\$79.09
Other OP Hospital			\$87.47			\$58.14			\$48.18
Physician			\$125.43			\$75.42			\$113.49
Prescription Drugs	32,412.47	\$64.27	\$173.61	35,678.17	\$67.14	\$199.62	31,887.50	\$62.73	\$166.69
Other			\$3.27			\$4.92			\$6.59
Total			\$577.83			\$463.00			\$473.34

Rate Cell:	D&P		Pregnant Females Adults						
Diagnosis:	PrgCMP		Pregnancy, complete						
	Molina			Select Access			HealthyU		
	Member Months	12,918		Member Months	18,135		Member Months	6,550	
	Risk Score	2.131		Risk Score	2.108		Risk Score	2.205	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	3,386.98	\$1,256.71	\$354.70	3,265.72	\$1,506.85	\$410.08	3,423.42	\$1,390.84	\$396.79
Emergency Room	1,220.78	\$904.51	\$92.02	1,207.29	\$742.19	\$74.67	1,454.35	\$713.37	\$86.46
Other OP Hospital			\$80.97			\$105.98			\$54.02
Physician			\$307.33			\$257.35			\$285.21
Prescription Drugs	16,481.25	\$32.34	\$44.42	15,647.57	\$35.28	\$46.00	14,802.37	\$31.26	\$38.56
Other			\$1.06			\$3.19			\$6.20
Total			\$880.49			\$897.28			\$867.23

Exhibit 6
Risk Stratification Method 1
CY 2008 Combined Rate Cells by Plan and Condition
Area Adjusted, Not Normalized or Adjusted for Overall Diagnosis Risk

Rate Cell:	G&H		Disabled Enrollees (All Ages)							
Diagnosis:	PulVH		Pulmonary, very high							
	Molina			Select Access			HealthyU			
Member Months	235			Member Months	1,390			Member Months	600	
Risk Score	7.404			Risk Score	8.955			Risk Score	8.768	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	7,744.53	\$2,439.29	\$1,574.26	7,716.64	\$3,193.99	\$2,053.91	10,459.77	\$2,279.61	\$1,987.02	
Emergency Room	2,329.39	\$997.60	\$193.65	1,902.93	\$1,152.90	\$182.82	1,309.36	\$901.93	\$98.41	
Other OP Hospital Physician			\$77.79			\$396.66			\$267.46	
			\$326.03			\$293.03			\$615.01	
Prescription Drugs	88,147.71	\$113.92	\$836.84	67,690.76	\$119.47	\$673.90	76,060.71	\$156.15	\$989.74	
Other			\$58.76			\$489.24			\$562.58	
Total			\$3,067.33			\$4,089.57			\$4,520.21	

Rate Cell:	G&H		Disabled Enrollees (All Ages)							
Diagnosis:	MRX3		Depression/Psychosis/Bipolar							
	Molina			Select Access			HealthyU			
Member Months	8,416			Member Months	17,923			Member Months	8,680	
Risk Score	1.159			Risk Score	1.336			Risk Score	1.475	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	772.88	\$2,720.34	\$175.21	733.99	\$2,906.13	\$177.76	977.14	\$2,315.68	\$188.56	
Emergency Room	799.34	\$1,010.95	\$67.34	671.58	\$840.62	\$47.05	590.03	\$770.32	\$37.88	
Other OP Hospital Physician			\$98.45			\$95.89			\$61.72	
			\$151.10			\$90.44			\$166.56	
Prescription Drugs	62,366.22	\$95.01	\$493.78	57,076.93	\$105.99	\$504.13	60,856.58	\$96.87	\$491.29	
Other			\$8.46			\$75.87			\$68.30	
Total			\$994.33			\$991.13			\$1,014.31	

Rate Cell:	G&H		Disabled Enrollees (All Ages)							
Diagnosis:	PulM		Pulmonary, medium							
	Molina			Select Access			HealthyU			
Member Months	745			Member Months	2,286			Member Months	1,347	
Risk Score	4.771			Risk Score	5.204			Risk Score	5.271	
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	7,897.07	\$2,757.69	\$1,814.81	8,571.44	\$3,224.45	\$2,303.19	8,488.82	\$2,536.88	\$1,794.59	
Emergency Room	1,873.62	\$1,523.97	\$237.94	2,324.75	\$1,052.01	\$203.81	1,815.23	\$935.97	\$141.58	
Other OP Hospital Physician			\$253.02			\$462.00			\$277.33	
			\$478.02			\$458.15			\$491.11	
Prescription Drugs	91,633.15	\$68.64	\$524.15	79,243.11	\$88.38	\$583.63	67,870.39	\$84.13	\$475.85	
Other			\$35.93			\$278.27			\$192.03	
Total			\$3,343.88			\$4,289.04			\$3,372.50	

Exhibit 6
Risk Stratification Method 1
CY 2008 Combined Rate Cells by Plan and Condition
Area Adjusted, Not Normalized or Adjusted for Overall Diagnosis Risk

Rate Cell:	K&L		Traditional Children (Birth up to 1 year)						
Diagnosis:	PulM		Pulmonary, medium						
	Molina			Select Access			HealthyU		
	Member Months			Member Months			Member Months		
	Risk Score			Risk Score			Risk Score		
	852			1,379			597		
	9.905			11.772			9.118		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	12,845.04	\$1,958.45	\$2,096.37	9,151.13	\$2,139.59	\$1,631.64	7,155.19	\$2,083.83	\$1,242.52
Emergency Room	2,166.84	\$718.81	\$129.80	1,610.52	\$528.39	\$70.92	1,596.53	\$492.49	\$65.52
Other OP Hospital			\$43.10			\$111.15			\$64.33
Physician			\$439.38			\$342.12			\$413.38
Prescription Drugs	13,046.38	\$38.29	\$41.63	10,616.52	\$50.27	\$44.47	11,619.49	\$34.96	\$33.85
Other			\$1.72			\$56.97			\$43.89
Total			\$2,751.99			\$2,257.27			\$1,863.49

Rate Cell:	K&L		Traditional Children (Birth up to 1 year)						
Diagnosis:	GIH		Gastro, high						
	Molina			Select Access			HealthyU		
	Member Months			Member Months			Member Months		
	Risk Score			Risk Score			Risk Score		
	122			207			91		
	43.119			57.158			44.629		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	29,941.76	\$2,868.56	\$7,157.48	75,326.08	\$2,983.95	\$18,730.77	11,265.23	\$1,911.40	\$1,794.37
Emergency Room	2,701.76	\$896.14	\$201.76	2,866.72	\$631.14	\$150.77	2,236.13	\$496.84	\$92.58
Other OP Hospital			\$138.39			\$139.41			\$308.86
Physician			\$974.87			\$2,102.07			\$2,028.48
Prescription Drugs	26,755.65	\$38.03	\$84.80	30,053.76	\$37.64	\$94.28	31,833.46	\$40.38	\$107.11
Other			\$63.89			\$755.50			\$616.91
Total			\$8,621.19			\$21,972.80			\$4,948.31

Rate Cell:	K&L		Traditional Children (Birth up to 1 year)						
Diagnosis:	CarM		Cardiovascular, medium						
	Molina			Select Access			HealthyU		
	Member Months			Member Months			Member Months		
	Risk Score			Risk Score			Risk Score		
	470			661			286		
	13.938			15.513			13.997		
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	9,076.74	\$1,962.18	\$1,484.19	14,838.07	\$2,551.63	\$3,155.10	5,545.16	\$1,263.95	\$584.07
Emergency Room	2,698.15	\$611.18	\$137.42	2,011.83	\$670.75	\$112.45	2,426.30	\$662.60	\$133.97
Other OP Hospital			\$84.38			\$91.90			\$91.98
Physician			\$444.00			\$567.76			\$387.32
Prescription Drugs	15,615.99	\$33.33	\$43.37	18,647.94	\$32.35	\$50.28	12,309.74	\$30.76	\$31.56
Other			\$7.18			\$137.92			\$142.78
Total			\$2,200.54			\$4,115.41			\$1,371.68

Exhibit 7
Risk Stratification Method 2
CY 2008 Combined Rate Cells by Plan for the Top 5 Conditions
Area Adjusted, Adjusted for Overall Diagnosis Risk, but not Normalized for Cell Specific Risk

Rate Cell:	A&C Traditional Children (1 through 18 years)																																																																																								
Diagnoses:	PSYML	Psychiatric, medium low																																																																																							
	PULL	Pulmonary, low																																																																																							
	MRX2	Cardiac																																																																																							
	GIL	Gastro, low																																																																																							
	MRX3	Depression/Psychosis/Bipolar																																																																																							
	<table border="1"> <tr> <td>Molina</td> <td>Select Access</td> <td>HealthyU</td> </tr> <tr> <td>Member Months</td> <td>36,159</td> <td>Member Months</td> <td>55,409</td> <td>Member Months</td> <td>21,178</td> </tr> <tr> <td>Risk Score</td> <td>2.596</td> <td>Risk Score</td> <td>2.868</td> <td>Risk Score</td> <td>2.671</td> </tr> </table>		Molina	Select Access	HealthyU	Member Months	36,159	Member Months	55,409	Member Months	21,178	Risk Score	2.596	Risk Score	2.868	Risk Score	2.671																																																																								
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Rate Cell:	B&D Non-Traditional Adults (19 though 64 years)																																																																																								
Diagnoses:	GIL	Gastro, low																																																																																							
	PULM	Pulmonary, medium																																																																																							
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Rate Cell:	D&P Pregnant Females Adults																																																																																								
Diagnoses:	PRGCMP	Pregnancy, complete																																																																																							
	MRX3	Depression/Psychosis/Bipolar																																																																																							
	GIL	Gastro, low																																																																																							
	SUBL	Substance abuse, low																																																																																							
	PULL	Pulmonary, low																																																																																							
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Exhibit 7
Risk Stratification Method 2
CY 2008 Combined Rate Cells by Plan for the Top 5 Conditions
Area Adjusted, Adjusted for Overall Diagnosis Risk, but not Normalized for Cell Specific Risk

Rate Cell:	G&H Disabled Enrollees (All Ages)								
Diagnoses:	PULVH	Pulmonary, very high							
	MRX3	Depression/Psychosis/Bipolar							
	PULM	Pulmonary, medium							
	CNSH	CNS, high							
	CNSL	CNS, low							
<table border="1" style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">Molina</td> <td style="width: 33%; text-align: center;">Select Access</td> <td style="width: 33%; text-align: center;">HealthyU</td> </tr> </table>			Molina	Select Access	HealthyU				
Molina	Select Access	HealthyU							
Member Months	14,023	Member Months	31,911	Member Months	16,834				
Risk Score	1.625	Risk Score	2.217	Risk Score	2.329				
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	869.48	\$2,586.26	\$187.39	713.38	\$3,100.70	\$184.33	824.00	\$2,411.52	\$165.59
Emergency Room	674.13	\$1,020.55	\$57.33	561.46	\$886.03	\$41.46	446.19	\$775.29	\$28.83
Other OP Hospital			\$85.54			\$72.67			\$43.10
Physician			\$122.95			\$68.45			\$113.73
Prescription Drugs	45,509.98	\$92.95	\$352.52	34,560.63	\$105.00	\$302.42	33,704.76	\$97.13	\$272.80
Other			\$8.23			\$58.06			\$48.68
Total			\$813.97			\$727.39			\$672.73

Rate Cell:	K&L Traditional Children (Birth up to 1 year)								
Diagnoses:	GIL	Gastro, low							
	PULM	Pulmonary, medium							
	GIH	Gastro, high							
	CARM	Cardiovascular, medium							
	INFM	Infectious, medium							
<table border="1" style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">Molina</td> <td style="width: 33%; text-align: center;">Select Access</td> <td style="width: 33%; text-align: center;">HealthyU</td> </tr> </table>			Molina	Select Access	HealthyU				
Molina	Select Access	HealthyU							
Member Months	6,443	Member Months	9,440	Member Months	3,140				
Risk Score	7.586	Risk Score	9.903	Risk Score	7.874				
Service Category	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM
Inpatient Hospital	931.12	\$1,577.96	\$122.44	951.86	\$1,724.07	\$136.76	766.29	\$1,522.92	\$97.25
Emergency Room	237.18	\$530.54	\$10.49	198.13	\$494.89	\$8.17	169.79	\$528.51	\$7.48
Other OP Hospital			\$5.22			\$6.84			\$4.67
Physician			\$36.15			\$38.10			\$40.65
Prescription Drugs	1,685.25	\$38.65	\$5.43	1,594.86	\$35.93	\$4.77	1,410.37	\$28.95	\$3.40
Other			\$0.73			\$5.16			\$4.44
Total			\$180.45			\$199.79			\$157.89

Exhibit 8
Risk Stratification Method 3
CY 2008 All Rate Cells of Interest Combined by Plan for Condition Category
Area Adjusted, Adjusted for Overall Diagnosis Risk, but not Normalized for Cell Specific Risk

Diagnoses Group: <input type="text" value="Gastro"/>										
<input type="text" value="Molina"/>			<input type="text" value="Select Access"/>				<input type="text" value="HealthyU"/>			
Member Months		<input type="text" value="19,784"/>		Member Months		<input type="text" value="32,011"/>		Member Months		<input type="text" value="15,580"/>
Risk Score		<input type="text" value="3.101"/>		Risk Score		<input type="text" value="3.845"/>		Risk Score		<input type="text" value="3.391"/>
Service Category										
	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	624.23	\$2,029.82	\$105.59	718.93	\$2,621.63	\$157.07	651.74	\$2,372.89	\$128.88	
Emergency Room	559.28	\$941.06	\$43.86	546.35	\$873.09	\$39.75	433.46	\$817.24	\$29.52	
Other OP Hospital			\$45.67			\$45.78			\$30.42	
Physician			\$71.33			\$52.37			\$73.68	
Prescription Drugs	13,281.87	\$74.29	\$82.22	11,737.65	\$80.88	\$79.12	13,111.22	\$76.35	\$83.42	
Other			\$3.83			\$23.41			\$22.89	
Total			\$352.49			\$397.50			\$368.81	

Diagnoses Group: <input type="text" value="Psychiatric"/>										
<input type="text" value="Molina"/>			<input type="text" value="Select Access"/>				<input type="text" value="HealthyU"/>			
Member Months		<input type="text" value="49,188"/>		Member Months		<input type="text" value="84,690"/>		Member Months		<input type="text" value="35,833"/>
Risk Score		<input type="text" value="1.738"/>		Risk Score		<input type="text" value="1.793"/>		Risk Score		<input type="text" value="1.836"/>
Service Category										
	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	443.14	\$2,232.11	\$82.43	417.55	\$2,744.13	\$95.48	529.40	\$2,346.67	\$103.53	
Emergency Room	658.79	\$909.75	\$49.94	685.65	\$792.92	\$45.31	533.28	\$794.47	\$35.31	
Other OP Hospital			\$42.10			\$46.19			\$30.96	
Physician			\$78.90			\$53.92			\$83.10	
Prescription Drugs	23,142.11	\$85.30	\$164.50	23,005.95	\$95.02	\$182.17	24,948.14	\$92.81	\$192.95	
Other			\$2.79			\$18.40			\$19.75	
Total			\$420.65			\$441.47			\$465.60	

Diagnoses Group: <input type="text" value="Pulmonary"/>										
<input type="text" value="Molina"/>			<input type="text" value="Select Access"/>				<input type="text" value="HealthyU"/>			
Member Months		<input type="text" value="31,940"/>		Member Months		<input type="text" value="47,921"/>		Member Months		<input type="text" value="22,317"/>
Risk Score		<input type="text" value="2.887"/>		Risk Score		<input type="text" value="3.446"/>		Risk Score		<input type="text" value="3.282"/>
Service Category										
	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	502.71	\$2,337.39	\$97.92	536.55	\$2,801.08	\$125.24	578.85	\$2,386.73	\$115.13	
Emergency Room	517.34	\$827.78	\$35.69	531.50	\$796.99	\$35.30	417.94	\$743.09	\$25.88	
Other OP Hospital			\$26.04			\$35.45			\$22.68	
Physician			\$52.83			\$43.12			\$60.60	
Prescription Drugs	10,402.35	\$67.91	\$58.87	10,160.81	\$78.23	\$66.24	10,611.38	\$77.78	\$68.78	
Other			\$2.49			\$17.90			\$17.64	
Total			\$273.82			\$323.26			\$310.71	

Exhibit 8
Risk Stratification Method 3
CY 2008 All Rate Cells of Interest Combined by Plan for Condition Category
Area Adjusted, Adjusted for Overall Diagnosis Risk, but not Normalized for Cell Specific Risk

Diagnoses Group: Cardiovascular										
Molina			Select Access				HealthyU			
Member Months		22,913		Member Months		42,118		Member Months		19,689
Risk Score		2.607		Risk Score		2.979		Risk Score		2.741
Service Category										
	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	737.77	\$2,399.00	\$147.49	719.44	\$2,897.24	\$173.70	730.09	\$2,558.07	\$155.64	
Emergency Room	578.22	\$1,046.32	\$50.42	576.04	\$920.07	\$44.17	443.81	\$866.02	\$32.03	
Other OP Hospital			\$58.03			\$57.66			\$44.87	
Physician			\$90.45			\$61.06			\$90.04	
Prescription Drugs	24,221.55	\$74.45	\$150.28	20,653.33	\$80.92	\$139.28	22,617.31	\$83.47	\$157.33	
Other			\$5.56			\$24.12			\$26.27	
Total			\$502.23			\$499.99			\$506.19	

Diagnoses Group: Diabetes										
Molina			Select Access				HealthyU			
Member Months		7,096		Member Months		12,172		Member Months		5,977
Risk Score		2.335		Risk Score		2.521		Risk Score		2.378
Service Category										
	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	Utilization per 1,000	Average Charge	PMPM	
Inpatient Hospital	963.48	\$2,300.69	\$184.72	834.57	\$2,929.62	\$203.75	808.70	\$2,776.11	\$187.09	
Emergency Room	669.13	\$1,127.25	\$62.86	711.77	\$1,007.80	\$59.78	512.23	\$823.81	\$35.17	
Other OP Hospital			\$59.91			\$66.61			\$41.54	
Physician			\$110.66			\$74.25			\$102.79	
Prescription Drugs	34,688.95	\$70.16	\$202.82	31,209.00	\$76.18	\$198.12	35,878.71	\$75.81	\$226.67	
Other			\$8.88			\$30.58			\$36.10	
Total			\$629.84			\$633.08			\$629.34	

Exhibit 9
Benchmarking to Other States Annual Rates of Utilization per 1,000
Utah CY 2008, Washington CY 2008, Nevada FY 2008

State	Population	Member Months	Utilization per 1,000								
			Inpatient Medical	Inpatient Surgical	Inpatient Maternity	Inpatient Hospital	Outpatient ER	Outpatient Surgery	Outpatient Hospital	Office Visits	Pharmacy
Utah	Children (1 through 18 years)	705,491	37.0	22.5	7.8	68.5	357.0	71.7	548.6	2,180.6	4,730.1
Washington	Children (1 through 18 years)	4,575,320	38.8	11.2	8.5	61.1	447.7	28.2	872.4	1,266.8	3,735.9
Nevada	Children (2 through 18 years)	362,580	33.6	26.4	27.0	120.2	332.3	61.5	422.4	1,450.2	3,072.1
Utah	Adult Male (19 through 64 years)	6,540	126.6	69.7	-	229.4	522.9	168.8	807.3	3,137.6	10,763.3
Washington	Adult Male (19 through 64 years)	170,915	174.5	61.2	-	240.3	930.8	102.6	1,931.3	1,683.3	13,359.3
Nevada	Adult Male (19 through 64 years)	17,609	100.2	142.9	-	258.5	440.5	53.3	551.8	1,432.7	10,337.9
Utah	Children (birth up to 1 year)	151,595	286.8	172.5	-	2,388.5	694.0	69.7	1,085.3	4,616.9	4,859.3
Washington	Children (birth up to 1 year)	427,576	662.8	798.3	-	1,665.5	1,042.2	31.2	1,864.8	2,827.3	4,614.2
Nevada	Children (birth up to 2 years)	55,651	182.0	169.4	-	1,713.4	763.8	54.7	863.7	3,428.4	3,949.9

Exhibit 10
Benchmarking to Medicaid Cost Model Annual Rates of Utilization per 1,000
Utah CY 2008

Plan	Population	Member Months	Utilization per 1,000								
			Inpatient Medical	Inpatient Surgical	Inpatient Maternity	Inpatient Hospital	Outpatient ER	Outpatient Surgery	Outpatient Hospital	Office Visits	Pharmacy
All Plans	Benchmark - Loosely Managed		126.6	48.7	207.2	718.7	807.2	66.6	2,062.3	2,654.6	7,346.5
All Plans	AFDC and TANF (A, B, C, D, P, K, & L)	1,043,986	86.4	55.5	187.8	625.9	545.5	101.6	952.1	2,865.1	7,078.6
All Plans	Benchmark - Well Managed		68.1	21.6	171.2	476.8	334.2	43.3	889.1	2,389.1	4,998.6
Healthy U	Benchmark - Loosely Managed		121.4	47.1	171.0	635.6	780.2	65.1	1,689.4	2,719.3	7,284.5
Healthy U	AFDC and TANF (A, B, C, D, P, K, & L)	217,212	92.9	53.5	150.8	521.5	433.2	61.4	628.2	2,426.8	6,187.0
Healthy U	Benchmark - Well Managed		65.3	20.8	139.7	414.7	323.0	42.3	742.5	2,447.4	4,944.8

Exhibit 11
Detailed Reconciliation of Modeled Expenditure Data

County Name	Grand Total Member Months	Managed Care (1) Molina, Select Access, HealthyU			Managed Care Considered (3) Expenditures	Other Expenditures Excluded from Consideration (3)	Grand Total Expenditures	Enrolled Percentage of Considered
		Member Months Enrolled (2)	Expenditure Enrolled (2)	Raw PMPM Enrolled (2)				
18 - SALT LAKE	988,465	688,205	\$210,400,812	\$305.72	\$327,424,434	\$215,624,300	\$543,048,733	64.3%
25 - UTAH	455,400	287,658	87,111,761	302.83	126,977,862	101,720,126	228,697,988	68.6%
29 - WEBER	252,296	185,843	53,736,776	289.15	72,544,880	48,429,714	120,974,593	74.1%
06 - DAVIS	210,159	149,125	43,222,919	289.84	60,831,090	47,251,117	108,082,207	71.1%
27 - WASHINGTON	162,365	24,866	3,954,028	159.01	37,852,494	28,035,151	65,887,645	10.4%
03 - CACHE	115,139	1,571	156,939	99.90	30,345,075	20,950,073	51,295,149	0.5%
11 - IRON	69,789	9,894	2,679,748	270.85	18,316,559	12,687,208	31,003,767	14.6%
23 - TOOELE	51,618	8,056	2,833,071	351.67	17,967,060	7,154,568	25,121,629	15.8%
04 - CARBON	34,691	0	0	0.00	14,072,108	8,436,834	22,508,941	0.0%
02 - BOX ELDER	47,536	1,431	273,732	191.29	12,406,469	10,138,161	22,544,631	2.2%
20 - SANPETE	39,048	77	11,572	150.29	10,858,184	9,231,685	20,089,869	0.1%
21 - SEVIER	32,572	180	18,900	105.00	10,643,110	5,378,664	16,021,775	0.2%
24 - UINTAH	26,032	0	0	0.00	8,834,859	5,760,886	14,595,745	0.0%
07 - DUCHESNE	22,843	1	772	772.35	7,096,169	4,375,916	11,472,085	0.0%
19 - SAN JUAN	34,775	31	908	29.28	6,224,332	4,297,935	10,522,267	0.0%
10 - GRAND	13,859	237	71,077	299.90	5,691,478	2,318,960	8,010,437	1.2%
22 - SUMMIT	13,218	478	119,086	249.13	4,270,715	1,976,386	6,247,102	2.8%
12 - JUAB	12,701	42	2,987	71.11	4,223,923	3,065,900	7,289,822	0.1%
14 - MILLARD	18,972	0	0	0.00	4,197,592	2,836,776	7,034,369	0.0%
08 - EMERY	13,830	2	0	0.00	4,106,123	2,409,835	6,515,958	0.0%
26 - WASATCH	13,187	0	0	0.00	3,741,092	2,473,702	6,214,794	0.0%
01 - BEAVER	9,451	100	63,627	636.27	2,541,437	1,541,440	4,082,876	2.5%
13 - KANE	6,998	332	19,418	58.49	1,420,446	1,032,647	2,453,093	1.4%
09 - GARFIELD	5,745	38	2,187	57.55	1,037,397	1,066,295	2,103,692	0.2%
15 - MORGAN	3,365	454	168,133	370.34	716,347	422,091	1,138,437	23.5%
16 - PIUTE	2,981	9	156	17.39	747,126	948,183	1,695,309	0.0%
28 - WAYNE	3,133	5	560	111.98	705,324	353,373	1,058,697	0.1%
17 - RICH	1,667	0	0	0.00	467,833	227,763	695,596	0.0%
05 - DAGGETT	318	0	0	0.00	104,854	31,141	135,995	0.0%
30 - OUT OF STATE	824	0	0	0.00	112,878	852,919	965,798	0.0%
OTHER						177,695,190	177,695,190	
GRAND TOTAL	2,662,977	1,358,635	\$404,849,168	\$297.98	\$796,479,249	\$728,724,940	\$1,525,204,189	50.8%
Top For Counties								
Sub Totals From Above		1,310,831	\$394,472,268	\$300.93	\$587,778,265	\$413,025,256	\$1,000,803,521	67.1%

- (1) Managed Care Expenditures are assigned to enrollee county of residence
- (2) Enrolled Expenditures are for All Rate Cells and Plans for the medical and pharmacy categories of service modeled through risk adjustment
- (3) Considered Expenditures are for the same medical and pharmacy categories of service modeled through risk adjustment with the Fee For Service expenditures incurred before plan enrollment assigned to county of service

Agency Response

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State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

**Utah Department of Health
Executive Director's Office**

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January 13, 2010

Mr. John M. Schaff, CIA
Legislative Auditor General
315 House Building
PO Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Schaff:

Thank you for the opportunity to review and to respond to your legislative audit titled "A Performance Audit of Utah Medicaid Managed Care" (Report No. 2010-01).

We in the Department of Health appreciate the work performed by you and your staff in the review of the Medicaid managed care program. We commend you all for your professionalism and cooperative efforts as you conducted your work and interacted with our staff.

Our responses to the recommendations accompany this letter. We look forward to working with you to ensure that our implementation plan is consistent with the intent of your recommendations.

Again, we thank you for your time and efforts in performing this program review and the resulting recommendations for improvement. We look forward to discussing the report and the recommendations with the Audit Subcommittee on January 19.

Sincerely,

David N. Sundwall, M.D.
Executive Director

Michael Hales
Deputy Director, Medicaid and Health Financing



Utah Department of Health's Response
to *A Performance Audit of Utah Medicaid Managed Care*

Background

At the beginning of calendar year 2002, the Department had capitated, risk-based contracts with four managed care companies to provide medical services to Medicaid enrollees along the Wasatch Front. The managed care companies were asking for an eight percent increase in premiums for state fiscal year 2003. Because the State was in a recession at that time, funding was not available for the desired increase.

As a result, two health plans decided to exit the Medicaid managed care market. The two remaining health plans agreed to continue to provide services to Medicaid clients, but were not willing to do so under a risk-based contract at the available level of funding. The contracts were changed to reimburse the plans based on the cost of medical claims plus an administrative fee, otherwise known as the "cost-plus" contracts. This allowed the managed care structure to remain in place, but did eliminate the incentives of a risk-based contract. Furthermore, the delay in the timing of these new contract payments to the health plans gave the State a cash float of approximately two months.

One of the plans that had originally chosen to exit the Medicaid managed care market reconsidered. This health plan agreed to maintain a provider network available to Medicaid clients if the Department paid the claims and performed other administrative functions previously performed by the plan. This is the origination of the current primary care case management (PCCM) contract.

The 2009 Legislature appropriated funding to pay the claims lag on the cost-plus contracts and allow them to be converted back to risk-based contracts.

Recommendations

Chapter 2 – Pages 23 - 24

1. *We recommend that Utah Medicaid appropriately incentivize the health plans to reduce utilization and contain costs.*

Response:

We concur. We appreciate the support the Legislature provided during the 2009 General Session that allowed the Molina health plan to be moved to a risk-based contract, which

provides a greater incentive for the plan to contain costs and utilization. As indicated in the audit report, the Department will continue to work with the University Health System to determine if it is feasible to move the Healthy U program to a risk-based contract. The Department will begin preparation work with Milliman to determine the feasibility of an RFP for the SelectAccess network. If the conversion of these remaining two contracts does not prove to be feasible, then the Department will create appropriate utilization and cost-containment incentives within the existing contract structure.

2. *We recommend that Utah Medicaid develop an RFP to encourage more managed care organizations to enter the state.*

Response:

We concur. The Department will begin preparation work with Milliman to determine the feasibility of an RFP for the SelectAccess network. The Department will also evaluate the effectiveness of arrangements with Molina and Healthy U to determine if an RFP for their networks would encourage more managed care organizations to enter the state.

3. *We recommend that Utah Medicaid review ways to achieve more cost control in its Select Access plan. This could be achieved by turning the population over to a managed care plan, or through other proven, cost-effective methods.*

Response:

We concur. The Department will begin preparation work with Milliman to determine the feasibility of an RFP for the SelectAccess network. If the conversion of this contract does not prove to be feasible, then the Department will create appropriate utilization and cost-containment incentives within the existing contract structure.

4. *We recommend the Legislature provide policy guidance to Utah Medicaid on appropriate cost control reimbursement methods and require Medicaid to submit progress reports to them on the issue.*

Response:

The recommendation is to the Legislature. The Department will cooperate and respond as directed.

5. *We recommend that Utah Medicaid review the viability and potential benefits of expanding managed care into more areas of the state. The Legislature should use Utah Medicaid's information to provide policy guidance on this issue.*

Response:

We concur. The Department will prepare recommendations on counties that would most likely benefit from expanded managed care and submit these recommendations to the Legislature for guidance and appropriations review.

It is worth noting that the Department currently offers a managed care plan to Medicaid clients in rural areas, but unlike in the Wasatch Front counties, enrollment is currently voluntary.

6. *We recommend that Utah Medicaid seek a waiver from Federal Medicaid to develop a method of auto-assigning members to the lowest-cost managed care plan after a recipient's open enrollment period has expired.*

Response:

The Department has contacted the Centers for Medicare and Medicaid Services (CMS) to explore the availability of such a waiver. Preliminary indications are that a limited waiver of federal law requiring equitable distribution of members may not be available. A waiver of this law may only be available in a comprehensive waiver that could put the State at risk for other costs. The Department will obtain additional information from CMS and then seek guidance from the Health and Human Services Appropriations Subcommittee.

7. *We recommend that Utah Medicaid review methods of accelerating the process of assigning Medicaid recipients to a managed care plan.*

Response:

We concur. We will review the practice of making calls to clients after the first 10 business days have passed to see if appropriate assignments can still be made while shortening the process. We will also determine if it would be cost effective to begin paying premiums for the period now covered under the fee-for-service plan.

Chapter 3 – Pages 37 - 38

1. *We recommend that, in the future, Utah Medicaid better compare Utah managed care plans through risk-adjusted analyses. Utah Medicaid should also benchmark Utah's plans to other well-managed plans.*

Response:

We concur. The Department has worked for several years with the health plans to get accurate encounter data submitted to the Department that can be used in conducting accurate risk-adjusted analyses. In the summer of 2009 during the actuarial rate construction process for the new risk-based contract with Molina Healthcare of Utah, the Department had Milliman perform comparative health plan analyses. This practice will continue as a part of the annual rate construction and negotiation process. Multi-year trend analyses will give the Department better information for contracting and for creating performance targets for the health plans.

2. *We recommend that Utah Medicaid develop appropriate performance goals, including cost and utilization goals, that can determine if the managed care plans are contributing adequate value to the Utah Medicaid program. Utah Medicaid should then hold the plans accountable to these goals.*

Response:

We concur. The Department will develop additional performance goals that include cost and utilization measures. The Department will then work with the health plans on a plan for accountability.

3. *We recommend that Utah Medicaid help facilitate the sharing of good health management practices between plans.*

Response:

We concur. The Department will look to better facilitate the sharing of good health management practices among the plans. The Department will expand on the content discussed and exchanged in monthly coordination meetings and quarterly clinical meetings with the health plans.

4. *We recommend that the Legislature direct Utah Medicaid to report to them on cost savings obtained through future contracting with the managed care plans.*

Response:

The recommendation is to the Legislature. The Department will cooperate and respond as directed.

Chapter 4 – Page 53

1. *We recommend that Utah Medicaid apply risk-adjusted relative costs to gain potential cost savings.*

Response:

We concur. The Department will work with Milliman to incorporate risk-adjusted cost data into the negotiation and contracting process with health plans to achieve potential cost savings.

2. *We recommend Utah Medicaid determine an acceptable cost-level for the plans and hold the plans to that level.*

Response:

We concur. The Department will work with Milliman to determine an acceptable cost level for the plans and hold the plans to that level.

3. *We recommend Utah Medicaid determine the actual amount and rate of administering the Select Access plan, managing claims, overseeing the health plans, and other cost centers so that it can be used in further analysis.*

Response:

We concur. As noted in the audit, the Department has determined the incremental cost of processing managed care claims through its fee-for-service system (1.2 percent). The Department's managed care activities span various current cost center accounting codes. We will perform a service-centered analysis of our administrative expenditures to assign costs specifically to managed care activities.

4. *We recommend that Utah Medicaid incorporate prior authorization data in their monitoring of the health plans.*

Response:

We concur. We will work with our actuaries to determine a meaningful way to use this information in the monitoring of the health plans. Differing case mixes and provider networks among the plans make it difficult to compare utilization based on prior authorization data.

5. *We recommend that the Legislature direct Utah Medicaid to report to them on cost-savings obtained through improved managed care contracting, and follow-up to ensure that the fullest, appropriate, cost-savings potential is realized.*

Response:

The recommendation is to the Legislature. The Department will cooperate and respond as directed.

Chapter 5 – Pages 63 - 64

1. *We recommend that the Bureau of Managed Health Care conduct a cost/benefit analysis of collecting similar health quality information, including HEDIS measures, for the Select Access plan.*

Response:

We concur. While HEDIS measures were designed to be applied to health maintenance organizations and have been extended to preferred provider organizations, HEDIS measures are useful for revealing areas that need improvement. HEDIS measures could be replicated in a fee-for-service (FFS) program if an infrastructure were developed and funded. Alternatively, the FFS population could be enrolled in a health plan where managed care processes such as HEDIS measurement are part of the normal course of business. The cost-benefit analysis will consider these factors.

2. *We recommend that the Bureau of Managed Health Care should establish a standard for quality of care appropriate for Utah.*

Response:

We concur. Standards for quality are important. Medicaid health plans currently participate in the same quality of care measurements as commercial and CHIP health plans. The data have been gathered consistently for more than a decade and the reports

are available to the general public. The Department will review the historical performance of the Medicaid plans and establish a standard performance level for quality of care that is appropriate for Utah.

3. *We recommend that the Bureau of Managed Health Care require the Annual External Quality Review Report for Prepaid Inpatient Health Plans to include a full summary of all results of the corrective action plans.*

Response:

We concur. The Department will ensure that a full summary of corrective action plan results will be included in the annual report.

4. *We recommend that the Bureau of Managed Health Care independently validate, through sampling, some of the information contained within the quality improvement reports (plan description, work plan, and work plan evaluation).*

Response:

We concur. The Department will sample some information included in the quality improvement reports to validate its accuracy. The sample will be of a limited size, but will provide the independence recommended.

5. *We recommend, for comparison purposes, that the Bureau of Managed Health Care ensure that the managed care plans adhere to their required format for quality improvement reporting.*

Response:

We concur. One of the health plan's reporting included more information than the standard state format required. Requiring compliance with the standardized format will allow for easier plan comparisons.

Chapter 6 – Page 80

1. *The Department of Health should frequently review emergent ER claims to verify the appropriate diagnosis is used to help ensure expected cost savings are realized.*

Response:

We concur. The Department's Office of Internal Audit Services (OIAS) will sample Emergency Department claims for compliance with appropriate billing standards.

2. *Utah Medicaid should monitor results of ER utilization grants to determine which grants could feasibly transfer to Utah hospitals.*

Response:

We concur. There is valuable information to be learned from the various Emergency Department diversion grants operating in other state Medicaid agencies. The Department participates in quarterly conference calls with the other state grantees to share information on the progress of their grants. When the grants are completed and their findings published, the Department will review the results and consider how successful grant practices can be implemented in Utah.

3. *Utah Medicaid should ensure that surgical center rates are being paid correctly and should consider adding to the list of defined reimbursement procedures as a way of controlling costs.*

Response:

We concur. The Department's Office of Internal Audit Services (OIAS) will sample surgical center reimbursements to ensure rates are being paid correctly. Furthermore, the Department will consider expanding the list of fixed-reimbursement procedures reimbursed in surgical centers.

4. *The Legislature and Utah Medicaid should consider moving away from a percent of charges to a revenue-code fee schedule.*

Response:

We concur. The Department believes this is an important policy discussion and is willing to work with the Legislature and the Utah Hospital Association on a resolution.

In the 2009 Legislative General Session, the Legislature directed the Department through intent language to study and report on how to change the outpatient hospital reimbursement. In September 2009, the Department submitted the report to the Health and Human Services Appropriations Subcommittee. It is titled “Changing Medicaid Outpatient Reimbursement” wherein two reimbursement methodology options were discussed.

That report can be found at:

<http://health.utah.gov/medicaid/stplan/LegReports/Changing%20Outpatient%20Reimbursement.pdf>

5. *Utah Medicaid should consider using more preventive care and case management through cost-saving programs such as medical homes and disease management.*

Response:

We concur. The Department has submitted a grant application that, if awarded, will provide funding for the development of a robust medical home program for children and youth with special health care needs. The grant is being developed in coordination with Primary Children’s Hospital, the University of Utah, Department of Pediatrics and the Idaho Medicaid program. The proposal is intended to be integrated with electronic medical records and electronic clinical data exchange.

The Department also has a successful disease management program for people with hemophilia. This program has allowed Medicaid to avoid costs of approximately \$2.1 million dollars in State Fiscal Year 2009. The Medicaid pharmacy team is actively pursuing expansion of this program to include other disease states.

6. *Utah Medicaid should determine potential cost savings that could be realized through HOAs, HIPP, and other programs, and implement or expand them if savings are shown.*

Response:

We concur. The Department will continue to review these and other programs with the potential for cost savings. As appropriate, the Department will either implement or expand the programs if cost savings can be shown.