Chase Center/Circle
111 Monument Circle
Suite 601
Indianapolis, IN 46204-5128
USA

Tel +1 317 639 1000
Fax +1 317 639 1001

milliman.com

March 18, 2013

Mr. James Parker
Illinois Department of Healthcare and Family Services
Prescott Bloom Building
201 S. Grand Avenue East, 2nd Floor
Springfield, IL 62763-0001

RE: MARCH 1, 2013 SERVICE PACKAGE I CAPITATION RATES – INTEGRATED CARE PROGRAM – V2

Dear Jim:

Milliman, Inc. (Milliman) has been retained by the State of Illinois, Department of Healthcare and Family Services (HFS) to provide actuarial and consulting services related to the development of capitation rates for Service Packages I and II of the Integrated Care Program for the Aged, Blind and Disabled non-Dual population. This letter provides the documentation for the development of the actuarially sound capitation rates for Service Package I. Service Package II capitation rate documentation has been provided in separate correspondence. This letter has been updated to reflect changes to the SMART act policy and program change rating impacts, including delay of implementation to April 1, 2013. This letter completely replaces our rate certification and data book correspondence dated January 31, 2013.

This documentation has been developed to address the items outlined in the Centers for Medicare and Medicaid Services rate setting checklist for regional offices regarding 42 CFR 438.6(c) for capitated Medicaid managed care plans. The attached rate certification and Data Book should be submitted to CMS for their review and approval.

LIMITATIONS

The services provided for this project were performed under the contract extension between Milliman and HFS dated September 27, 2012.

The information contained in this letter, including the enclosures, has been prepared for the State of Illinois, Department of Healthcare and Family Services and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for HFS by Milliman 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 letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

The information contained in this letter was prepared as documentation of the actuarially sound capitation rates for Medicaid managed care for the Aged, Blind and Disabled non-Dual population in the State of Illinois. The information may not be appropriate for any other purpose. Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual health plan.

DATA RELIANCE

The information contained in this letter has been prepared for the State of Illinois, Department of Healthcare and Family Services (HFS) and their consultants and advisors. Although the data were reviewed for reasonableness, we have accepted the data without audit. To the extent that the data provided to Milliman was not complete or accurate, the capitation rates presented in this letter may need to be modified. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter. Specifically, we relied upon the following information provided by HFS to develop the actuarially sound capitation rates for the March 1, 2013 through December 31, 2013 contract period:

1. Data and information provided for the October 1, 2011 to September 30, 2012 actuarially sound capitation rate development;

2. Monthly data extract of claim and eligibility information for the FFS program;

3. December 2012 health plan enrollment;

4. Fee schedule information including historical changes in fees for services included in Service Package I rates; and,

5. Data and information related to SMART Act policy and program changes, including provider notice documentation and estimated total impact amounts.

EXECUTIVE SUMMARY

The State of Illinois, Department of Healthcare and Family Services (HFS) provides a managed care program for the Aged, Blind and Disabled (ABD) non-dual eligible population for a limited geographic region. This letter contains the supporting materials and documentation of the development for the capitation rates for Service Package I, acute care services, for the period March 1, 2013 through December 31, 2013. Capitation rates for Service Package II, long-term services and supports, for the period February 1, 2013 through December 31, 2013 are documented in separate correspondence.

Table 1 illustrates the percentage change in Service Package I capitation rates for each population rate cell for the original six-county geographic region in which the program was implemented.

Table 1

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind, and Disabled Non-Dual
Service Package I Capitation Rate Changes – Proposed over Current Rates
Collar Counties Only

Rate Cell	Feb 2013 PMPM Rates	Mar - Dec 2013 PMPM Rates	Percentage Change
Community Residents	$ 985.35	$ 890.59	(9.6%)
Developmentally Disabled Waiver	753.06	655.70	(12.9%)
ICF/MR	891.55	832.52	(6.6%)
Nursing Facility	2,146.33	1,773.44	(17.4%)
Other Waiver	1,726.74	1,786.59	3.5%
State Operated Facility	269.71	117.66	(56.4%)
Composite – Collar Counties	$ 1,063.76	$ 974.65	(8.4%)

Note: The composite change reflects the changes in aggregate PMPM rates based on the projected contract period distribution of enrolled members for the counties of DuPage, Kane, Kankakee, Lake, Will, and Cook, excluding zip codes that begin with "606".

The overall rate changes above reflect updated base experience, medical inflation, and policy and program adjustments between the base data period and the effective rate period. The methodology is similar to that of the previous rate development. However, the base data and specific assumptions and adjustments developed by Milliman may be different from those used previously.

In developing the capitation rates illustrated above, we used FFS experience for the original demonstration counties as well as for three new counties. For the purposes of this rate development, we have assigned two capitation rate regions. The first includes the counties where the program was initially implemented: DuPage, Kane, Kankakee, Lake, Will, and Cook, excluding zip codes that begin with "606". This document will refer to this region as the "Collar Counties". The second region includes the counties where the program is expanding as of April 1, 2013: Boone, McHenry, and Winnebago. This document will refer to this region as "Expansion Counties".

We developed an estimated capitation amount by region for each population rate cell, but due to a limited number of lives in the Expansion Counties the final capitation rate payments are blended rates using the combined experience from both regions. The payment rates were blended using projected contract period member months for each region and rate cell to create weighted average final capitation rates.

Table 2 provides a summary of the March 1, 2013 through December 31, 2013 capitation amounts by geographic region and population as well as the final blended capitation rates which will be paid to the health plans.

Table 2

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind, and Disabled Non-Dual
Service Package I Capitation Rates by Region – March 1, 2013 to December 31, 2013

Rate Cell	Collar Counties	Expansion Counties	Final Blended Rate
Community Residents	$ 880.38	$ 986.66	$ 890.59
Developmentally Disabled Waiver	663.56	570.10	655.70
ICF/MR	848.42	763.89	832.52
Nursing Facility	1,750.85	2,313.08	1,773.44
Other Waiver	1,821.35	1,640.26	1,786.59
State Operated Facility	$ 117.66	$ 117.66	$ 117.66

An actuarial certification will be provided by Milliman and signed by Robert M. Damler, FSA, a Principal and Consulting Actuary in the Indianapolis office of Milliman, Inc. Mr. Damler is a Member of the American Academy of Actuaries and meets the qualification standards established by the American Academy of Actuaries.

Enclosure 1 contains the March 1, 2013 through December 31, 2013 capitation rates and projected expenditures for each rate cell and geographic region.

Enclosure 2 contains an actuarial certification regarding the actuarial soundness of the capitation rates.

Enclosure 3 provides the Data Book containing the documentation of the March 1, 2013 through December 31, 2013 capitation rates.

This letter should be provided in its entirety, including the Data Book, to CMS for their review and approval of the capitation rates.

CAPITATION RATE DEVELOPMENT METHODOLOGY

The capitation rates were developed based on the state fiscal year (SFY) 2010 and 2011 data with trend information from SFY 2007 through 2011, the ***Milliman Medicaid Cost Guidelines*** (***Guidelines***), other Milliman proprietary data, and our actuarial judgment. The capitation rates were developed on an actuarially sound basis using fee-for-service (FFS) claim experience with adjustments for healthcare management, trend, and health plan administration. The actuarially sound capitation rates were developed following the requirements outlined in the rate setting checklist CMS developed for its Regional Offices regarding 42 CFR 438.6(c) for capitated Medicaid managed care plans. This section of the letter follows the checklist and provides the required documentation.

AA.1. – Overview of Rate Setting Methodology

AA.1.0. – Overview of Rate Setting Methodology

HFS contracted with Milliman to determine actuarially sound capitation rates for Service Package I of the Integrated Care Program (ICP). The actuarially sound capitation rates were developed from historical FFS claims and enrollment data. The FFS population has been limited to the population to be enrolled with the risk-based managed care health plans. The historical experience was converted to a per member per month (PMPM) basis and stratified by population category and category of service. The historical experience from SFY 2010 and SFY 2011 was blended assuming equal weight (i.e. 50% SFY 2010 and 50% SFY 2011).

For Service Package I, acute care services, the blended utilization and cost per service rates were adjusted for policy and program changes, managed care improvements, and contracting adjustments. The adjusted PMPM values were trended forward to the midpoint of the March 1, 2013 through December 31, 2013 contract period. Adjustments were applied to the PMPM values to reflect changes in benefits between the base period and effective rate period. The resulting PMPMs established the adjusted claim cost by population rate cell for the contract period. The adjusted claim cost was modified to include the impact of the administrative allowance. The capitation rates will be offered to qualifying health plans as determined by HFS.

AA.1.1. – Actuarial Certification

An actuarial certification has been included in Enclosure 2 of this letter. The letter has been signed by Robert M. Damler, FSA, a Principal and Consulting Actuary in the Indianapolis office of Milliman, Inc. Mr. Damler is a Member of the American Academy of Actuaries and meets the qualification standards established by the American Academy of Actuaries. This letter has been used to supplement the Actuarial Certification by outlining a detailed description of the rate setting methodology and the applicable checklist. The attached Data Book enclosure should be considered a supplement to the Actuarial Certification. The capitation rate calculations by population rate cell are provided as attachments to the Data Book.

AA.1.2. – Projection of Expenditures

In aggregate, the contract period March 1, 2013 through December 31, 2013 capitation rates for the Collar Counties reflect a decrease of (8.4%) in relation to the current February 2013 capitation rates. Table 3 illustrates the expenditure impact using average projected contract period enrollment. Both the State and Federal and Federal only financial projections are shown. The Federal only expenditures were estimated using a 50.00% FMAP rate based on federal fiscal year 2013 and 2014 FMAP rates published by the Department of Health and Human Services in the November 30, 2011 and November 30, 2012 Federal Registers. Projected enrollment for the Collar Counties was developed using December 2011 health plan enrollment information, trended forward 1% annually to the midpoint of the contract period. Projected enrollment for the Expansion Counties was estimated using trended SFY 2011 FFS enrollment information, assuming managed care penetration consistent with experience from the Collar Counties. We have not illustrated a fiscal impact for the Expansion Counties because there are currently no rates in effect for this region.

Table 3

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind, and Disabled Non-Dual
Contract Period (10 month) Impact of Capitation Rate Increase
{Dollars shown in Millions}

Collar Counties

Fiscal Basis	Contract Period Projected Enrollment	Current Expenditures	Proposed Expenditures	% Change
State and Federal	342,064	$ 363.9	$ 333.4	(8.4%)
Federal Only	342,064	$ 181.9	$ 166.7	(8.4%)

Expansion Counties

Fiscal Basis	Contract Period Projected Enrollment	Proposed Expenditures
State and Federal	39,565	$ 41.4
Federal Only	39,565	$ 20.7

Note: Values have been rounded.

AA.1.3. – Procurement, Prior Approval and Rate Setting

HFS signs contracts with entities meeting the technical programmatic requirements of the state. The entities agree to accept the actuarially-sound, state-determined rate.

AA.1.5. – Risk Contracts

The capitation rates in Table 2 are intended as payment in full for Service Package I services when combined with any cost sharing from the members. The contracting entity will assume risk for the cost of services covered under the contract and will incur loss if the cost of furnishing the services exceeds the payments under the contract.

AA.1.6. – Limit on Payment to Other Providers

This section is a contractual issue between HFS and the health plans.

AA.1.7. – Rate Modifications

The March 1, 2013 through December 31, 2013 capitation rates reflect a re-basing of experience.

AA.2. – Base Year Utilization and Cost Data

AA.2.0. – Base Year Utilization and Cost Data

The base year data summaries were derived from Illinois FFS experience for the population to be enrolled in the risk-based managed care health plans as defined in Section A.A.2.1. HFS provided detail FFS claims and enrollment experience for SFY 2007 through 2011. The base year utilization and cost was developed from SFY 2010 and SFY 2011 experience data. Milliman used the most recent four years of experience data to develop trend rates.

AA.2.1. – Medicaid Eligibles under the Contract

HFS limited the historical expenditures and enrollment to populations to be enrolled in the risk-based managed care program. The population was limited to two geographic regions: the initial six selected Illinois counties, including DuPage, Kane, Kankakee, Lake, Will, and Cook, excluding zip codes that begin with "606", with the addition of Boone, McHenry, and Winnebago counties for this rating period. The population was limited to non-dual eligible ABD individuals only and by age to include all individuals 19 years of age and over.

AA.2.2 – Dual Eligibles

Medicare Dual Eligibles are not eligible for the ICP risk-based managed care program and were not included in the base data.

AA.2.3 – Spenddown

Spenddown Eligibles are not eligible for the ICP risk-based managed care program and were not included in the base data.

AA.2.4. – State Plan Services Only

Service Package I capitation rates for the ICP were developed from FFS data that included only state plan approved services and home and community based services (HCBS) that the health plans are required to provide under the contract. We have included a "Service Package II Transition Cost" for non-Developmentally Disabled HCBS waiver services in the Service Package I capitation rate for the Community Residents population. This cost reflects services incurred in a month for members who transition to a waiver from the community.

AA.2.5. – Capitated Entity Services

Milliman did not include any adjustments to the FFS data to reflect additional services that may be covered by the managed care organizations from the contract savings.

AA.3. – Adjustments to the Base Year Data

AA.3.1 – Benefit Differences

The FFS data were adjusted to remove services that are excluded from the Medicaid managed care covered services for Service Package I of the ICP.

Additionally, in May 2012, the General Assembly passed the Save Medicaid Access and Resources Together Act (SMART). This legislation reduces benefits and reimbursement levels for the Medicaid program for certain services, effective for the Integrated Care Program on April 1, 2013.

HFS routinely updates the fee schedules for supportive living facility and nursing facility rates. The capitation rates were adjusted to reflect fee changes between the base data period and the contract period of March 1, 2013 through December 31, 2013. This adjustment includes the SMART Act provider rate decrease of 2.7%.

In January 2013, the Affordable Care Act requires an increase in the Medicaid physician fee schedule for certain providers for all Evaluation and Management (E&M) and certain vaccine administration services to 100% of the Medicare physician fee schedule. It is our understanding that HFS will reimburse providers for the additional fee amount outside of the capitated program for ICP-enrolled individuals. As such, we have not made an adjustment to reflect a physician fee schedule increase within the capitation payment rates.

A detailed list and the impact to the capitation rates of the adjustments discussed above are included in Section VI.b. of the attached Data Book.

AA.3.2. – Administrative Cost Allowance Calculations

In the development of the Service Package I actuarially sound capitation rates, Milliman included an administrative cost allowance which varies by population rate cell. The administrative allowance was included as 6.0% of the medical claim cost plus a fixed fee. The fixed fee has been established at $40 PMPM for Nursing Home and Other Waiver populations and $25 PMPM for all other populations.

The administrative cost allowance includes administration, profit/contingency, and surplus contribution. On a composite basis, the administrative cost allowance is approximately 8.2% of the total program capitation rate. The actual administrative cost allowance will vary for each health plan based on the distribution of members among rate cells.

AA.3.3. – Special Populations' Adjustments

The base data reflects the population that is eligible to participate in the Integrated Care Program.

AA.3.4. – Eligibility Adjustments

Managed Care entities will not be at risk for retroactive eligibility months for their ICP members. Milliman adjusted the FFS experience to exclude retroactive eligibility. The data provided to Milliman did not contain an identifier to exclude retroactive eligibility months. As such, we estimated retroactive eligibility to be the first three months of FFS enrollment for individuals with new Medicaid eligibility.

AA.3.5. – DSH Payments

DSH payments were not included in the development of the actuarially sound capitation rates. The claims information used in developing the capitation rates excluded DSH payments.

AA.3.6. – Third Party Liability

Milliman used FFS experience which was net of third party liability recoveries to develop the base data for Service Package I services. The estimated third party liability recovery rate is expected to be consistent with that experienced by the health plans, excluding claim avoidance.

AA.3.7. – Copayments

The health plans may collect copayments consistent with the FFS program. A policy change adjustment was included to reflect increasing copayment levels between the base data period and the contract period. A detailed discussion about this change and its impact to the capitation rates is included in Section VI.b. of the Data Book.

AA.3.8. – Graduate Medical Education

Graduate medical education payments are not included in the capitation rates.

AA.3.9. – FQHC and RHC Reimbursement

Milliman did not adjust the FFS data for FQHC and RHC reimbursement in the development of the capitation rates.

AA.3.10. – Cost Trending / Inflation

The historical experience for the base year data was trended to the midpoint of the contract rate period. The contract will be for the period March 1, 2013 through December 31, 2013, with a midpoint of August 1, 2013. A historical trend analysis was developed from SFY 2007 through SFY 2011 FFS claims and enrollment data. Trend rates by category of service and population rate cell are illustrated in Section VI.e. of the attached Data Book.

AA.3.11. – Utilization Adjustments

Milliman adjusted the FFS utilization and reimbursement rates per service to reflect the managed care environment. Milliman calculated percentage reductions to reflect the utilization differential between a moderately managed population and a FFS population. The percentage reductions were applied to the FFS experience. The managed care adjustments are further discussed in Section VI.c. of the Data Book. The adjustments are illustrated by population and category of service in the capitation rate calculations in Attachment 4 of the Data Book.

AA.3.12. –Utilization and Cost Assumptions

Through the selection process of the populations from the FFS experience, HFS has developed a data extract of the population that will enroll in the managed care program. Based on this process, it is anticipated that the morbidity of the FFS population is consistent with the population that will enroll. Contractual reimbursement adjustment factors are illustrated in Section VI.d. of the Data Book. The contractual adjustment factors are intended to reflect the anticipated average contracted rates between the health plans and the providers as compared to the existing contracted rates between HFS and the providers. In addition to the contractual adjustments, the capitation rates include $4.00 PMPM for PCP fees.

AA.3.13. – Post-eligibility Treatment of Income

Milliman did not adjust the data to reflect the post-eligibility treatment of income. The expenditures included in the capitation rate reflect the net liability for HFS.

AA.3.14. – Incomplete Data Adjustment

Milliman used FFS data for services incurred from July 1, 2008 through June 30, 2011, paid through June 2012 to develop completion factors to be applied to the base data summaries. Separate claim completion factors were applied to the services incurred during SFY 2010 and SFY 2011. Completion factors were applied to the base utilization amounts as illustrated in Section VI.a of the Data Book.

AA.4.0. – Rate Category Groupings

AA.4.1. and AA.4.2 – Age and Gender Rating Categories

The managed care contract is limited to individuals 19 years of age and over. The capitation rates do not vary by age or gender because the medical costs for this population do not vary significantly by age or gender.

AA.4.3. – Locality / Region

The managed care program will only include enrollees in all or portions of nine selected Illinois counties: DuPage, Kane, Kankakee, Lake, Will, Cook, Boone, McHenry, and Winnebago. Due to a limited number of lives in the Expansion Counties, we have developed a single blended rate for all counties.

AA.4.4. – Eligibility Categories

The following eligibility rating categories were defined based on setting of care, qualification for waiver programs and/or category of assistance: ICF/MR State Operated Facilities, Other ICF/MR, Nursing Facility, Developmentally Disabled Waiver, Other Waiver, and Community Residents. The definition of each eligibility category has been provided in Section IV. of the Data Book.

AA.5.0., AA.5.1, and AA.5.2. – Data Smoothing

Milliman and HFS reviewed the historical experience and did not identify any required adjustments for large claims or data distortions.

AA.5.3. – Risk-Adjustment

The managed care health plans will receive reimbursement based upon enrolled population type. The six included populations are: ICF/MR State Operated Facilities, Other ICF/MR, Nursing Facility, Developmentally Disabled Waiver, Other Waiver, and Community Residents. In addition, capitation rates for Service Package I services will be modified using a standard risk adjustment tool. We anticipate using CDPS, Medicaid RX or CDPS + Medicaid RX. Risk scores will be developed to be budget neutral within each of the six populations.

AA.6.0. – Stop Loss, Reinsurance, or Risk-sharing Arrangements

HFS does not provide any reinsurance provision.

AA.6.1 – Commercial Reinsurance

HFS does not require the health plans to maintain any specific reinsurance.

AA.6.2 – Simple Stop Loss Program

HFS does not provide for any of these provisions in the terms of their contract with the managed care organizations.

AA.6.3 – Risk Corridor Program

HFS does not have a risk corridor program.

AA.7.0 – Incentive Arrangements

Under the terms of the contract, HFS will withhold 1% of the capitation rates certified in this letter. The withhold plus up to 5% of submitted capitation rates will be returned to the health plans based on meeting specified HEDIS measure improvements. Total payments under the contract including incentives will not exceed 105% of the submitted capitation rates. All incentives will utilize an actuarially sound methodology. The capitation rates certified in this letter have been determined to be actuarially sound in the event that the withhold amount is not returned to the health plans.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

If you have any questions regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

ELECTRONIC SIGNATURE

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

T:\2013\ILM\3.039-ILM40\11-ICP Mar-Dec 2013 Capitation Rate Documentation v2 - Final.doc

ENCLOSURE 1

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Capitation Rates
March 1, 2013 to December 31, 2013 Contract Period
SMART Policy and Program Changes Effective April 1, 2013

Rate Cell/Region	Projected 2013 Member Months	Current Capitation Rate	Current Expenditures	Proposed Capitation Rate	Proposed Expenditures	% Change	$ Change
Service Package I							
Community - Collar Counties	281,631	$ 985.35	$ 277,500,000	$ 889.94	$ 250,630,000	(9.7%)	$ (26,870,000)
DD Waiver - Collar Counties	17,730	753.06	13,350,000	654.87	11,610,000	(13.0%)	(1,740,000)
ICFMR - Collar Counties	2,893	891.55	2,580,000	831.58	2,410,000	(6.7%)	(170,000)
Nursing Facility - Collar Counties	9,174	2,146.33	19,690,000	1,771.84	16,260,000	(17.4%)	(3,430,000)
Other Waiver - Collar Counties	29,158	1,726.74	50,350,000	1,785.33	52,060,000	3.4%	1,710,000
State Operated Facility - Collar Counties	1,477	269.71	400,000	117.66	170,000	(56.4%)	(230,000)
Collar County Composite SPI	*342,064*	*$ 1,063.76*	*$ 363,870,000*	*$ 973.90*	*$ 333,140,000*	*(8.4%)*	*$ (30,730,000)*
Community - Expansion Counties	29,955	-	-	$ 889.94	$ 26,660,000		
DD Waiver - Expansion Counties	1,628	-	-	654.87	1,070,000		
ICFMR - Expansion Counties	670	-	-	831.58	560,000		
Nursing Facility - Expansion Counties	384	-	-	1,771.84	680,000		
Other Waiver - Expansion Counties	6,927	-	-	1,785.33	12,370,000		
State Operated Facility - Expansion Counties	-	-	-	117.66	-		
Expansion County Composite SPI	*39,565*	*$ 0.00*	*$ 0*	*$ 1,044.61*	*$ 41,340,000*		

ENCLOSURE 2

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
Service Package I - Integrated Care Program
Capitation Rates Effective March 1, 2013 through December 31, 2013

Actuarial Certification

I, Robert M. Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I was retained by the State of Illinois, Department of Healthcare and Family Services to perform an actuarial review and certification regarding the development of the capitation rates for the Service Package I of the Integrated Care Program for the Aged, Blind, and Disabled (ABD) non-dual population to be effective for the contract period of March 1, 2013 through December 31, 2013. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion.

I reviewed the historical claims experience for reasonableness and consistency. I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods. I have complied with the elements of the rate setting checklist CMS developed for its Regional Offices regarding 42 CFR 438.6(c) for capitated Medicaid managed care plans.

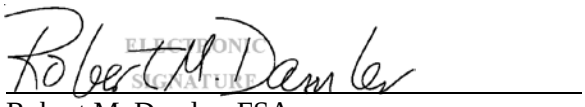
The capitation rates provided with this certification are effective for the ten month rating period beginning March 1, 2013 through December 31, 2013. At the end of the period, the capitation rates will be updated for calendar year 2014. The update may be based on fee-for-service experience, managed care utilization and trend experience, policy and procedure changes, and other changes in the health care market. A separate certification will be provided with the updated rates.

The capitation rates provided with this certification are considered actuarially sound, defined as:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42 CFR 438.6(c).

This certification is intended for the State of Illinois and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

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



Robert M. Damler, FSA
Member, American Academy of Actuaries

March 18, 2013
Date

ENCLOSURE 3

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

DATA BOOK

MARCH 1, 2013 – DECEMBER 31, 2013

INTEGRATED CARE PROGRAM FOR
AGED, BLIND, or DISABLED NON-DUAL (ICP)
SERVICE PACKAGE I

March 18, 2013

Prepared by:

Milliman, Inc.

Robert M. Damler, FSA, MAAA
Jeremy D. Palmer, FSA, MAAA
Jennifer L. Gerstorff, ASA, MAAA

Milliman

TABLE OF CONTENTS

I. INTRODUCTION

The State of Illinois, Department of Healthcare and Family Services (HFS) currently provides a managed care program for the Aged, Blind and Disabled (ABD) non-dual eligible population in six selected counties. HFS plans to expand the program to an additional three counties as of April 1, 2013. This Data Book has been prepared by Milliman, Inc. (Milliman) under the direction of HFS to provide historical data and information to the health plans for contract rates for the ABD non-dual population. The contractors will be offered the enclosed capitation rates for Service Package I services to be effective for the period of March 1, 2013 through December 31, 2013.

The Data Book consists of a series of actuarial models which develop the contract capitation rates. The base data models include historical fee-for-service (FFS) claim experience. The final models include the capitation rates for each of six distinct populations: ICF/MR State Operated Facilities, Other ICF/MR, Nursing Facility, Developmentally Disabled Waiver, Other Waiver and Community Residents. The actuarial models illustrate the expenditures on a detail basis for Service Package I services. Historical claim cost and utilization has been provided by category of service for each rate cell and region. The Data Book provides a series of actuarial models for each region, rate cell, and time period stratification.

The Integrated Care Program (ICP) for the ABD non-dual eligible population is being implemented in phases by Service Package. This Data Book documents the development of capitation rates for Service Package I services, which include acute care services such as Inpatient Hospital, Outpatient Hospital, Ancillary, and Professional services which are not considered long-term care, mental health, or substance abuse services. Service Package II and Service Package III expenditures, which include long-term care services and supports, are shown in aggregate on a per member per month basis in the base year actuarial models only. Service Package II capitation rates were developed separately for the period of February 1, 2013 through December 31, 2013. Service Package III services are not included within the capitation rate for the 2013 contract period.

This data book has been updated to reflect changes to the SMART act policy and program change rating impacts, including delay of implementation to April 1, 2013. This document completely replaces our data book correspondence dated January 31, 2013.

II. LIMITATIONS AND DATA RELIANCE

The services provided for this project were performed under the contract extension between Milliman and HFS dated September 27, 2012.

The information contained in the Data Book has been prepared for the State of Illinois, Department of Healthcare and Family Services (HFS) and their consultants and advisors. It is our understanding that the information contained in Data Book may be utilized in a public document. To the extent that the information contained in this document is provided to third parties, the document should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this document to third parties. Likewise, third parties are instructed that they are to place no reliance upon this document prepared for HFS by Milliman 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 document must rely upon their own experts in drawing conclusions about the HFS's capitation rates, assumptions, and trends.

The information contained in this Data Book was prepared as documentation of the capitation rates for Service Package I services of the Integrated Care Program for the Aged, Blind and Disabled (ABD) non-Dual population and to provide historical data and information to the health plans for contract rates for the ABD non-dual population. This information may not be appropriate for any other purpose. Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual health plan. The Data Book has been developed from data and information provided to Milliman by HFS. Although the data were reviewed for reasonableness, we have accepted the data without audit. To the extent the information provided to Milliman was not complete or accurate, the capitation rates presented in this letter may need to be modified. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this document. HFS and Milliman provide no guarantee, either written or implied, that the data and information is 100% accurate or error free.

III. ACTUARIAL MODELS

The Data Book describes in detail the development of the March 1, 2013 through December 31, 2013 capitation rates for the Service Package I of the Integrated Care Program for the Aged, Blind, and Disabled (ABD) non-dual population. Actuarial models for base year data and capitation rates with detailed category of service definitions are provided as attachments to the Data Book. The following paragraphs provide a description of each of the actuarial models and attachments. The following sections of the Data Book provide the detailed methodology used in the development of actuarially sound capitation rates for the ABD population with reference to the actuarial models and attachments described in this section.

The Data Book Attachments are listed below:

- Attachment 1: Illustration of Rate Development Methodology
- Attachment 2: Category of Service Definitions
- Attachment 3: State Fiscal Year 2010/2011 FFS Summaries
- Attachment 4: Capitation Rate Development Summaries
- Attachment 5: Current vs. Proposed Capitation Rate Comparison

Attachment 1 contains an illustrative chart outlining the methodology that was used to develop the March 1, 2013 through December 31, 2013 Service Package I capitation rates for the ABD non-dual population.

Attachment 2 contains the category of service definitions included in the development of the capitation rates. The category of service definitions rely upon service category definitions contained in the detailed data extracts provided by HFS, as well as commonly defined Medicare DRGs, UB-92 revenue codes, CPT-4 codes, and HCPCS codes.

Attachment 3 provides the historical experience for SFY 2010 and SFY 2011 for the FFS population on a service category and geographic region basis. For each year, utilization, average cost per service, and PMPM values are shown. Attachment 3 reflects only the population eligible to enroll in the Integrated Care Program.

Attachment 4 contains the SFY 2011 adjusted base experience and the projected contract period capitation rates for each population rate cell. The base data reflected in Attachment 4 were adjusted for completion and policy and program changes and trended forward to the SFY 2011 period. Due to a limited number of lives in the Expansion Counties, we have developed a single blended rate for all counties. We have blended the SFY 2011 adjusted base experience for all counties. The adjusted SFY 2011 utilization and cost per service rates were then trended forward to August 1, 2013 and adjusted for managed care efficiency and contractual arrangements between the managed care entities and

healthcare providers. The resulting PMPM, after adjustment for completion, medical inflation, policy and program changes, and managed care adjustments establishes the regional adjusted claim cost for the health plans in the contract period. The non-claim items, such as administrative cost allowance and PCP fee, are applied to the adjusted claim cost to develop the contract period capitation rates.

Attachment 5 compares the March 1, 2013 through December 31, 2013 proposed capitation rates with the current February 2013 capitation rates based on the projected 2013 contract period enrollment distribution by region for the ICP population. The comparison has been illustrated on a PMPM and total expenditure basis.

IV. COVERED POPULATION

The population has been limited to all or portions of nine selected Illinois counties. For the purposes of this rate development, we have assigned two capitation rate regions. The first includes the counties where the program was initially implemented: DuPage, Kane, Kankakee, Lake, Will, and Cook, excluding zip codes that begin with "606". This document will refer to this region as the "Collar Counties". The second region includes the counties where the program is expanding as of April 1, 2013: Boone, McHenry, and. This document will refer to this region as "Expansion Counties". Base data were reviewed separately by region for each rate cell with the exception of the ICF/MR State Operated Facility Population. Due to a limited number of lives in the Expansion Counties, we have developed a single blended capitation rate by population rate cell for all counties.

The population has been stratified into six distinct populations which correspond directly to the capitation rate cells. Individual members were assigned a specific population category based on his or her setting of care on the first day of each month. The population has been limited to non-dual eligible ABD individuals. The population has also been limited by age to include individuals 19 years of age and over.

Attachments 3 and 4 illustrate member months for each population and time period. An individual member month was assigned for each month a member was eligible.

The following describes each of the six distinct populations which correspond directly with the capitation rate cells. To the extent that an individual meets multiple population definitions during the assignment month, the hierarchy below applies.

- **ICF/MR State Operated Facility Population** – This population includes individuals residing in a State Operated ICF/MR facility. Milliman identified the population by reviewing the claim expenditures and identifying State Operated ICF/MR Facility expenditures. All claims with provider type of '034' – State-operated Facility (SOPF, SODC) were considered to be State Operated ICF/MR Facility expenditures. A member was assigned this rating category for a particular month if he or she had a claim which met the qualifying criteria on the first day of that month.

- **Other ICF/MR Population** – This population includes individuals residing in an intermediate care facility for the mentally retarded (ICF/MR); known in Illinois as an intermediate care facility for the developmentally disabled. Milliman identified the population by reviewing the claim expenditures and identifying privately operated ICF/MR claim expenditures. All claims with a provider type of '029' or '037' were considered to be privately operated ICF/MR expenditures. A member was assigned the rating category for a particular month if he or she had a claim which met the qualifying criteria on the first day of that month.

- **Nursing Facility Population** – This population includes individuals residing in a nursing facility. Milliman identified the population by identifying nursing facility expenditures in each month, using provider type codes of '033' and '038'. A member was assigned the rating category for a particular month if he or she had a claim which met the qualifying criteria on the first day of that month.

- **Developmentally Disabled Waiver Population** – This population includes individuals participating in one of the home and community based service (1915(c)) waiver programs for persons with a developmental disability. A member was assigned the rating category for a particular month if he or she was not residing in an ICF/MR or nursing facility on the first day of the month and was assigned one of the qualifying Waiver Special Eligibility Codes maintained by HFS within the Medicaid Management Information System (MMIS) eligibility file. The following waiver programs were included in this population category:

Federal waiver designation	*Description*
0350.R02.01	Adults with developmental disabilities.
0464.R00.01	Children and young adults with developmental disabilities (Support).
0473.R00.01	Children and young adults with developmental disabilities (Residential).

- **Other Waiver Population** – This population includes individuals participating in one of the other 1915(c) waiver programs operating in Illinois. A member was assigned the rating category for a particular month if he or she was not residing in an ICF/MR or nursing facility on the first day of the month and was assigned one of the qualifying Waiver Special Eligibility Codes maintained by HFS within the MMIS eligibility file. The following waiver programs were included in this population category:

Federal waiver designation	*Description*
0143.R05.00	Persons who are elderly.
0329.R03.00	Persons with a brain injury.
0202.R03.00	Persons with HIV or AIDS.
0326.R02.00	Supportive living program.
0278.R03.00	Children that are medically fragile, technology dependent
0142.R05.00	Persons with disabilities.

- **Community Residents Population** – This population includes all other ABD non-dual individuals age 19 and over who were not previously categorized. This population is comprised of individuals who are neither institutionalized nor participating in a 1915(c) waiver program on the first day of a month.

V. BASE DATA STRATIFICATION

The base fee-for-service experience for SFY 2010 and SFY 2011 included in each actuarial model reflects claims paid through June 2012.

Service Package I Expenditures

The historical expenditures were stratified using date of service, HFS assigned category of service, provider type, Diagnostic Related Groups (DRGs), revenue codes, CPT-4 codes, and HCPCS codes. The following provides additional details regarding the expenditures.

- **Date of Service** – The data have been stratified into state fiscal years which begin on July 1st and end on June 30th. The date of service was assigned to the fiscal year based on the first date of service. In the base data, if a hospital inpatient admission extended beyond the end of the fiscal year, all days of the admission were assigned to the fiscal year associated with the date of admission. Because the contract will require that the health plan cover hospital expenditures based upon discharge date, Milliman has developed and applied a Inpatient Hospital timing adjustment. The Inpatient Hospital timing adjustment was developed separately by population and varies for medical/surgical versus inpatient psych and substance abuse services.

- **Category of Service** – Expenditures were stratified by the category of service assigned and maintained by HFS in the MMIS claim system. A list of category of service codes and descriptions is included in Attachment 2.

- **Provider Type** – Expenditures were stratified by provider type. The provider type includes hospital, physician, and ancillary services. The following provides additional information regarding the provider type.

    - Hospital services were stratified between inpatient and outpatient services. Inpatient services include all services performed and billed on the hospital facility claim, including any outpatient services that may have occurred in conjunction with that inpatient admission. This would include emergency room services that may have been incurred if the individual was admitted to the hospital.

        - Hospital Inpatient services were allocated to individual categories of service based on the DRG on the claim. Utilization rates have been shown for the number of admissions, length of stay, and days.

        - Hospital Outpatient services were allocated to individual categories of service based on the revenue codes on the claim. All line items on an individual claim were allocated to a single category of service. This is a result of the reimbursement method used by HFS. Utilization represents the number of hospital outpatient cases.

- Service Package I Nursing Facility services reflect nursing facility expenditures for the transition period of individuals who are not residing in a nursing facility on the first day of a month. All nursing facility expenditures for individuals assigned to the Nursing Facility population were categorized as Service Package II expenditures.

- Physician services were stratified by CPT-4 code and HFS category of service. Milliman relied on the HFS category of service codes for several categories. Milliman performed additional stratifications for physician services by CPT-4 code to provide details regarding the services provided. Utilization represents the number of units on each individual claim. Claims expenditures associated with PCP fees were removed from the base data and included as a fixed $4.00 PMPM fee in the final rate development.

- Ancillary services were stratified by HCPCS code and HFS category of service. Pharmacy services have been included in the capitation rates. Utilization for pharmacy services represents the number of individual prescriptions. Utilization for other ancillary services represents the number of units on each individual claim.

- Service Package II Transition services reflect non-Developmental Disability 1915(c) waiver services for the Community Residents population. These services were incurred in a month for members who transitioned to a waiver from the community, but who were not enrolled in a waiver program on the first of the month.

Service Package II and Service Package III Services

Capitation rates for Service Package II services were included in separate correspondence. Service Package III services will not be included within the capitation rate during the 2013 contract. Service Package II and Service Package III services were identified in the historical expenditures by HFS. The following identifies the primary services included within each Service Package. Additional services were incurred; however, the services are not identified below.

- Service Package II Services
  - Long term care services—Nursing Facility services
    - All Nursing Facility services for those in the Nursing Facility population
  - Long term care services—1915(c) waiver services for non-Developmentally Disabled; including, but not limited to personal attendant, nursing, and homemaker services.

- Service Package III Services
  - Long term care services—ICF/MR services.
  - Long term care services—1915(c) waiver services for the Developmentally Disabled; including, but not limited to supported employment and developmental training.

Actuarial Modeling

Each actuarial model illustrates annual utilization rates per 1,000, average cost per service, and per member per month (PMPM) claims cost developed using FFS data. Attachment 3 contains actuarial models for services incurred during SFY 2010 and SFY 2011, paid through June 2012. The following provides a brief description of each of the data fields. Attachment 4 contains actuarial models for the adjusted, trended base period data as well as the final capitation rate data.

- **Annual Utilization Per 1,000** – This value represents the annual utilization rates per 1,000 by type of service. The value was calculated by dividing the total units for each service category by the member months in the corresponding period and multiplying by 12 times 1,000.

- **Average Cost Per Service –** This value represents the net paid amount per unit of service. The value is net of third party liability (TPL) recoveries and member copayments and does not include adjustments to hospital payments for DSH.

- **Member Months –** This value represents the number of enrollee months in each rate cell during each experience period. Each enrollee was assumed to be eligible for the entire month.

- **PMPM –** The per member per month (PMPM) value represents the net claim cost for each type of service. The value was calculated by multiplying the annual utilization per 1,000 times the average cost per service and dividing by the product of 12 times 1,000.

VI. ADJUSTMENTS TO EXPERIENCE DATA IN RATE DEVELOPMENT PROCESS

Adjustments were made to the base experience data to determine the March 1, 2013 through December 31, 2013 capitation rates. The following outlines each of the adjustments applied in development of the capitation rates.

a. Completion Factors

Milliman used fee-for-service data for services incurred from July 1, 2009 through June 30, 2011, paid through June 2012. Because of the significant claims run-out included in the analysis, applied completion adjustments were minimal. Milliman applied separate claim completion factors to the services incurred during SFY 2010 and SFY 2011. The claim completion factors were developed by service category, population rate cell, and region and have been applied to the base utilization amounts. Table 1 illustrates the aggregate impact to base claims data of the completion adjustments.

Table 1

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind, and Disabled Non-Dual
Aggregate Completion Impact

	Collar Counties		Expansion Counties	
Category of Service	**SFY 2010**	**SFY 2011**	**SFY 2010**	**SFY 2011**
Inpatient Hospital	0.1%	2.0%	0.1%	1.9%
Outpatient Hospital	0.0%	0.3%	0.0%	0.3%
Pharmacy	0.0%	0.0%	0.0%	0.0%
Other Ancillaries	0.1%	0.5%	0.1%	0.5%
Professional	0.0%	0.4%	0.0%	0.4%
Nursing Facility	0.0%	0.2%	0.0%	0.3%

b. Policy and Program Changes

The FFS data were adjusted to reflect services that are excluded from the Medicaid managed care covered services for Service Package I of the ICP.

Additionally, in May 2012, the General Assembly passed the Save Medicaid Access and Resources Together Act (SMART). This legislation reduces benefits and reimbursement levels for the Medicaid program for the following services, effective for the Integrated Care Program on April 1, 2013:

- **Maximum copayments.** The full federally-allowable copays for all eligible services will be charged as the maximum allowable $3.65 for Inpatient Hospital, Physician, FQHC/RHC, Podiatric services, and Pharmacy brand name drugs. Pharmacy generic drugs will be have a $2.00 copay. Currently applicable co-pays are $3.00 for hospital services, $2.00 for professional services, $0.00 for FQHC & RHC encounters, $3.00 for brand drugs, and $0.00 for generic drugs. An aggregate PMPM adjustment was made to the capitation rates to reflect the reduced claim expenditures expected due to the difference between the member copays reflected in the base claims data and the maximum copay amounts that will be charged.

- **Elimination of adult dental services, except for emergency care.** Benefits will only include an emergency exam (D0140), X-rays (D0220, D0230, or D0330), and sedation (D9230 or D9248) in conjunction with an extraction (D7140 or D7210). The projected "Dental" service category has been adjusted to limit the cost and utilization to reflect the removal of all other dental claims (service category 002).

- **Elimination of adult chiropractic services.** Chiropractic services will no longer be a Medicaid-covered service for adults. An adjustment was applied to the "Chiropractor" service category to remove the utilization and cost of these services.

- **Limitation of adult podiatry services.** Claims submitted for participants age 21 years and older must include a primary diagnosis of diabetes (ICD-9-CM 259.xx range) and a secondary diagnosis code reflecting the condition being treated. An adjustment was applied to the "Podiatrist" service category to remove the utilization and cost of these services for non-diabetic participants.

- **Limitation of adult therapy services.** An annual cap of 20 visits per discipline per fiscal year for physical, speech, and occupational therapy services is being implemented for participants age 21 years and older. An adjustment was applied to the "Other Professional" service category to remove the utilization and cost of services in excess of 20 visits per year.

- **Adult eyeglasses policy change.** The new policy for adult eyeglasses limits recipients to one new pair of eyeglasses every two years. The projected "DME/Prosthetics/Orthotics" service category has been adjusted to limit the cost and utilization to reflect the removal of all excess eyeglasses prescriptions during the period.

- **Group psychotherapy for nursing home residents.** Group psychotherapy (procedure codes 90853 and 90849) for residents in a nursing facility, including a nursing facility classified as an institution for mental diseases, or a facility licensed under the Specialized Mental Health Rehabilitation Act will no longer be covered. The projected "Outpatient Behavioral Health" service category has been adjusted to limit the cost and utilization to reflect the removal of these claims.

- **Monthly prescription limit for pharmaceuticals.** A prior approval for brand or generic prescriptions will be required for a client after a client has filled four prescriptions in a 30 day period. There will be exceptions to the limit for drugs for which a prescription limit is not logical. Examples are drugs such as antibiotics, total parenteral nutrition combinations, over-the-counter drugs, and non-drug items such as blood glucose test strips. The projected "Pharmacy" service category has been adjusted to limit the cost and utilization to reflect the removal of excess prescriptions during the period. The applied adjustment was reduced from the full impact adjustment to reflect the nature of the denial rate of the prior approval process.

- **Incontinence supply quantity limit.** The DME Fee Schedule is being revised to change maximum quantity for incontinence supplies from 300 per month to 200 per month. The following procedure codes are affected: T4521-T4535, T4541-T4543. An adjustment was applied to the "DME/Prosthetics/Orthotics" service category to reflect the expected reduction in utilization.

- **Long-term acute (LTAC) hospital rates for ventilator-dependent patients.** Effective October 1, 2010, HFS began making supplemental payments to LTAC hospitals for ventilator-dependent patients. The payment will be set at the October 1, 2010 payment schedule, reduced by 3.5%. The projected "Medical/Surgical Inpatient Hospital" service category has been adjusted to reflect the addition of these payments at the reduced rate to the base data.

- **Institutional provider rate reductions.** A 3.5% reduction to Medicaid reimbursement for hospital inpatient and outpatient services, excluding Safety Net Hospitals or Critical Access Hospitals is effective during the contract period for these capitation rates. An adjustment was applied to the inpatient and outpatient hospital service categories to reflect the expected reduction in cost.

- **General medical provider rate reductions.** A 2.7% rate reduction to Medicaid reimbursement for audiologists, chiropractors, durable medical equipment and supplies providers, home health agencies, hospitals billing non-institutional FFS claims (including Safety Net and Critical Access hospitals), imaging centers, independent laboratories, independent diagnostic testing facilities, occupational therapists, optometrists (non-physician service codes), opticians, optical companies, physical therapists, podiatrists, speech therapists, and transportation providers is effective during the contract period for these capitation rates. An adjustment was applied to inpatient hospital, outpatient hospital, ancillary, and other professional service categories to reflect the expected reduction in cost.

HFS routinely updates the fee schedules for supportive living facility and nursing facility rates. The capitation rates were adjusted to reflect fee changes between the base data period and the contract period of March 1, 2013 through December 31, 2013. This adjustment includes the SMART Act provider rate decrease of 2.7%.

In January 2013, the Affordable Care Act requires an increase in the Medicaid physician fee schedule for certain providers for all Evaluation and Management (E&M) and certain vaccine administration services to 100% of the Medicare physician fee schedule. It is our understanding that HFS will reimburse providers for the additional fee amount outside of the capitated program for ICP-enrolled individuals. As such, we have not made an adjustment to reflect a physician fee schedule increase within the capitation payment rates.

We have not included an adjustment related to the Health Insurer Assessment fee established by the Affordable Care Act based on current guidance. The fee will be collected in 2014 and assessed on 2013 premium values.

Table 2 below illustrates the aggregate impact as a percentage of the capitation rates for each of the program adjustments by geographic region. The adjustments reflect implementation of the SMART act program changes during nine of the ten months of the contract period.

Table 2

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind, and Disabled Non-Dual
Summary of Policy and Program Change Impact

Program Adjustment	Collar Counties	Expansion Counties
Maximum Copayments	(0.7%)	(0.8%)
Dental Benefit Cut	(0.4%)	(0.4%)
Chiropractic Benefit Cut	(0.0%)	(0.0%)
Podiatry Benefit Cut	(0.0%)	(0.0%)
PT/ST/TO Benefit Cut	(0.0%)	(0.0%)
Eyeglass Benefit Cut	(0.0%)	(0.0%)
Group Psych Benefit Cut	(0.5%)	(0.0%)
Prescription Benefit Cut	(1.4%)	(1.9%)
Incontinence Supply Limit	(0.0%)	(0.0%)
LTAC Supplemental Rate Change	0.5%	0.4%
Hospital Rate Cut	(1.4%)	(1.4%)
General Provider Rate Cut	(0.2%)	(0.2%)
Nursing Facility Fee Changes	0.0%	0.0%

c. Managed Care Adjustments

Milliman calculated percentage adjustments to the fee-for-service base experience data to reflect the utilization differential between the base experience and the levels targeted for the managed care environment. Milliman developed the targeted managed care utilization adjustments through review and analysis of the ***Milliman Medicaid Cost Guidelines*** (***Guidelines***), and other Milliman proprietary data. In addition to adjusting utilization rates to reflect healthcare management targets, Milliman correspondingly adjusted the average reimbursement rates to reflect changes in the mix / intensity of services due to the management of health care. The reimbursement rate changes were developed from data and information contained in the ***Guidelines***.

Inpatient Hospital Services – In addition to review of the data and information contained in the Guidelines, Milliman reviewed HEDIS Inpatient Admission Statistics in the determination of managed care adjustments for Inpatient Hospital utilization. The actuarial models were adjusted to reflect that reductions in Hospital Inpatient Services would be partially offset by increases in Service Package I Nursing Home services and Outpatient Surgery services.

Emergency Room Services - For the outpatient hospital emergency room service category and the corresponding physician emergency room visits category, Milliman reviewed the resulting classification of claims using the NYU Center for Health and Public Service Research (CHPSR) Emergency Department Algorithm. Both the Guidelines and the CHPSR Algorithm suggested similar levels of potential for reduced utilization in outpatient hospital emergency room services.

The NYU CHPSR tool classifies emergency room utilization into four (4) primary categories as well as categories that are excluded from the grouping. The four categories include: Non-emergent, Emergent/Primary Care Treatable, Emergent–Preventable/Avoidable, and Emergent–Not Preventable/Avoidable. Subsequent to the review of the experience into these defined categories, Milliman developed specific adjustments for the first three categories to reflect the target utilization levels for the managed care plans. The following illustrates the adjustments by emergency room classification:

- Non-emergent – 50% Reduction
- Emergent/Primary Care Treatable – 33% Reduction
- Emergent – Preventable/Avoidable – 10% Reduction

In coordination with determination of the managed care adjustments for hospital outpatient emergency room services, Milliman assumed that 75% of the emergency room visits reduced would be replaced with an office visit.

Outpatient Behavioral Health – As a component of the utilization differential between the base experience and the levels targeted for the managed care environment, Milliman reflect the impact of limiting outpatient behavioral health group therapy sessions to two per week. This benefit change has a significant impact on both Outpatient Behavioral Health and Transportation utilization for the Nursing Facility population.

Pharmacy – In addition to minor utilization savings, the assumed cost per script by population was adjusted to reflect a target of 68% generic utilization for the ICF/MR and Developmentally Disabled Waiver populations and 72% for all other populations.

d. Contractual Adjustments

Table 3 illustrates the contractual adjustment factors which are intended to reflect the anticipated average contracted rates between the health plans and healthcare providers as compared to the existing contracted rates between HFS and the providers. In addition to the contractual adjustments provided in Table 3, the actuarial models include $4.00 PMPM for PCP fees.

Table 3

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind, and Disabled Non-Dual
Contractual Adjustments

Category of Service	Adjustment
Hospital Inpatient	1.01
Hospital Outpatient	1.02
Pharmacy	0.95
Dental Services	1.02
Other Ancillary Services	1.00
Physician Services	1.02

e. Trend Rates

Trend rates were developed to adjust the current capitation rates to reflect changes in medical cost inflation. The trend rate adjustments were applied from the midpoint of the base data periods to the midpoint of the rate period (August 1, 2013).

The trend rates were developed from historical fee-for-service (FFS) claims and enrollment data incurred in state fiscal years 2007 through 2011. The ICP enrolled population is comparable to the FFS population used in the development of the trend rates. The experience data were adjusted by the following factors: claims completion, fee screen changes, and changes in rate cell mix of the population. We performed exponential regression analysis and an ARIMA time-series forecast using the adjusted experience data to calculate historical and projected trend rate estimates. We also reviewed trend rates used in other programs as well as National Health Expenditure projections published by CMS. Table 4 illustrates our selected trend rates separately for utilization and service cost by major category of service.

Table 4

State of Illinois
Department of Healthcare and Family Services
Annual PMPM Trend Rates by Service Category

Utilization

Population	Inpatient Hospital	Service Package 1 NF	Outpatient Hospital	Pharmacy	Ancillary	Physician
ICF/MR SOF	0.0%	0.0%	1.0%	1.5%	0.5%	2.0%
ICF/MR Other	0.0%	0.0%	0.5%	1.0%	1.0%	2.0%
Nursing Facility	0.0%	0.0%	0.0%	2.0%	0.5%	1.0%
DD Waiver	0.0%	0.0%	0.5%	1.5%	0.5%	1.0%
Other Waiver	0.0%	0.0%	1.0%	1.5%	1.0%	2.0%
Community	0.0%	0.0%	0.0%	2.0%	0.5%	1.0%

Service Cost

Population	Inpatient Hospital	Service Package 1 NF	Outpatient Hospital	Pharmacy	Ancillary	Physician
ICF/MR SOF	(0.5%)	0.0%	2.0%	1.5%	0.0%	0.0%
ICF/MR Other	1.0%	0.0%	0.5%	1.0%	0.0%	0.0%
Nursing Facility	(0.5%)	0.0%	0.5%	2.0%	0.0%	0.0%
DD Waiver	(0.5%)	0.0%	0.5%	1.5%	0.0%	0.0%
Other Waiver	(0.5%)	0.0%	2.0%	1.5%	0.0%	0.0%
Community	(0.5%)	0.0%	0.5%	2.0%	0.0%	0.0%

f. Administrative Allowance

In the development of the Service Package I actuarially sound capitation rates, Milliman included an administrative cost allowance which varies by population rate cell and service package. The administrative allowance was included as 6.0% of the medical claim cost plus a fixed fee. The fixed fee has been established at $40 PMPM for Nursing Home and Other Waiver populations and $25 PMPM for all other populations.

The administrative cost allowance includes administration, profit/contingency and surplus contribution. On a composite basis, the administrative cost allowance is approximately 8.2% of the total program composite capitation rate. The administrative cost allowance will vary for each health plan based on the distribution of members among rate cells.

g. Primary Care Provider (PCP) Management Fee

A $4 PMPM has been added to each rate cell to reflect fees that may be paid to primary care physicians for their participation in risk-based managed care.

h. Capitation Rate

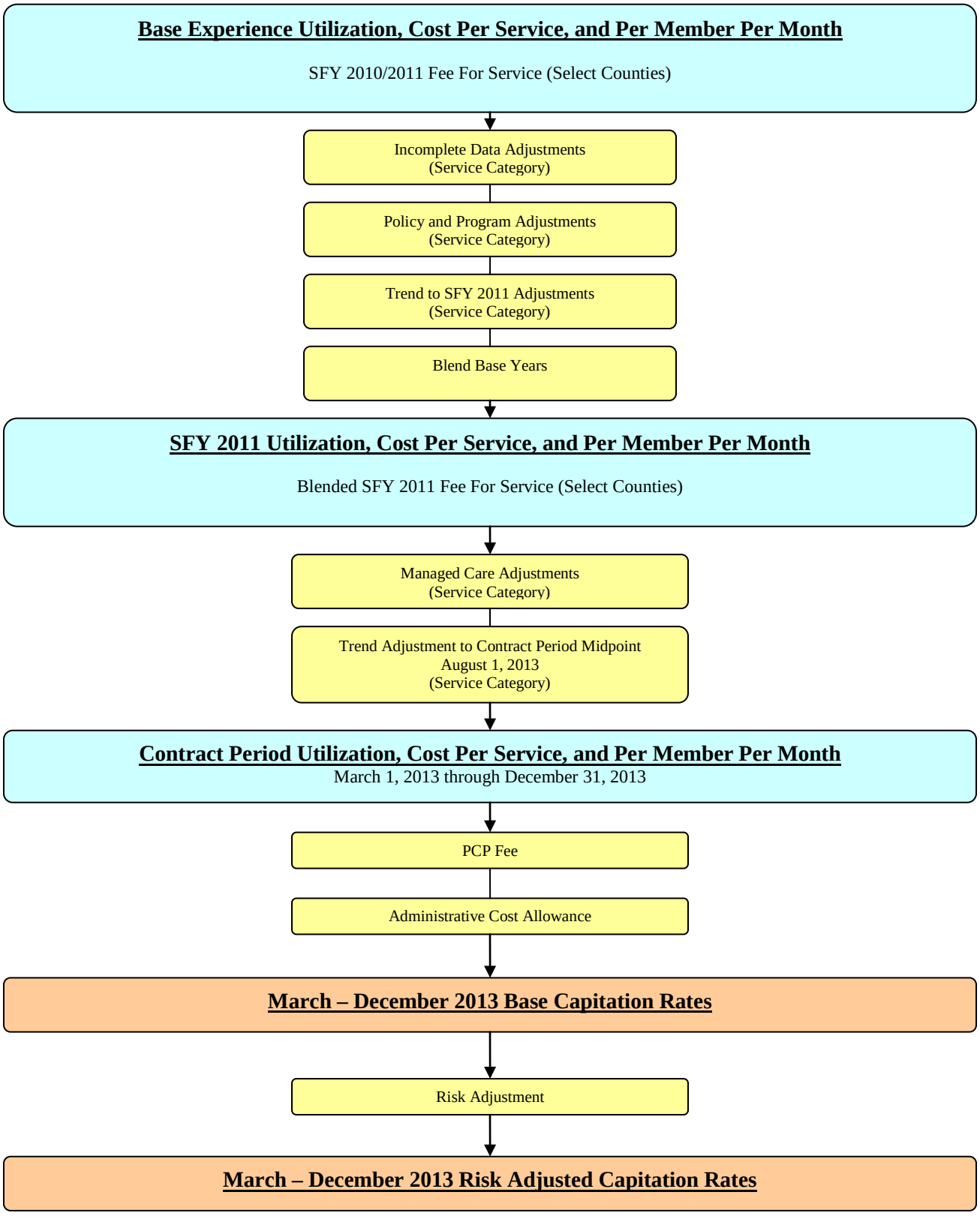
The capitation rate was calculated using the following formula.

Service Package I Claims and Service Package II Transition Cost
less Copay Adjustment PMPM
plus 6% Administrative Load
plus Fixed Administration Fee
plus PCP Fee
equals Total Capitation Rate (effective March 1, 2013)

VII. RISK ADJUSTMENT

The methodology described in this Data Book was used to develop the base capitation rates for the March 1, 2013 through December 31, 2013 contract period for each population rate cell. Milliman will apply risk adjustments to the base rates for each managed care entity. Risk adjustment factors will be calculated using a standard risk adjustment tool for Medicaid populations. We anticipate using CDPS, Medicaid RX or CDPS + Medicaid RX. Risk scores will be developed to be budget neutral within each of the six populations.

ATTACHMENT 1



ATTACHMENT 2

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development
Service Category Mapping

Category/Sub-Category	*Primary Criteria*	*Secondary Criteria*	*Unit Counting Methodology*
Inpatient Hospital			
Medical/Surgical			
	DRG = 001-369, 392-424, 439-520, 524-579		Days
Psychiatric/Substance Abuse			
	DRG = 425-438, 521-523		Days
Service Package I Nursing Facility			
	Provider Type Code = 033, 038	First 90 days of NF stay where member is not identified as part of the nursing facility population rate cell.	Days
Other			
	All other claims where CatgOfServiceCd = 020, 021, 022, 061, 065		Days

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development
Service Category Mapping

Category/Sub-Category	*Primary Criteria*	*Secondary Criteria*	*Unit Counting Methodology*
Outpatient Hospital			
Emergency Room			
	CatgOfServiceCd = 024, 025 AND Revenue Code = 450-459, 981		Encounters
Surgery			
	CatgOfServiceCd = 024, 025 AND Revenue Code = 360-362, 367, 369, 481, 490, 499, 750, 759, 790, 791, 799		Encounters
General			
	All other CatgOfServiceCd = 024		Encounters
End-Stage Renal Disease			
	All other CatgOfServiceCd = 025		Encounters

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development
Service Category Mapping

Category/Sub-Category	***Primary Criteria***	***Secondary Criteria***	***Unit Counting Methodology***
Ancillary			
Pharmacy			
	CatgOfServiceCd = 040		Scripts
Transportation			
	CatgOfServiceCd = 050, 051, 052, 053, 054, 055, 056	Unless identified as SPII or SPIII by HFS	Claim Lines
DME/Prosthetics/Orthotics			
	CatgOfServiceCd = 041, 044, 045, 048		Reported Units (EISServiceUnitsNbr)
Home Health/Hospice			
	CatgOfServiceCd = 016, 060, 066 for all populations OR CatgOfServiceCd = 010, 015 for Community population only		Reported Units (EISServiceUnitsNbr)
Dental			
	CatgOfServiceCd = 002		Reported Units (EISServiceUnitsNbr)
Other Ancillaries			
	CatgOfServiceCd = 003, 004, 005, 014		Reported Units (EISServiceUnitsNbr)

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development
Service Category Mapping

Category/Sub-Category	***Primary Criteria***	***Secondary Criteria***	***Unit Counting Methodology***
Physician			
Surgery			
	ProcedureCode = 10021-69020, 69100-69990, 92973-92974, 92980-93462, 93501-93533, 93580-93581, G0104-G0105, G0127, G0168-G0173, G0251, G0259, G0267, G0269, G0289-G0291, G0297-G0343, G0364, G0392-G0393, G0412-G0419, G0440-G0441, M0301, S0400, S0601, S2053-S2118, S2135-S2152, S2205-S2235, S2270-S2900, S9034	CatgOfServiceCd <> 011, 012, 013, 017, 047, 059, 034, 035, 058, 003, 004, 005, 014, 041, 044, 045, 048	Claim Lines
Anesthesia			
	CatgOfServiceCd = 017		Claim Lines
Hospital Inpatient Visits			
	ProcedureCode = 90816-99233, 99238-99239, 99251-99255, 99289-99318, 99356-99357, 99436-99440, 99464-99476, 99478-99480, G0390, G0406-G0408, G0425-G0427, S0310	CatgOfServiceCd <> 011, 012, 013, 017, 047, 059, 034, 035, 058, 003, 004, 005, 014, 041, 044, 045, 048	Claim Lines
Office Visits/Consults			
	ProcedureCode = 98966-98969, 99201-99215, 99241-99245, 99324-99355, 99358-99359, 99361-99362, 99366-99380, 99441-99444, 99499, G0179-G0182, G0337, S0220-S0260, S0273-S0274	CatgOfServiceCd <> 011, 012, 013, 017, 047, 059, 034, 035, 058, 003, 004, 005, 014, 041, 044, 045, 048	Reported Units (EISServiceUnitsNbr)
Office Administered Drugs			
	ProcedureCode = 90281-90399, 90760-90779, 96360-96549, A4641-A4642, A9500-A9700, G0332, G3001, G9017-G9020, G9147, J0120-J9999, Q0081-Q0085, Q0138-Q0181, Q0515, Q2004-Q2027, Q2041-Q2042, Q2044-Q3001, Q3025-Q3026, Q4074-Q4092, Q4095-Q4099, Q9945-Q9968, S0012-S0179, S0181-S0194, S0196-S0197, S4993, S5000-S5014, S5550-S5553	CatgOfServiceCd <> 011, 012, 013, 017, 047, 059, 034, 035, 058, 003, 004, 005, 014, 041, 044, 045, 048	Reported Units (EISServiceUnitsNbr)
Physical Exams			
	ProcedureCode = 99381-99435, 99460-99463, G0101-G0102, G0344, G0366-G0368, G0402-G0405, G0438-G0439, S0302, S0605-S0613	CatgOfServiceCd <> 011, 012, 013, 017, 047, 059, 034, 035, 058, 003, 004, 005, 014, 041, 044, 045, 048	Reported Units (EISServiceUnitsNbr)
Emergency Room Visits			
	ProcedureCode = 99217-99220, 99224-99226, 99234-99236, 99281-99288, G0378-G0384	CatgOfServiceCd <> 011, 012, 013, 017, 047, 059, 034, 035, 058, 003, 004, 005, 014, 041, 044, 045, 048	Reported Units (EISServiceUnitsNbr)
Clinic Visits/Services			
	CatgOfServiceCd = 026, 027, 028, 029		Reported Units (EISServiceUnitsNbr)

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development
Service Category Mapping

Category/Sub-Category	*Primary Criteria*	*Secondary Criteria*	*Unit Counting Methodology*
Radiology			
	ProcedureCode = 70000-79999, 0066T, G0130, G0202-G0235, G0252, G0275-G0278, G0288, G0389, Q0092, R0070-R0076, S8030-S8037, S8042-S8092, S9024	CatgOfServiceCd <> 011, 012, 013, 017, 047, 059, 034, 035, 058, 003, 004, 005, 014, 041, 044, 045, 048	Reported Units (EISServiceUnitsNbr)
Pathology			
	ProcedureCode = 36415-36416, 80000-89999, G0027, G0103, G0265-G0266, G0306-G0307, G0328, G0394, G0430-G0431, G0434, G9143, P2028-P2038, P7001, Q0111-G0115, Q3031, S2120, S3600-S3630, S3650-S3890, S9529	CatgOfServiceCd <> 011, 012, 013, 017, 047, 059, 034, 035, 058, 003, 004, 005, 014, 041, 044, 045, 048	Reported Units (EISServiceUnitsNbr)
Outpatient Behavioral Health			
	CatgOfServiceCd = 047, 059 OR ProcedureCode = 90801-90815, 90845-90899, G0129, G0176-G0177, G0409-G0411, H0031-H0037, H0041-H0046, H1011, H2013-H2014, H2017-H2018, H2023-H2032, M0064, S0201, S3005, S9476-S9485		Reported Units (EISServiceUnitsNbr)
DMHDD Rehabilitation Option Services			
	CatgOfServiceCd = 034		Reported Units (EISServiceUnitsNbr)
Mental Health			
	CatgOfServiceCd = 035, 058		Reported Units (EISServiceUnitsNbr)
Other Professional			
	All other professional claims not assigned elsewhere		Reported Units (EISServiceUnitsNbr)

State of Illinois
Department of Healthcare and Family Services
HFS Service Category Codes

CatgOfServiceCd	Definition	ICP Service Package
001	Physician Services	SP I
002	Dental Services	SP I
003	Optometric Services	SP I
004	Podiatric Services	SP I
005	Chiropractic Services	SP I
006	Physicians Psychiatric Services	EXCLUDED
007	Development Therapy, Orientation and Mobility Services (Waivers)	SP I
008	DSCC Counseling/Fragile Children	EXCLUDED
009	DCFS Rehab Option Services	EXCLUDED
010	Nursing service	SP II
011	Physical Therapy Services	SP I
012	Occupational Therapy Services	SP I
013	Speech Therapy/Pathology Services	SP I
014	Audiology Services	SP I
015	Sitter Services	SP II
016	Home Health Aides	SP I
017	Anesthesia Services	SP I
018	Midwife Services	SP I
019	Genetic Counseling	EXCLUDED
020	Inpatient Hospital Services (General)	SP I
021	Inpatient Hospital Services (Psychiatric)	SP I
022	Inpatient Hospital Services (Physical Rehabilitation)	SP I
023	Inpatient Hospital Services (ESRD)	EXCLUDED
024	Outpatient Services (General)	SP I
025	Outpatient Services (ESRD)	SP I
026	General Clinic Services	SP I
027	Psychiatric Clinic Services (Type 'A')	SP I
028	Psychiatric Clinic Services (Type 'B')	SP I
029	Clinic Services (Physical Rehabilitation)	SP I
030	Healthy Kids Services	SP I
031	Early Intervention Services	SP I
032	Environmental modifications (waiver)	SP III
033	Mental Health Clinic Option Services	EXCLUDED
034	Mental Health Rehab Option Services	SP I
035	Alcohol and Substance Abuse Rehab. Services	SP I
036	Juvenile Rehabilitation	EXCLUDED
037	Skilled Care - Hospital Residing	EXCLUDED
038	Exceptional Care	SP II & III
039	DD/MI Non-Acute Care - Hospital Residing	EXCLUDED
040	Pharmacy Services (Drug and OTC)	SP I
041	Medical equipment/prosthetic devices	SP I
042	Family planning service	EXCLUDED
043	Clinical Laboratory Services	SP I
044	Portable X-Ray Services	SP I
045	Optical Supplies	SP I
046	Psychiatric Drugs	EXCLUDED
047	Targeted case management service (mental health)	SP I & III
048	Medical Supplies	SP I
049	DCFS Targeted Case Management Services	EXCLUDED
050	Emergency Ambulance Transportation	SP I
051	Non-Emergency Ambulance Transportation	SP I
052	Medicar Transportation	SP I
053	Taxicab Services	SP I
054	Service Car	SP I
055	Auto transportation (private)	SP I
056	Other Transportation	SP I
057	Nurse Practitioners Services	SP I
058	Social work service	SP I
059	Psychologist service	SP I
060	Home Care	SP I
061	General Inpatient	SP I
062	Continuous Care Nursing	SP II
063	Respite Care	SP II
064	Other Behavioral Health Services	SP I
065	LTC Full Medicare Coverage	SP II
066	Home Health Services	SP I
067	All Kids application agent (valid on provider file only)	SP I
068	Targeted case management service (early intervention)	EXCLUDED
069	Subacute Care Program	EXCLUDED
070	LTC - Skilled	SP II

State of Illinois
Department of Healthcare and Family Services
HFS Service Category Codes

CatgOfServiceCd	Definition	ICP Service Package
071	LTC - Intermediate	SP II
072	LTC--NF skilled (partial Medicare coverage)	SP II
073	LTC--ICF/MR	SP III
074	LTC--ICF/MR skilled pediatric	SP III
075	LTC - MI Recipient age 22-64	SP III
076	LTC - Specialized Living Center - Intermediate MR	SP III
077	SOPF--MI recipient over 64 years of age	SP III
078	SOPF--MI recipient under 22 years of age	SP III
079	SOPF--MI recipient non-matchable	SP III
080	Rehabilitation option service (special LEA service)	EXCLUDED
081	Capitation Services	EXCLUDED
082	LTC--Developmental training (level I)	SP III
083	LTC--Developmental training (level II)	SP II
084	LTC--Developmental training (level III)	SP III
085	LTC - Recipient 22-64 in IMD not MI or MR	SP III
086	LTC SLF Dementia Care	SP III
087	LTC - Supportive Living Facility (Waivers)	SP II
088	LTC - MR Recipient between ages 21-65	SP III
089	LTC - MR Recipient - Inappropriately Placed	SP III
090	Case Management	SP II & III
091	Homemaker	SP II & III
092	Agency Providers RN, LPN, CNA and Therapies	SP II & III
093	Individual Providers PA, RN, LPN, CNA and Therapies	SP II & III
094	Adult Day Health	SP II & III
095	Habilitation Services	SP II & III
096	Respite Care	SP II & III
097	Other HCFA Approved Services	SP II & III
098	Electronic Home Response/EHR Installation(MARS), MPE Certification(Provider)	SP II & III
099	Transplants	EXCLUDED
100	Genetic counseling	EXCLUDED
102	Fluoride varnish	SP I
CS	Counseling for medically fragile children	SP II
EA	Utilities	SP II
EM	Access to home or vehicle	SP II
ES	Extermination Services	SP II
FT	Family training	SP II
ME	Specialized medical equipment/supplies	SP II

ATTACHMENT 3

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Collar Counties **Member Months:** 292,201 **Member Months:** 321,128
Population: Community Residents

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	367.9	5.8	2,127.0	$ 1,553.17	$ 275.30	359.0	5.6	1,993.5	$ 1,559.13	$ 259.01
Psychiatric/Substance Abuse	179.1	5.6	1,011.7	584.40	49.27	167.4	5.7	958.4	597.50	47.72
Service Package 1 Nursing Facility	37.4	25.7	960.4	120.45	9.64	40.7	21.6	880.5	126.75	9.30
Other	9.7	4.1	39.5	1,552.41	5.11	9.5	4.1	38.5	2,091.43	6.71
Subtotal	594.1	7.0	4,138.6	$ 983.87	$ 339.32	576.6	6.7	3,870.9	$ 1,000.51	$ 322.74
Outpatient Hospital										
Emergency Room			1,361.7	$ 178.89	$ 20.30			1,352.8	$ 183.18	$ 20.65
Surgery			189.9	935.86	14.81			195.4	932.24	15.18
General			773.6	385.01	24.82			822.1	381.41	26.13
End-Stage Renal Disease			121.4	1,796.05	18.17			115.2	1,889.58	18.14
Subtotal			2,446.6	$ 383.06	$ 78.10			2,485.5	$ 386.72	$ 80.10
Ancillaries										
Pharmacy			36,204.1	$ 73.40	$ 221.45			37,081.8	$ 73.42	$ 226.88
Transportation			7,643.4	16.06	10.23			7,508.3	16.49	10.32
DME/Prosthetics/Orthotics			2,322.9	80.18	15.52			2,396.0	83.49	16.67
Home Health/Hospice			1,043.2	184.39	16.03			1,151.7	190.88	18.32
Dental			1,391.8	43.02	4.99			1,305.9	44.02	4.79
Other Ancillary			392.1	28.77	0.94			405.9	29.86	1.01
Subtotal			48,997.5	$ 65.92	$ 269.16			49,849.6	$ 66.92	$ 277.99
Physician										
Surgery			728.0	$ 252.86	$ 15.34			751.5	$ 251.18	$ 15.73
Anesthesia			194.5	205.45	3.33			201.9	200.89	3.38
Hospital Inpatient Visits			4,990.7	38.18	15.88			4,921.6	38.57	15.82
Office Visits/Consults			3,814.5	50.15	15.94			3,859.2	48.97	15.75
Office Administered Drugs			646.8	333.02	17.95			738.7	344.23	21.19
Physical Exams			72.5	84.41	0.51			81.0	85.93	0.58
Emergency Room Visits			1,302.7	50.30	5.46			1,269.4	51.24	5.42
Clinic Visit/Services			4,038.6	41.72	14.04			3,970.0	42.74	14.14
Radiology			3,392.1	36.01	10.18			3,340.3	36.64	10.20
Pathology			21,874.4	6.05	11.03			23,046.5	5.91	11.36
Outpatient Behavioral Health			1,807.8	35.91	5.41			1,632.4	37.12	5.05
DMHDD Rehabilitation Option Services			5,061.4	49.03	20.68			4,785.0	49.86	19.88
Mental Health			424.4	89.35	3.16			470.6	84.91	3.33
Other Professional			9,894.4	12.39	10.22			10,113.3	11.90	10.03
Subtotal			58,242.8	$ 30.73	$ 149.13			59,181.4	$ 30.79	$ 151.86
Service Package II										
Nursing Facility			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Homemaker			6.4	1,068.75	0.57			6.4	1,068.75	0.57
PA, RN, LPN, CNA Providers and Therapies			4.7	357.45	0.14			2.4	400.00	0.08
Assisted Living			118.4	73.99	0.73			86.5	73.53	0.53
Adult Day Health			-	-	0.03			-	-	-
Home Health/Hospice			-	-	-			-	-	-
Electronic Home Response/EHR Installation			0.7	-	-			0.1	-	-
DORS			13.4	510.45	0.57			96.9	570.90	4.61
Other Waiver Services			-	-	-			0.2	13,200.00	0.22
Subtotal			143.6	$ 170.47	$ 2.04			192.5	$ 374.65	$ 6.01
Service Package III										
ICF/MR			33.5	$ 411.94	$ 1.15			25.7	$ 354.86	$ 0.76
DD Waiver Services			36.6	85.25	0.26			72.0	103.33	0.62
Subtotal			70.1	$ 241.37	$ 1.41			97.7	$ 169.50	$ 1.38
Total Service Package 1 Claims/Benefit Cost			113,825.5	$ 88.10	$ 835.71			115,387.4	$ 86.60	$ 832.69
Total Service Package 2 Claims/Benefit Cost			143.6	$ 170.47	$ 2.04			192.5	$ 374.65	$ 6.01
Total Service Package 3 Claims/Benefit Cost			70.1	$ 241.37	$ 1.41			97.7	$ 169.50	$ 1.38

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Collar Counties **Member Months:** 17,861 **Member Months:** 19,766
Population: Disabled Waiver

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	146.5	6.0	878.8	$ 1,504.78	$ 110.20	161.5	5.1	819.6	$ 1,170.13	$ 79.92
Psychiatric/Substance Abuse	144.4	7.8	1,126.7	592.28	55.61	160.3	8.3	1,333.8	621.14	69.04
Service Package 1 Nursing Facility	6.7	18.1	121.6	121.38	1.23	10.9	13.8	150.6	134.66	1.69
Other	2.0	2.4	4.7	944.68	0.37	2.4	2.8	6.7	841.79	0.47
Subtotal	299.6	7.1	2,131.8	$ 942.36	$ 167.41	335.1	6.9	2,310.7	$ 784.80	$ 151.12
Outpatient Hospital										
Emergency Room			853.3	$ 167.49	$ 11.91			848.7	$ 171.37	$ 12.12
Surgery			83.3	1,326.77	9.21			83.2	1,018.27	7.06
General			309.1	296.99	7.65			312.7	382.99	9.98
End-Stage Renal Disease			28.2	2,812.77	6.61			18.8	3,344.68	5.24
Subtotal			1,273.9	$ 333.28	$ 35.38			1,263.4	$ 326.74	$ 34.40
Ancillaries										
Pharmacy			52,038.5	$ 75.98	$ 329.47			51,930.4	$ 75.27	$ 325.72
Transportation			7,187.5	15.83	9.48			3,578.9	25.38	7.57
DME/Prosthetics/Orthotics			5,997.0	113.62	56.78			5,719.5	116.63	55.59
Home Health/Hospice			143.1	72.96	0.87			238.0	91.76	1.82
Dental			1,642.7	33.38	4.57			1,491.0	31.87	3.96
Other Ancillary			1,138.8	21.60	2.05			1,095.2	22.90	2.09
Subtotal			68,147.6	$ 71.00	$ 403.22			64,053.0	$ 74.33	$ 396.75
Physician										
Surgery			340.0	$ 171.88	$ 4.87			338.2	$ 190.89	$ 5.38
Anesthesia			116.2	233.39	2.26			124.5	229.40	2.38
Hospital Inpatient Visits			2,903.1	35.38	8.56			2,749.6	36.35	8.33
Office Visits/Consults			3,722.7	46.45	14.41			3,629.9	45.69	13.82
Office Administered Drugs			201.6	328.57	5.52			105.6	397.73	3.50
Physical Exams			186.8	84.80	1.32			213.1	85.03	1.51
Emergency Room Visits			841.2	49.22	3.45			820.2	50.48	3.45
Clinic Visit/Services			735.7	122.01	7.48			796.5	126.70	8.41
Radiology			1,696.4	31.62	4.47			1,646.5	33.67	4.62
Pathology			20,035.4	5.88	9.81			19,324.7	5.92	9.54
Outpatient Behavioral Health			2,071.3	32.68	5.64			1,848.0	38.90	5.99
DMHDD Rehabilitation Option Services			3,464.8	44.64	12.89			3,828.4	45.86	14.63
Mental Health			2.7	44.44	0.01			4.2	57.14	0.02
Other Professional			3,376.1	23.78	6.69			3,134.5	21.25	5.55
Subtotal			39,694.0	$ 26.42	$ 87.38			38,563.9	$ 27.11	$ 87.13
Service Package II										
Nursing Facility			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Homemaker			-	-	-			-	-	-
PA, RN, LPN, CNA Providers and Therapies			-	-	-			-	-	-
Assisted Living			-	-	-			-	-	-
Adult Day Health			-	-	-			-	-	-
Home Health/Hospice			-	-	-			-	-	-
Electronic Home Response/EHR Installation			-	-	-			-	-	-
DORS			-	-	-			-	-	-
Other Waiver Services			-	-	-			-	-	-
Subtotal			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Service Package III										
ICF/MR			176.7	$ 317.15	$ 4.67			66.2	$ 192.15	$ 1.06
DD Waiver Services			451,799.6	110.10	4,145.17			442,665.6	104.98	3,872.69
Subtotal			451,976.3	$ 110.18	$ 4,149.84			442,731.8	$ 105.00	$ 3,873.75
Total Service Package 1 Claims/Benefit Cost			111,247.3	$ 74.79	$ 693.39			106,191.0	$ 75.64	$ 669.40
Total Service Package 2 Claims/Benefit Cost			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Total Service Package 3 Claims/Benefit Cost			451,976.3	$ 110.18	$ 4,149.84			442,731.8	$ 105.00	$ 3,873.75

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Collar Counties **Member Months:** 4,944 **Member Months:** 5,033
Population: ICF MR

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	318.0	5.3	1,669.9	$ 1,433.55	$ 199.49	369.6	6.3	2,322.3	$ 1,576.23	$ 305.04
Psychiatric/Substance Abuse	36.4	6.7	245.1	563.53	11.51	71.5	6.5	467.3	549.03	21.38
Service Package 1 Nursing Facility	14.6	12.6	184.5	122.28	1.88	26.2	15.0	393.4	194.61	6.38
Other	-	-	-	-	-	-	-	-	-	-
Subtotal	369.0	5.7	2,099.5	$ 1,216.75	$ 212.88	467.3	6.8	3,183.0	$ 1,254.67	$ 332.80
Outpatient Hospital										
Emergency Room			686.9	$ 161.07	$ 9.22			753.4	$ 177.44	$ 11.14
Surgery			97.1	1,080.12	8.74			102.5	620.49	5.30
General			400.5	209.44	6.99			314.7	235.27	6.17
End-Stage Renal Disease			-	-	-			23.8	3,418.49	6.78
Subtotal			1,184.5	$ 252.76	$ 24.95			1,194.4	$ 295.28	$ 29.39
Ancillaries										
Pharmacy			66,747.6	$ 69.67	$ 387.51			69,944.8	$ 68.37	$ 398.49
Transportation			3,832.5	38.23	12.21			4,739.9	42.53	16.80
DME/Prosthetics/Orthotics			2,560.7	284.55	60.72			2,374.7	297.44	58.86
Home Health/Hospice			101.9	306.18	2.60			290.9	315.98	7.66
Dental			873.8	32.96	2.40			724.8	36.92	2.23
Other Ancillary			2,997.6	21.38	5.34			2,744.3	20.29	4.64
Subtotal			77,114.1	$ 73.26	$ 470.78			80,819.4	$ 72.56	$ 488.68
Physician										
Surgery			485.4	$ 149.81	$ 6.06			670.0	$ 134.33	$ 7.50
Anesthesia			174.8	214.19	3.12			162.1	219.86	2.97
Hospital Inpatient Visits			9,475.7	30.53	24.11			11,234.7	32.49	30.42
Office Visits/Consults			2,286.4	45.40	8.65			2,474.9	45.04	9.29
Office Administered Drugs			46.1	898.05	3.45			35.8	1,032.40	3.08
Physical Exams			94.7	78.56	0.62			83.4	83.45	0.58
Emergency Room Visits			640.8	50.00	2.67			670.0	53.55	2.99
Clinic Visit/Services			305.8	111.45	2.84			338.6	117.31	3.31
Radiology			2,284.0	25.43	4.84			3,011.3	22.00	5.52
Pathology			25,985.4	6.45	13.97			29,662.6	6.12	15.14
Outpatient Behavioral Health			1,106.8	31.55	2.91			1,156.4	33.00	3.18
DMHDD Rehabilitation Option Services			143.2	20.95	0.25			38.1	47.24	0.15
Mental Health			-	-	-			-	-	-
Other Professional			5,310.7	12.68	5.61			5,724.6	10.98	5.24
Subtotal			48,339.8	$ 19.64	$ 79.10			55,262.5	$ 19.41	$ 89.37
Service Package II										
Nursing Facility			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Homemaker			252.0	50.00	1.05			2.4	50.00	0.01
PA, RN, LPN, CNA Providers and Therapies			-	-	-			-	-	-
Assisted Living			-	-	-			-	-	-
Adult Day Health			-	-	-			-	-	-
Home Health/Hospice			-	-	-			-	-	-
Electronic Home Response/EHR Installation			-	-	-			-	-	-
DORS			-	-	-			-	-	-
Other Waiver Services			-	-	-			-	-	-
Subtotal			252.0	$ 50.00	$ 1.05			2.4	$ 50.00	$ 0.01
Service Package III										
ICF/MR			362,320.4	$ 179.08	$ 5,407.06			363,638.4	$ 180.69	$ 5,475.56
DD Waiver Services			203,830.1	66.24	1,125.20			204,112.1	67.51	1,148.32
Subtotal			566,150.5	$ 138.46	$ 6,532.26			567,750.5	$ 140.00	$ 6,623.88
Total Service Package 1 Claims/Benefit Cost			128,737.9	$ 73.42	$ 787.71			140,459.3	$ 80.33	$ 940.24
Total Service Package 2 Claims/Benefit Cost			252.0	$ 50.00	$ 1.05			2.4	$ 50.00	$ 0.01
Total Service Package 3 Claims/Benefit Cost			566,150.5	$ 138.46	$ 6,532.26			567,750.5	$ 140.00	$ 6,623.88

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Collar Counties **Member Months:** 32,687 **Member Months:** 33,748
Population: Nursing Facility

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	731.7	6.2	4,521.8	$ 1,426.74	$ 537.62	744.6	6.3	4,682.2	$ 1,389.73	$ 542.25
Psychiatric/Substance Abuse	422.9	6.8	2,892.5	603.51	145.47	431.0	7.1	3,062.2	626.84	159.96
Service Package 1 Nursing Facility	-	-	-	-	-	-	-	-	-	-
Other	0.4	8.3	3.3	181.82	0.05	2.8	6.1	17.1	1,235.09	1.76
Subtotal	1,155.0	6.4	7,417.6	$ 1,105.17	$ 683.14	1,178.4	6.6	7,761.5	$ 1,088.40	$ 703.97
Outpatient Hospital										
Emergency Room			1,507.0	$ 193.90	$ 24.35			1,567.7	$ 198.63	$ 25.95
Surgery			206.7	775.62	13.36			210.1	597.43	10.46
General			509.6	391.37	16.62			506.3	327.32	13.81
End-Stage Renal Disease			384.4	1,642.35	52.61			314.7	1,630.12	42.75
Subtotal			2,607.7	$ 492.11	$ 106.94			2,598.8	$ 429.29	$ 92.97
Ancillaries										
Pharmacy			111,789.8	$ 67.72	$ 630.83			113,083.7	$ 69.09	$ 651.05
Transportation			105,948.5	10.61	93.65			54,829.9	13.71	62.66
DME/Prosthetics/Orthotics			4,841.6	81.64	32.94			5,212.4	82.12	35.67
Home Health/Hospice			404.6	288.28	9.72			699.8	258.93	15.10
Dental			1,374.5	48.02	5.50			1,493.4	50.54	6.29
Other Ancillary			3,811.4	21.00	6.67			3,698.7	21.19	6.53
Subtotal			228,170.4	$ 40.99	$ 779.31			179,017.9	$ 52.10	$ 777.30
Physician										
Surgery			1,404.6	$ 156.60	$ 18.33			1,330.9	$ 168.07	$ 18.64
Anesthesia			219.2	208.58	3.81			277.3	184.35	4.26
Hospital Inpatient Visits			23,580.4	30.03	59.01			23,750.4	30.59	60.54
Office Visits/Consults			2,128.6	46.85	8.31			2,249.0	43.81	8.21
Office Administered Drugs			388.4	319.77	10.35			343.1	484.76	13.86
Physical Exams			20.6	93.20	0.16			30.2	95.36	0.24
Emergency Room Visits			1,337.4	56.17	6.26			1,419.5	56.81	6.72
Clinic Visit/Services			331.9	186.56	5.16			306.2	226.91	5.79
Radiology			4,357.3	34.84	12.65			4,536.1	33.52	12.67
Pathology			54,241.4	6.03	27.27			57,208.4	6.03	28.76
Outpatient Behavioral Health			40,040.5	34.23	114.23			22,863.6	34.71	66.14
DMHDD Rehabilitation Option Services			3,960.8	44.11	14.56			4,648.1	43.63	16.90
Mental Health			4,085.3	53.87	18.34			7,922.2	50.86	33.58
Other Professional			17,175.6	10.22	14.63			18,400.0	10.36	15.88
Subtotal			153,272.0	$ 24.51	$ 313.07			145,285.0	$ 24.13	$ 292.19
Service Package II										
Nursing Facility			354,912.1	$ 113.09	$ 3,344.68			358,396.0	$ 116.11	$ 3,467.65
Homemaker			37.2	58.10	0.18			53.7	58.10	0.26
PA, RN, LPN, CNA Providers and Therapies			9.9	593.94	0.49			10.7	560.75	0.50
Assisted Living			57.3	75.39	0.36			63.6	75.47	0.40
Adult Day Health			-	-	-			-	-	-
Home Health/Hospice			-	-	-			-	-	-
Electronic Home Response/EHR Installation			10.3	23.30	0.02			6.4	18.75	0.01
DORS			231.7	638.07	12.32			108.1	334.14	3.01
Other Waiver Services			0.4	900.00	0.03			0.7	171.43	0.01
Subtotal			355,258.9	$ 113.43	$ 3,358.08			358,639.2	$ 116.17	$ 3,471.84
Service Package III										
ICF/MR			34.9	$ 165.04	$ 0.48			12.8	$ 178.13	$ 0.19
DD Waiver Services			55.1	91.47	0.42			38.8	89.69	0.29
Subtotal			90.0	$ 120.00	$ 0.90			51.6	$ 111.63	$ 0.48
Total Service Package 1 Claims/Benefit Cost			391,467.7	$ 57.70	$ 1,882.46			334,663.2	$ 66.92	$ 1,866.43
Total Service Package 2 Claims/Benefit Cost			355,258.9	$ 113.43	$ 3,358.08			358,639.2	$ 116.17	$ 3,471.84
Total Service Package 3 Claims/Benefit Cost			90.0	$ 120.00	$ 0.90			51.6	$ 111.63	$ 0.48

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Collar Counties **Member Months:** 31,124 **Member Months:** 34,793
Population: Other Waiver

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	957.7	6.6	6,321.6	$ 1,487.09	$ 783.40	800.2	6.2	4,966.2	$ 1,465.80	$ 606.62
Psychiatric/Substance Abuse	83.3	6.1	512.0	587.34	25.06	58.6	5.5	319.4	569.57	15.16
Service Package 1 Nursing Facility	87.1	15.5	1,351.0	128.97	14.52	57.9	14.8	858.8	131.77	9.43
Other	3.1	7.1	22.0	2,890.91	5.30	2.1	5.9	12.4	2,970.97	3.07
Subtotal	1,131.2	7.3	8,206.6	$ 1,211.14	$ 828.28	918.8	6.7	6,156.8	$ 1,236.25	$ 634.28
Outpatient Hospital										
Emergency Room			1,962.5	$ 196.89	$ 32.20			1,689.0	$ 208.74	$ 29.38
Surgery			275.7	873.99	20.08			301.1	1,208.37	30.32
General			1,376.8	316.12	36.27			1,251.6	339.31	35.39
End-Stage Renal Disease			419.9	1,428.91	50.00			403.9	1,540.78	51.86
Subtotal			4,034.9	$ 412.05	$ 138.55			3,645.6	$ 483.71	$ 146.95
Ancillaries										
Pharmacy			68,815.7	$ 74.62	$ 427.91			69,026.3	$ 82.61	$ 475.18
Transportation			20,152.9	16.37	27.49			19,024.9	15.72	24.93
DME/Prosthetics/Orthotics			14,806.5	123.83	152.79			13,830.0	121.05	139.51
Home Health/Hospice			5,389.7	110.01	49.41			4,843.0	106.03	42.79
Dental			1,367.9	48.07	5.48			1,489.3	50.52	6.27
Other Ancillary			615.7	30.40	1.56			655.6	31.48	1.72
Subtotal			111,148.4	$ 71.76	$ 664.64			108,869.1	$ 76.10	$ 690.40
Physician										
Surgery			1,395.3	$ 223.35	$ 25.97			1,358.5	$ 235.05	$ 26.61
Anesthesia			331.6	209.89	5.80			322.5	220.65	5.93
Hospital Inpatient Visits			12,810.1	38.94	41.57			10,666.3	38.81	34.50
Office Visits/Consults			6,477.7	49.70	26.83			6,387.8	49.14	26.16
Office Administered Drugs			1,224.1	339.09	34.59			1,145.1	314.28	29.99
Physical Exams			72.1	86.55	0.52			84.8	87.74	0.62
Emergency Room Visits			1,881.9	54.33	8.52			1,631.0	55.55	7.55
Clinic Visit/Services			2,029.2	102.01	17.25			2,377.7	81.25	16.10
Radiology			6,543.6	34.66	18.90			5,797.0	35.69	17.24
Pathology			44,036.9	5.27	19.33			41,566.6	5.30	18.35
Outpatient Behavioral Health			1,009.8	36.36	3.06			834.3	36.68	2.55
DMHDD Rehabilitation Option Services			1,155.1	57.87	5.57			951.6	56.62	4.49
Mental Health			207.8	81.42	1.41			223.8	76.68	1.43
Other Professional			8,670.7	23.04	16.65			9,703.0	19.29	15.60
Subtotal			87,845.9	$ 30.87	$ 225.97			83,050.0	$ 29.93	$ 207.12
Service Package II										
Nursing Facility			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Homemaker			30,539.1	84.47	214.97			42,385.8	84.47	298.36
PA, RN, LPN, CNA Providers and Therapies			11,987.7	708.99	708.26			11,454.7	748.13	714.13
Assisted Living			4,689.9	70.31	27.48			5,505.6	72.69	33.35
Adult Day Health			3,095.5	48.69	12.56			3,955.6	48.69	16.05
Home Health/Hospice			813.5	358.89	24.33			491.8	412.36	16.90
Electronic Home Response/EHR Installation			1,231.1	27.10	2.78			1,268.9	27.05	2.86
DORS			7,425.8	621.69	384.71			7,676.0	680.21	435.11
Other Waiver Services			441.1	335.71	12.34			348.3	378.64	10.99
Subtotal			60,223.7	$ 276.46	$ 1,387.43			73,086.7	$ 250.84	$ 1,527.75
Service Package III										
ICF/MR			16.2	$ 177.78	$ 0.24			11.7	$ 194.87	$ 0.19
DD Waiver Services			142.7	79.05	0.94			131.1	56.75	0.62
Subtotal			158.9	$ 89.11	$ 1.18			142.8	$ 68.07	$ 0.81
Total Service Package 1 Claims/Benefit Cost			211,235.8	$ 105.52	$ 1,857.44			201,721.5	$ 99.87	$ 1,678.75
Total Service Package 2 Claims/Benefit Cost			60,223.7	$ 276.46	$ 1,387.43			73,086.7	$ 250.84	$ 1,527.75
Total Service Package 3 Claims/Benefit Cost			158.9	$ 89.11	$ 1.18			142.8	$ 68.07	$ 0.81

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Expansion Counties **Member Months:** 30,914 **Member Months:** 34,156
Population: Community Residents

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	342.0	5.3	1,815.9	$ 2,014.27	$ 304.81	351.0	5.1	1,778.8	$ 1,941.33	$ 287.77
Psychiatric/Substance Abuse	147.5	5.1	748.8	544.71	33.99	129.6	5.5	715.3	679.60	40.51
Service Package 1 Nursing Facility	19.0	28.7	545.0	111.85	5.08	24.2	16.6	401.2	124.43	4.16
Other	13.6	4.2	56.7	579.89	2.74	17.6	2.8	48.8	818.85	3.33
Subtotal	522.1	6.1	3,166.4	$ 1,313.62	$ 346.62	522.4	5.6	2,944.1	$ 1,368.58	$ 335.77
Outpatient Hospital										
Emergency Room			1,930.0	$ 152.33	$ 24.50			1,958.7	$ 157.39	$ 25.69
Surgery			222.8	664.09	12.33			261.4	777.20	16.93
General			804.3	388.06	26.01			1,018.5	360.77	30.62
End-Stage Renal Disease			40.0	1,908.00	6.36			48.8	2,016.39	8.20
Subtotal			2,997.1	$ 277.07	$ 69.20			3,287.4	$ 297.28	$ 81.44
Ancillaries										
Pharmacy			38,871.3	$ 78.18	$ 253.25			41,260.8	$ 74.35	$ 255.65
Transportation			3,930.6	30.29	9.92			5,776.2	23.83	11.47
DME/Prosthetics/Orthotics			2,189.3	80.14	14.62			2,476.2	81.90	16.90
Home Health/Hospice			1,129.6	162.22	15.27			1,303.8	150.48	16.35
Dental			1,598.9	45.11	6.01			1,634.7	45.22	6.16
Other Ancillary			385.5	26.15	0.84			336.6	28.16	0.79
Subtotal			48,105.2	$ 74.81	$ 299.91			52,788.3	$ 69.86	$ 307.32
Physician										
Surgery			852.4	$ 227.92	$ 16.19			873.8	$ 222.06	$ 16.17
Anesthesia			190.6	217.21	3.45			198.5	207.36	3.43
Hospital Inpatient Visits			3,676.0	38.75	11.87			4,047.3	39.11	13.19
Office Visits/Consults			3,881.7	48.44	15.67			4,064.2	46.59	15.78
Office Administered Drugs			890.5	461.94	34.28			1,522.0	395.80	50.20
Physical Exams			85.8	75.52	0.54			76.2	72.44	0.46
Emergency Room Visits			1,810.1	48.66	7.34			1,800.6	50.72	7.61
Clinic Visit/Services			6,319.1	34.39	18.11			7,037.1	34.31	20.12
Radiology			3,606.9	34.50	10.37			4,015.0	34.88	11.67
Pathology			23,050.1	6.21	11.92			28,034.3	5.44	12.71
Outpatient Behavioral Health			1,491.8	33.54	4.17			1,505.8	33.55	4.21
DMHDD Rehabilitation Option Services			12,215.0	55.62	56.62			12,191.1	58.43	59.36
Mental Health			542.7	96.85	4.38			672.1	99.27	5.56
Other Professional			7,435.5	13.23	8.20			7,473.8	13.90	8.66
Subtotal			66,048.2	$ 36.90	$ 203.11			73,511.8	$ 37.40	$ 229.13
Service Package II										
Nursing Facility			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Homemaker			-	6,156.52	-			4.6	6,156.52	2.36
PA, RN, LPN, CNA Providers and Therapies			7.4	502.70	0.31			20.0	594.00	0.99
Assisted Living			141.7	68.60	0.81			118.0	70.17	0.69
Adult Day Health			-	-	-			-	-	-
Home Health/Hospice			-	-	-			-	-	-
Electronic Home Response/EHR Installation			2.3	52.17	0.01			3.2	37.50	0.01
DORS			179.3	683.99	10.22			231.2	708.48	13.65
Other Waiver Services			1.6	13,950.00	1.86			-	-	-
Subtotal			332.3	$ 477.04	$ 13.21			377.0	$ 563.40	$ 17.70
Service Package III										
ICF/MR			1.9	$ 442.11	$ 0.07			19.7	$ 499.49	$ 0.82
DD Waiver Services			-	-	-			53.8	95.91	0.43
Subtotal			1.9	$ 442.11	$ 0.07			73.5	$ 204.08	$ 1.25
Total Service Package 1 Claims/Benefit Cost			120,316.9	$ 91.64	$ 918.84			132,531.6	$ 86.35	$ 953.66
Total Service Package 2 Claims/Benefit Cost			332.3	$ 477.04	$ 13.21			377.0	$ 563.40	$ 17.70
Total Service Package 3 Claims/Benefit Cost			1.9	$ 442.11	$ 0.07			73.5	$ 204.08	$ 1.25

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Expansion Counties **Member Months:** 1,639 **Member Months:** 1,815
Population: Disabled Waiver

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	109.8	5.0	549.1	$ 1,162.63	$ 53.20	132.2	6.5	859.5	$ 924.40	$ 66.21
Psychiatric/Substance Abuse	7.3	8.0	58.6	364.51	1.78	19.8	5.7	112.4	571.17	5.35
Service Package 1 Nursing Facility	22.0	6.0	131.8	117.45	1.29	13.2	12.0	158.7	122.50	1.62
Other	-	-	-	-	-	-	-	-	-	-
Subtotal	139.1	5.3	739.5	$ 913.10	$ 56.27	165.2	6.8	1,130.6	$ 776.72	$ 73.18
Outpatient Hospital										
Emergency Room			380.7	$ 169.27	$ 5.37			390.1	$ 188.57	$ 6.13
Surgery			95.2	519.33	4.12			165.3	1,054.08	14.52
General			139.1	209.63	2.43			350.4	255.48	7.46
End-Stage Renal Disease			-	-	-			-	-	-
Subtotal			615.0	$ 232.59	$ 11.92			905.8	$ 372.40	$ 28.11
Ancillaries										
Pharmacy			53,183.6	$ 84.30	$ 373.63			50,214.9	$ 79.56	$ 332.94
Transportation			490.5	52.11	2.13			568.6	40.94	1.94
DME/Prosthetics/Orthotics			5,410.6	154.94	69.86			5,090.9	135.04	57.29
Home Health/Hospice			51.3	60.82	0.26			19.8	60.61	0.10
Dental			2,738.3	35.93	8.20			2,016.5	29.81	5.01
Other Ancillary			915.2	17.57	1.34			1,038.0	20.81	1.80
Subtotal			62,789.5	$ 87.04	$ 455.42			58,948.7	$ 81.24	$ 399.08
Physician										
Surgery			336.8	$ 154.63	$ 4.34			515.7	$ 165.68	$ 7.12
Anesthesia			65.9	191.20	1.05			138.8	206.63	2.39
Hospital Inpatient Visits			1,171.4	34.73	3.39			1,527.3	32.29	4.11
Office Visits/Consults			3,411.8	43.47	12.36			3,702.5	45.34	13.99
Office Administered Drugs			702.9	259.50	15.20			714.0	405.55	24.13
Physical Exams			292.9	83.17	2.03			290.9	82.50	2.00
Emergency Room Visits			358.8	53.18	1.59			317.4	55.58	1.47
Clinic Visit/Services			410.0	108.88	3.72			284.3	99.19	2.35
Radiology			1,303.2	26.89	2.92			1,527.3	38.97	4.96
Pathology			14,233.1	6.57	7.79			17,619.8	5.64	8.28
Outpatient Behavioral Health			248.9	32.78	0.68			482.6	35.81	1.44
DMHDD Rehabilitation Option Services			95.2	128.57	1.02			13.2	45.45	0.05
Mental Health			-	-	-			-	-	-
Other Professional			4,129.3	23.42	8.06			3,299.2	21.86	6.01
Subtotal			26,760.2	$ 28.77	$ 64.15			30,433.0	$ 30.87	$ 78.30
Service Package II										
Nursing Facility			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Homemaker			-	-	-			-	-	-
PA, RN, LPN, CNA Providers and Therapies			-	-	-			-	-	-
Assisted Living			-	-	-			-	-	-
Adult Day Health			-	-	-			-	-	-
Home Health/Hospice			-	-	-			-	-	-
Electronic Home Response/EHR Installation			-	-	-			-	-	-
DORS			-	-	-			-	-	-
Other Waiver Services			-	-	-			-	-	-
Subtotal			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Service Package III										
ICF/MR			-	$ 0.00	$ 0.00			211.6	$ 134.97	$ 2.38
DD Waiver Services			485,622.9	142.94	5,784.57			450,783.5	136.71	5,135.55
Subtotal			485,622.9	$ 142.94	$ 5,784.57			450,995.1	$ 136.71	$ 5,137.93
Total Service Package 1 Claims/Benefit Cost			90,904.2	$ 77.59	$ 587.76			91,418.1	$ 75.96	$ 578.67
Total Service Package 2 Claims/Benefit Cost			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Total Service Package 3 Claims/Benefit Cost			485,622.9	$ 142.94	$ 5,784.57			450,995.1	$ 136.71	$ 5,137.93

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Expansion Counties **Member Months:** 1,163 **Member Months:** 1,166
Population: ICF MR

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	165.1	7.6	1,258.8	$ 2,322.02	$ 243.58	329.3	8.1	2,665.5	$ 1,764.01	$ 391.83
Psychiatric/Substance Abuse	-	-	-	-	-	-	-	-	-	-
Service Package 1 Nursing Facility	-	-	-	-	-	20.6	17.0	349.9	136.50	3.98
Other	-	-	-	-	-	-	-	-	-	-
Subtotal	165.1	7.6	1,258.8	$ 2,322.02	$ 243.58	349.9	8.6	3,015.4	$ 1,575.15	$ 395.81
Outpatient Hospital										
Emergency Room			443.7	$ 186.07	$ 6.88			494.0	$ 172.96	$ 7.12
Surgery			61.9	469.14	2.42			82.3	332.44	2.28
General			288.9	208.10	5.01			339.6	211.31	5.98
End-Stage Renal Disease			-	-	-			-	-	-
Subtotal			794.5	$ 216.14	$ 14.31			915.9	$ 201.51	$ 15.38
Ancillaries										
Pharmacy			70,720.6	$ 47.61	$ 280.59			65,989.7	$ 50.18	$ 275.94
Transportation			1,166.0	51.05	4.96			1,656.9	41.50	5.73
DME/Prosthetics/Orthotics			1,506.4	618.32	77.62			2,058.3	590.06	101.21
Home Health/Hospice			-	-	-			-	-	-
Dental			1,485.8	33.60	4.16			1,677.5	29.83	4.17
Other Ancillary			887.4	17.71	1.31			1,718.7	18.01	2.58
Subtotal			75,766.2	$ 58.39	$ 368.64			73,101.1	$ 63.96	$ 389.63
Physician										
Surgery			454.0	$ 86.17	$ 3.26			689.5	$ 127.40	$ 7.32
Anesthesia			51.6	165.12	0.71			133.8	197.31	2.20
Hospital Inpatient Visits			4,963.0	31.92	13.20			6,370.5	32.44	17.22
Office Visits/Consults			2,084.3	35.70	6.20			2,449.4	36.40	7.43
Office Administered Drugs			72.2	31.58	0.19			164.7	453.92	6.23
Physical Exams			288.9	87.64	2.11			319.0	82.01	2.18
Emergency Room Visits			443.7	57.88	2.14			380.8	61.45	1.95
Clinic Visit/Services			41.3	130.75	0.45			72.0	58.33	0.35
Radiology			1,320.7	21.62	2.38			1,862.8	17.33	2.69
Pathology			16,777.3	7.55	10.56			35,783.9	4.83	14.41
Outpatient Behavioral Health			10.3	23.30	0.02			92.6	54.43	0.42
DMHDD Rehabilitation Option Services			-	-	-			10.3	244.66	0.21
Mental Health			-	-	-			20.6	58.25	0.10
Other Professional			1,444.5	32.15	3.87			2,634.6	28.88	6.34
Subtotal			27,951.8	$ 19.36	$ 45.09			50,984.5	$ 16.25	$ 69.05
Service Package II										
Nursing Facility			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Homemaker			-	-	-			-	-	-
PA, RN, LPN, CNA Providers and Therapies			-	-	-			-	-	-
Assisted Living			-	-	-			-	-	-
Adult Day Health			-	-	-			-	-	-
Home Health/Hospice			-	-	-			-	-	-
Electronic Home Response/EHR Installation			-	-	-			-	-	-
DORS			-	-	-			-	-	-
Other Waiver Services			-	-	-			-	-	-
Subtotal			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Service Package III										
ICF/MR			360,361.1	$ 172.12	$ 5,168.91			362,871.4	$ 165.35	$ 5,000.18
DD Waiver Services			209,829.8	63.78	1,115.23			213,138.9	63.63	1,130.16
Subtotal			570,190.9	$ 132.25	$ 6,284.14			576,010.3	$ 127.71	$ 6,130.34
Total Service Package 1 Claims/Benefit Cost			105,771.3	$ 76.20	$ 671.62			128,016.9	$ 81.54	$ 869.87
Total Service Package 2 Claims/Benefit Cost			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Total Service Package 3 Claims/Benefit Cost			570,190.9	$ 132.25	$ 6,284.14			576,010.3	$ 127.71	$ 6,130.34

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Expansion Counties **Member Months:** 1,239 **Member Months:** 1,413
Population: Nursing Facility

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	745.8	5.4	4,009.7	$ 1,669.59	$ 557.88	1,138.0	6.2	7,031.8	$ 1,896.35	$ 1,111.23
Psychiatric/Substance Abuse	261.5	8.0	2,082.3	699.61	121.40	237.8	7.6	1,808.9	722.10	108.85
Service Package 1 Nursing Facility	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-
Subtotal	1,007.3	6.0	6,092.0	$ 1,338.04	$ 679.28	1,375.8	6.4	8,840.7	$ 1,656.09	$ 1,220.08
Outpatient Hospital										
Emergency Room			2,004.8	$ 188.61	$ 31.51			2,191.1	$ 197.76	$ 36.11
Surgery			387.4	482.29	15.57			416.1	728.77	25.27
General			765.1	306.63	19.55			1,078.6	763.66	68.64
End-Stage Renal Disease			319.6	3,581.23	95.38			509.6	3,100.08	131.65
Subtotal			3,476.9	$ 559.15	$ 162.01			4,195.4	$ 748.45	$ 261.67
Ancillaries										
Pharmacy			121,607.7	$ 73.00	$ 739.77			128,458.6	$ 71.96	$ 770.31
Transportation			32,125.9	18.69	50.04			33,528.7	21.99	61.43
DME/Prosthetics/Orthotics			4,542.4	108.95	41.24			6,131.6	103.86	53.07
Home Health/Hospice			1,656.2	149.18	20.59			2,029.7	224.19	37.92
Dental			1,762.7	36.63	5.38			1,605.1	37.98	5.08
Other Ancillary			3,748.2	19.82	6.19			3,091.3	21.54	5.55
Subtotal			165,443.1	$ 62.61	$ 863.21			174,845.0	$ 64.06	$ 933.36
Physician										
Surgery			1,491.5	$ 149.81	$ 18.62			2,140.1	$ 177.41	$ 31.64
Anesthesia			193.7	185.23	2.99			373.7	238.59	7.43
Hospital Inpatient Visits			21,501.2	31.47	56.38			24,501.1	34.41	70.25
Office Visits/Consults			2,401.9	48.66	9.74			2,564.8	46.55	9.95
Office Administered Drugs			77.5	48.00	0.31			407.6	87.73	2.98
Physical Exams			38.7	99.22	0.32			42.5	64.94	0.23
Emergency Room Visits			1,724.0	55.55	7.98			1,893.8	59.50	9.39
Clinic Visit/Services			435.8	97.48	3.54			636.9	126.99	6.74
Radiology			5,046.0	32.41	13.63			6,174.1	31.84	16.38
Pathology			55,709.4	5.95	27.60			77,791.9	5.72	37.10
Outpatient Behavioral Health			6,924.9	39.09	22.56			4,993.6	33.86	14.09
DMHDD Rehabilitation Option Services			44,232.4	27.41	101.03			34,743.1	26.74	77.41
Mental Health			193.7	71.86	1.16			220.8	66.30	1.22
Other Professional			15,147.7	12.14	15.32			19,600.8	13.22	21.60
Subtotal			155,118.4	$ 21.75	$ 281.18			176,084.8	$ 20.88	$ 306.41
Service Package II										
Nursing Facility			347,506.1	$ 113.51	$ 3,287.12			352,628.5	$ 117.87	$ 3,463.62
Homemaker			-	691.76	-			8.5	691.76	0.49
PA, RN, LPN, CNA Providers and Therapies			106.5	1,073.80	9.53			135.9	537.75	6.09
Assisted Living			-	-	-			237.8	76.70	1.52
Adult Day Health			-	56.47	-			8.5	56.47	0.04
Home Health/Hospice			-	-	-			-	-	-
Electronic Home Response/EHR Installation			48.4	27.27	0.11			17.0	28.24	0.04
DORS			1,346.2	712.94	79.98			331.2	690.58	19.06
Other Waiver Services			-	-	-			17.0	42.35	0.06
Subtotal			349,007.2	$ 116.10	$ 3,376.74			353,384.4	$ 118.54	$ 3,490.92
Service Package III										
ICF/MR			-	$ 0.00	$ 0.00			246.3	$ 171.01	$ 3.51
DD Waiver Services			445.5	106.94	3.97			67.9	151.99	0.86
Subtotal			445.5	$ 106.94	$ 3.97			314.2	$ 166.90	$ 4.37
Total Service Package 1 Claims/Benefit Cost			330,130.4	$ 72.18	$ 1,985.68			363,965.9	$ 89.73	$ 2,721.52
Total Service Package 2 Claims/Benefit Cost			349,007.2	$ 116.10	$ 3,376.74			353,384.4	$ 118.54	$ 3,490.92
Total Service Package 3 Claims/Benefit Cost			445.5	$ 106.94	$ 3.97			314.2	$ 166.90	$ 4.37

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: Expansion Counties **Member Months:** 7,941 **Member Months:** 8,266
Population: Other Waiver

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	757.1	6.2	4,684.5	$ 1,903.32	$ 743.01	720.1	5.1	3,654.0	$ 1,656.19	$ 504.31
Psychiatric/Substance Abuse	77.1	5.4	420.1	519.02	18.17	68.2	5.9	403.6	619.03	20.82
Service Package 1 Nursing Facility	58.9	15.5	911.2	136.04	10.33	40.6	14.7	595.2	115.73	5.74
Other	4.5	3.7	16.6	9,824.10	13.59	5.8	1.8	10.2	988.24	0.84
Subtotal	897.6	6.7	6,032.4	$ 1,561.77	$ 785.10	834.7	5.6	4,663.0	$ 1,368.33	$ 531.71
Outpatient Hospital										
Emergency Room			2,771.4	$ 169.34	$ 39.11			2,581.2	$ 169.83	$ 36.53
Surgery			414.1	673.17	23.23			338.3	715.81	20.18
General			1,402.3	368.74	43.09			1,634.6	327.27	44.58
End-Stage Renal Disease			191.9	2,328.71	37.24			137.9	2,019.72	23.21
Subtotal			4,779.7	$ 358.19	$ 142.67			4,692.0	$ 318.41	$ 124.50
Ancillaries										
Pharmacy			70,686.8	$ 64.14	$ 377.84			72,342.6	$ 64.39	$ 388.18
Transportation			14,325.7	16.92	20.20			16,790.7	14.58	20.40
DME/Prosthetics/Orthotics			11,664.5	109.42	106.36			11,457.1	120.54	115.09
Home Health/Hospice			4,027.2	94.87	31.84			4,141.8	96.48	33.30
Dental			1,636.6	46.93	6.40			1,490.9	49.18	6.11
Other Ancillary			544.0	28.01	1.27			628.6	33.41	1.75
Subtotal			102,884.8	$ 63.44	$ 543.91			106,851.7	$ 63.43	$ 564.83
Physician										
Surgery			1,538.3	$ 218.58	$ 28.02			1,324.0	$ 197.31	$ 21.77
Anesthesia			356.6	193.49	5.75			286.0	197.20	4.70
Hospital Inpatient Visits			8,448.8	39.88	28.08			6,714.3	41.03	22.96
Office Visits/Consults			5,550.4	46.46	21.49			5,548.5	44.88	20.75
Office Administered Drugs			1,125.8	333.10	31.25			1,235.4	378.44	38.96
Physical Exams			66.5	83.01	0.46			59.5	80.67	0.40
Emergency Room Visits			2,624.9	52.62	11.51			2,420.0	53.95	10.88
Clinic Visit/Services			3,614.7	97.30	29.31			8,051.3	43.22	29.00
Radiology			6,670.2	32.45	18.04			6,047.9	33.55	16.91
Pathology			42,352.9	5.46	19.27			43,688.4	5.45	19.86
Outpatient Behavioral Health			876.5	34.36	2.51			1,010.4	31.71	2.67
DMHDD Rehabilitation Option Services			5,580.7	60.79	28.27			5,388.8	61.39	27.57
Mental Health			349.1	78.37	2.28			892.8	89.65	6.67
Other Professional			5,325.3	26.39	11.71			8,719.1	16.69	12.13
Subtotal			84,480.7	$ 33.80	$ 237.95			91,386.4	$ 30.89	$ 235.23
Service Package II										
Nursing Facility			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Homemaker			7,744.8	72.25	46.63			10,623.8	72.25	63.96
PA, RN, LPN, CNA Providers and Therapies			18,035.5	763.85	1,148.03			17,647.2	789.89	1,161.61
Assisted Living			470.0	68.17	2.67			1,267.4	69.69	7.36
Adult Day Health			482.9	141.65	5.70			339.7	141.65	4.01
Home Health/Hospice			742.0	331.54	20.50			405.0	392.59	13.25
Electronic Home Response/EHR Installation			1,373.6	27.52	3.15			1,556.3	27.68	3.59
DORS			6,547.8	690.57	376.81			4,208.6	760.07	266.57
Other Waiver Services			500.2	145.14	6.05			483.4	422.76	17.03
Subtotal			35,896.8	$ 538.06	$ 1,609.54			36,531.4	$ 505.01	$ 1,537.38
Service Package III										
ICF/MR			-	$ 0.00	$ 0.00			42.1	$ 119.71	$ 0.42
DD Waiver Services			284.1	51.95	1.23			62.4	53.85	0.28
Subtotal			284.1	$ 51.95	$ 1.23			104.5	$ 80.38	$ 0.70
Total Service Package 1 Claims/Benefit Cost			198,177.6	$ 103.52	$ 1,709.63			207,593.1	$ 84.18	$ 1,456.27
Total Service Package 2 Claims/Benefit Cost			35,896.8	$ 538.06	$ 1,609.54			36,531.4	$ 505.01	$ 1,537.38
Total Service Package 3 Claims/Benefit Cost			284.1	$ 51.95	$ 1.23			104.5	$ 80.38	$ 0.70

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Base Data

Region: All Counties **Member Months:** 3,265 **Member Months:** 3,129
Population: State Operated Facility

Type of Service	Fiscal Year 2010 Admits Per 1,000	Fiscal Year 2010 Average Length of Stay	Fiscal Year 2010 Utilization Per 1,000	Fiscal Year 2010 Cost per Service	Fiscal Year 2010 PMPM	Fiscal Year 2011 Admits Per 1,000	Fiscal Year 2011 Average Length of Stay	Fiscal Year 2011 Utilization Per 1,000	Fiscal Year 2011 Cost per Service	Fiscal Year 2011 PMPM
Inpatient Hospital										
Medical/Surgical	150.7	4.6	687.3	$ 803.84	$ 46.04	161.1	5.5	889.7	$ 1,049.07	$ 77.78
Psychiatric/Substance Abuse	3.7	2.0	7.4	551.35	0.34	-	-	-	-	-
Service Package 1 Nursing Facility	3.7	10.9	40.4	145.54	0.49	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-
Subtotal	158.1	4.6	735.1	$ 765.12	$ 46.87	161.1	5.5	889.7	$ 1,049.07	$ 77.78
Outpatient Hospital										
Emergency Room			14.7	$ 155.10	$ 0.19			7.7	$ 311.69	$ 0.20
Surgery			3.7	1,589.19	0.49			-	-	-
General			22.1	358.37	0.66			-	-	-
End-Stage Renal Disease			-	-	-			-	-	-
Subtotal			40.5	$ 397.04	$ 1.34			7.7	$ 311.69	$ 0.20
Ancillaries										
Pharmacy			396.9	$ 26.61	$ 0.88			15.3	$ 15.69	$ 0.02
Transportation			136.0	75.88	0.86			226.3	82.72	1.56
DME/Prosthetics/Orthotics			47.8	40.17	0.16			7.7	15.58	0.01
Home Health/Hospice			-	-	-			-	-	-
Dental			44.1	38.10	0.14			19.2	37.50	0.06
Other Ancillary			11.0	21.82	0.02			15.3	109.80	0.14
Subtotal			635.8	$ 38.88	$ 2.06			283.8	$ 75.69	$ 1.79
Physician										
Surgery			165.4	$ 235.07	$ 3.24			99.7	$ 294.88	$ 2.45
Anesthesia			110.3	225.20	2.07			80.5	204.22	1.37
Hospital Inpatient Visits			893.1	40.17	2.99			1,254.1	44.59	4.66
Office Visits/Consults			544.0	53.82	2.44			395.0	42.53	1.40
Office Administered Drugs			-	-	-			-	-	-
Physical Exams			-	-	-			-	-	-
Emergency Room Visits			55.1	74.05	0.34			69.0	78.26	0.45
Clinic Visit/Services			-	-	-			11.5	-	-
Radiology			771.8	32.50	2.09			809.2	28.18	1.90
Pathology			4,498.6	5.39	2.02			3,221.5	4.58	1.23
Outpatient Behavioral Health			-	-	-			-	-	-
DMHDD Rehabilitation Option Services			-	-	-			-	-	-
Mental Health			-	-	-			-	-	-
Other Professional			301.4	23.09	0.58			253.1	26.55	0.56
Subtotal			7,339.7	$ 25.78	$ 15.77			6,193.6	$ 27.16	$ 14.02
Service Package II										
Nursing Facility			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Homemaker			-	-	-			-	-	-
PA, RN, LPN, CNA Providers and Therapies			-	-	-			-	-	-
Assisted Living			-	-	-			-	-	-
Adult Day Health			-	-	-			-	-	-
Home Health/Hospice			-	-	-			-	-	-
Electronic Home Response/EHR Installation			-	-	-			-	-	-
DORS			-	-	-			-	-	-
Other Waiver Services			-	-	-			-	-	-
Subtotal			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Service Package III										
ICF/MR			360,665.2	$ 494.61	$ 14,865.63			364,134.2	$ 520.75	$ 15,801.79
DD Waiver Services			1,124.7	101.25	9.49			-	-	-
Subtotal			361,789.9	$ 493.38	$ 14,875.12			364,134.2	$ 520.75	$ 15,801.79
Total Service Package 1 Claims/Benefit Cost			8,751.1	$ 90.56	$ 66.04			7,374.8	$ 152.61	$ 93.79
Total Service Package 2 Claims/Benefit Cost			-	$ 0.00	$ 0.00			-	$ 0.00	$ 0.00
Total Service Package 3 Claims/Benefit Cost			361,789.9	$ 493.38	$ 14,875.12			364,134.2	$ 520.75	$ 15,801.79

ATTACHMENT 4

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development

Region: All Program Counties **SFY 2011 FFS Member Months:** 355,284 **Contract Period MCO Estimated Member Months:** 309,936
Population: Community Residents

	Base Adjusted/Blended/Trended to SFY 2011								March 2013 - December 2013		
Type of Service	**Utilization Per 1,000**	**Cost per Service**	**PMPM**	**MC Adj Util**	**Intensity Adj Cost**	**Contracting Adj Cost**	**Annual Trend Util**	**Annual Trend Cost**	**Utilization Per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital											
Medical/Surgical	2,066.0	$ 1,559.33	$ 268.46	0.8816	1.0473	1.0100	1.0000	0.9950	1,821.3	$ 1,628.21	$ 247.12
Psychiatric/Substance Abuse	975.4	580.59	47.19	0.8475	1.0245	1.0100	1.0000	0.9950	826.6	593.02	40.85
Service Package 1 Nursing Facility	878.4	133.14	9.75	1.0373	1.0000	1.0100	1.0000	0.9950	911.2	132.74	10.08
Other	40.9	1,627.03	5.55	0.9430	1.0187	1.0100	1.0000	0.9950	38.6	1,652.56	5.32
Subtotal	3,960.8	$ 1,002.69	$ 330.95						3,597.7	$ 1,011.86	$ 303.36
Outpatient Hospital											
Emergency Room	1,423.6	$ 173.87	$ 20.63	0.8950	1.0400	1.0200	1.0098	1.0200	1,306.7	$ 194.12	$ 21.14
Surgery	198.8	890.64	14.75	1.1780	1.0500	1.0200	1.0098	1.0200	240.1	1,003.94	20.09
General	814.4	373.81	25.37	1.0000	1.0000	1.0200	1.0098	1.0200	835.1	401.30	27.93
End-Stage Renal Disease	112.0	1,805.99	16.85	1.0000	1.0000	1.0200	1.0098	1.0200	114.8	1,938.80	18.55
Subtotal	2,548.7	$ 365.36	$ 77.60						2,496.8	$ 421.55	$ 87.71
Ancillaries											
Pharmacy	35,417.2	$ 74.54	$ 219.99	0.9790	0.9509	0.9500	1.0148	1.0150	36,012.7	$ 69.98	$ 210.00
Transportation	7,364.8	16.51	10.13	0.9458	1.0000	1.0000	1.0050	1.0000	7,056.0	16.51	9.71
DME/Prosthetics/Orthotics	2,131.3	88.31	15.68	1.0000	1.0000	1.0000	1.0050	1.0000	2,158.9	88.31	15.89
Home Health/Hospice	1,116.6	183.62	17.09	1.0000	1.0000	1.0000	1.0050	1.0000	1,131.1	183.62	17.31
Dental	415.1	38.15	1.32	1.0000	1.0000	1.0200	1.0050	1.0000	420.5	38.91	1.36
Other Ancillary	270.2	29.10	0.66	1.0000	1.0000	1.0000	1.0050	1.0000	273.7	29.10	0.66
Subtotal	46,715.2	$ 68.04	$ 264.87						47,052.9	$ 65.02	$ 254.93
Physician											
Surgery	760.9	$ 249.02	$ 15.79	0.9532	1.0357	1.0200	1.0200	1.0000	763.3	$ 263.06	$ 16.73
Anesthesia	200.3	204.00	3.40	1.0000	1.0000	1.0200	1.0200	1.0000	210.8	208.08	3.66
Hospital Inpatient Visits	4,911.4	38.42	15.72	0.8740	1.0300	1.0200	1.0200	1.0000	4,517.9	40.36	15.20
Office Visits/Consults	3,897.7	49.33	16.02	1.0300	1.0000	1.0200	1.0200	1.0000	4,225.3	50.31	17.72
Office Administered Drugs	750.8	345.64	21.63	1.0000	1.0000	1.0200	1.0200	1.0000	790.2	352.56	23.22
Physical Exams	78.1	84.07	0.55	3.0000	1.0000	1.0200	1.0200	1.0000	246.6	85.75	1.76
Emergency Room Visits	1,352.7	50.59	5.70	0.8950	1.0100	1.0200	1.0200	1.0000	1,274.2	52.12	5.53
Clinic Visit/Services	4,314.4	41.04	14.75	1.0000	1.0000	1.0200	1.0200	1.0000	4,540.8	41.86	15.84
Radiology	3,451.4	36.06	10.37	0.9650	1.0000	1.0200	1.0200	1.0000	3,505.4	36.79	10.75
Pathology	23,034.2	5.89	11.30	0.9300	1.0000	1.0200	1.0200	1.0000	22,546.2	6.00	11.28
Outpatient Behavioral Health	1,720.6	36.23	5.19	0.9300	1.0000	1.0200	1.0200	1.0000	1,684.1	36.96	5.19
DMHDD Rehabilitation Option Services	5,694.0	51.01	24.20	1.0000	1.0000	1.0200	1.0200	1.0000	5,992.9	52.03	25.98
Mental Health	468.4	88.44	3.45	0.9300	1.0000	1.0200	1.0200	1.0000	458.5	90.21	3.45
Other Professional	9,856.5	12.18	10.00	1.0000	1.0000	1.0200	1.0200	1.0000	10,373.9	12.42	10.74
Subtotal	60,491.4	$ 31.36	$ 158.09						61,130.2	$ 32.79	$ 167.03
Service Package I Medical Cost	113,716.1	$ 87.75	$ 831.52	0.9433	1.0070	0.9965	1.0089	1.0038	114,277.6	$ 85.38	$ 813.04
Service Package II Transition Cost	188.5	$ 329.87	$ 5.18	0.9800	1.0000	1.0000	1.0200	1.0000	194.4	329.87	5.34
									Copay Adjustment		(5.56)
									Variable Admin	6.0%	48.77
									Fixed Admin		25.00
									PCP Fee		4.00
									Service Package I Capitation Rate		$ 890.59

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development

Region: All Program Counties **SFY 2011 FFS Member Months:** 21,581 **Contract Period MCO Estimated Member Months:** 19,358
Population: Developmentally Disabled Waiver

	Base Adjusted/Blended/Trended to SFY 2011								March 2013 - December 2013		
Type of Service	**Utilization Per 1,000**	**Cost per Service**	**PMPM**	**MC Adj Util**	**Intensity Adj Cost**	**Contracting Adj Cost**	**Annual Trend Util**	**Annual Trend Cost**	**Utilization Per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital											
Medical/Surgical	837.3	$ 1,288.11	$ 89.87	0.8878	1.0400	1.0100	1.0000	1.0100	743.3	$ 1,388.30	$ 86.00
Psychiatric/Substance Abuse	1,134.3	597.84	56.51	0.8468	1.0100	1.0100	1.0000	1.0100	960.6	625.73	50.09
Service Package 1 Nursing Facility	137.1	137.95	1.58	1.0484	1.0000	1.0100	1.0000	1.0100	143.7	142.95	1.71
Other	5.2	888.09	0.39	1.0385	1.0000	1.0100	1.0000	1.0100	5.4	920.33	0.42
Subtotal	2,113.9	$ 842.14	$ 148.35						1,853.0	$ 895.06	$ 138.22
Outpatient Hospital											
Emergency Room	813.9	$ 164.95	$ 11.19	0.9300	1.0300	1.0200	1.0050	1.0050	766.7	$ 175.54	$ 11.22
Surgery	87.4	1,100.68	8.02	1.1685	1.0400	1.0200	1.0050	1.0050	103.5	1,182.75	10.20
General	306.1	323.93	8.26	1.0000	1.0000	1.0200	1.0050	1.0050	310.0	334.69	8.65
End-Stage Renal Disease	21.6	3,033.35	5.46	1.0000	1.0000	1.0200	1.0050	1.0050	21.9	3,134.14	5.71
Subtotal	1,228.9	$ 321.49	$ 32.92						1,202.0	$ 357.10	$ 35.77
Ancillaries											
Pharmacy	49,048.4	$ 77.02	$ 314.81	0.9790	0.8634	0.9500	1.0099	1.0100	49,256.3	$ 64.82	$ 266.05
Transportation	5,011.9	18.76	7.84	0.9515	1.0000	1.0000	1.0100	1.0000	4,893.0	18.76	7.65
DME/Prosthetics/Orthotics	4,750.7	138.42	54.80	1.0000	1.0000	1.0000	1.0100	1.0000	4,874.4	138.42	56.23
Home Health/Hospice	178.4	83.08	1.24	1.0000	1.0000	1.0000	1.0100	1.0000	183.1	83.08	1.27
Dental	327.1	36.80	1.00	1.0000	1.0000	1.0200	1.0100	1.0000	335.6	37.54	1.05
Other Ancillary	547.4	21.86	1.00	1.0000	1.0000	1.0000	1.0100	1.0000	561.7	21.86	1.02
Subtotal	59,864.0	$ 76.31	$ 380.68						60,104.1	$ 66.54	$ 333.27
Physician											
Surgery	350.1	$ 179.20	$ 5.23	0.9500	1.0325	1.0200	1.0200	1.0000	350.1	$ 188.72	$ 5.51
Anesthesia	120.1	229.19	2.29	1.0000	1.0000	1.0200	1.0200	1.0000	126.4	233.78	2.46
Hospital Inpatient Visits	2,732.1	35.75	8.14	0.8740	1.0200	1.0200	1.0200	1.0000	2,513.2	37.19	7.79
Office Visits/Consults	3,706.5	45.92	14.18	1.0150	1.0000	1.0200	1.0200	1.0000	3,959.6	46.84	15.46
Office Administered Drugs	202.8	342.21	5.78	1.0000	1.0000	1.0200	1.0200	1.0000	213.5	349.05	6.21
Physical Exams	209.8	84.65	1.48	1.5000	1.0000	1.0200	1.0200	1.0000	331.3	86.34	2.38
Emergency Room Visits	798.0	49.97	3.32	0.9300	1.0100	1.0200	1.0200	1.0000	781.1	51.48	3.35
Clinic Visit/Services	738.6	123.65	7.61	1.0000	1.0000	1.0200	1.0200	1.0000	777.4	126.12	8.17
Radiology	1,668.0	32.61	4.53	0.9650	1.0000	1.0200	1.0200	1.0000	1,694.1	33.26	4.70
Pathology	19,577.1	5.82	9.49	0.9300	1.0000	1.0200	1.0200	1.0000	19,162.3	5.93	9.48
Outpatient Behavioral Health	1,846.3	35.57	5.47	0.9300	1.0000	1.0200	1.0200	1.0000	1,807.2	36.28	5.46
DMHDD Rehabilitation Option Services	3,379.4	45.38	12.78	1.0000	1.0000	1.0200	1.0200	1.0000	3,556.8	46.28	13.72
Mental Health	3.2	52.12	0.01	0.9300	1.0000	1.0200	1.0200	1.0000	3.1	53.16	0.01
Other Professional	3,246.7	22.03	5.96	1.0000	1.0000	1.0200	1.0200	1.0000	3,417.1	22.47	6.40
Subtotal	38,578.8	$ 26.84	$ 86.29						38,693.1	$ 28.25	$ 91.09
Service Package I Medical Cost	101,785.7	$ 76.42	$ 648.25	0.9586	0.9416	0.9817	1.0087	1.0074	101,852.2	$ 70.50	$ 598.35
Service Package II Transition Cost	-	$ 0.00	$ 0.00	-	-	-	-	-	-	-	-
									Copay Adjustment		(7.12)
									Variable Admin	6.0%	35.47
									Fixed Admin		25.00
									PCP Fee		4.00
									Service Package I Capitation Rate		$ 655.70

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development

Region: All Program Counties **SFY 2011 FFS Member Months:** 6,199 **Contract Period MCO Estimated Member Months:** 3,564
Population: ICF MR

	Base Adjusted/Blended/Trended to SFY 2011								March 2013 - December 2013		
Type of Service	**Utilization Per 1,000**	**Cost per Service**	**PMPM**	**MC Adj Util**	**Intensity Adj Cost**	**Contracting Adj Cost**	**Annual Trend Util**	**Annual Trend Cost**	**Utilization Per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital											
Medical/Surgical	1,989.7	$ 1,554.51	$ 257.75	0.8585	1.0198	1.0100	1.0000	0.9950	1,708.2	$ 1,580.49	$ 224.98
Psychiatric/Substance Abuse	289.2	553.05	13.33	0.8400	1.0100	1.0100	1.0000	0.9950	242.9	556.90	11.27
Service Package 1 Nursing Facility	268.0	178.91	4.00	1.1062	1.0000	1.0100	1.0000	0.9950	296.4	178.37	4.41
Other	-	-	-	1.0000	1.0000	1.0100	1.0000	0.9950	-	-	-
Subtotal	2,546.9	$ 1,296.06	$ 275.08						2,247.6	$ 1,284.94	$ 240.66
Outpatient Hospital											
Emergency Room	672.9	$ 166.10	$ 9.31	0.9300	1.0300	1.0200	1.0000	1.0050	625.8	$ 176.77	$ 9.22
Surgery	94.6	756.92	5.97	1.1400	1.0400	1.0200	1.0000	1.0050	107.8	813.35	7.31
General	349.4	212.78	6.20	1.0000	1.0000	1.0200	1.0000	1.0050	349.4	219.85	6.40
End-Stage Renal Disease	9.7	3,418.49	2.75	1.0000	1.0000	1.0200	1.0000	1.0050	9.7	3,532.07	2.84
Subtotal	1,126.6	$ 258.08	$ 24.23						1,092.7	$ 283.03	$ 25.77
Ancillaries											
Pharmacy	65,024.2	$ 66.15	$ 358.42	0.9790	0.9087	0.9500	1.0196	1.0200	66,933.4	$ 60.10	$ 335.22
Transportation	3,754.2	39.95	12.50	0.9560	1.0000	1.0000	1.0050	1.0000	3,635.7	39.95	12.10
DME/Prosthetics/Orthotics	2,146.4	360.66	64.51	1.0000	1.0000	1.0000	1.0050	1.0000	2,174.2	360.66	65.35
Home Health/Hospice	159.7	313.26	4.17	1.0000	1.0000	1.0000	1.0050	1.0000	161.8	313.26	4.22
Dental	229.0	37.09	0.71	1.0000	1.0000	1.0200	1.0050	1.0000	232.0	37.83	0.73
Other Ancillary	1,264.1	21.78	2.29	1.0000	1.0000	1.0000	1.0050	1.0000	1,280.5	21.78	2.32
Subtotal	72,577.6	$ 73.18	$ 442.60						74,417.6	$ 67.72	$ 419.95
Physician											
Surgery	579.5	$ 135.28	$ 6.53	0.9632	1.0223	1.0200	1.0100	1.0000	572.7	$ 141.06	$ 6.73
Anesthesia	155.1	213.68	2.76	1.0000	1.0000	1.0200	1.0100	1.0000	159.1	217.95	2.89
Hospital Inpatient Visits	9,524.2	31.66	25.13	0.8530	1.0100	1.0200	1.0100	1.0000	8,335.6	32.62	22.66
Office Visits/Consults	2,372.3	43.52	8.60	1.0170	1.0000	1.0200	1.0100	1.0000	2,475.5	44.39	9.16
Office Administered Drugs	55.8	697.03	3.24	1.0000	1.0000	1.0200	1.0100	1.0000	57.3	710.97	3.39
Physical Exams	130.2	82.54	0.90	3.0000	1.0000	1.0200	1.0100	1.0000	400.8	84.20	2.81
Emergency Room Visits	613.1	52.78	2.70	0.9300	1.0100	1.0200	1.0100	1.0000	585.1	54.38	2.65
Clinic Visit/Services	273.7	113.35	2.59	1.0000	1.0000	1.0200	1.0100	1.0000	280.9	115.62	2.71
Radiology	2,461.6	22.87	4.69	0.9650	1.0000	1.0200	1.0100	1.0000	2,437.3	23.33	4.74
Pathology	27,677.8	6.07	14.00	0.9300	1.0000	1.0200	1.0100	1.0000	26,410.6	6.19	13.62
Outpatient Behavioral Health	933.6	32.48	2.53	0.9300	1.0000	1.0200	1.0100	1.0000	890.9	33.13	2.46
DMHDD Rehabilitation Option Services	75.2	29.25	0.18	1.0000	1.0000	1.0200	1.0100	1.0000	77.1	29.84	0.19
Mental Health	1.9	58.25	0.01	0.9300	1.0000	1.0200	1.0100	1.0000	1.9	59.42	0.01
Other Professional	4,890.2	13.17	5.37	1.0000	1.0000	1.0200	1.0100	1.0000	5,017.5	13.43	5.61
Subtotal	49,744.3	$ 19.11	$ 79.22						47,702.3	$ 20.03	$ 79.64
Service Package I Medical Cost	125,995.4	$ 78.21	$ 821.13	0.9396	0.9677	0.9841	1.0100	1.0072	125,460.2	$ 73.27	$ 766.03
Service Package II Transition Cost	-	$ 0.00	$ 0.00	-	-	-	-	-	-	-	-
									Copay Adjustment		(7.99)
									Variable Admin	6.0%	45.48
									Fixed Admin		25.00
									PCP Fee		4.00
									Service Package I Capitation Rate		$ 832.52

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development

Region: All Program Counties **SFY 2011 FFS Member Months:** 35,161 **Contract Period MCO Estimated Member Months:** 10,423
Population: Nursing Facility

	Base Adjusted/Blended/Trended to SFY 2011								March 2013 - December 2013		
Type of Service	**Utilization Per 1,000**	**Cost per Service**	**PMPM**	**MC Adj Util**	**Intensity Adj Cost**	**Contracting Adj Cost**	**Annual Trend Util**	**Annual Trend Cost**	**Utilization Per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital											
Medical/Surgical	4,642.0	$ 1,386.06	$ 536.18	0.8615	1.0432	1.0100	1.0000	0.9950	3,999.3	$ 1,441.66	$ 480.46
Psychiatric/Substance Abuse	2,937.9	614.04	150.33	0.8574	1.0099	1.0100	1.0000	0.9950	2,518.8	618.25	129.77
Service Package 1 Nursing Facility	-	-	-	1.0000	1.0000	1.0100	1.0000	0.9950	-	-	-
Other	9.8	1,064.74	0.87	0.9042	1.0224	1.0100	1.0000	0.9950	8.9	1,085.38	0.80
Subtotal	7,589.7	$ 1,086.81	$ 687.38						6,526.9	$ 1,123.41	$ 611.03
Outpatient Hospital											
Emergency Room	1,564.3	$ 190.59	$ 24.84	0.9300	1.0300	1.0200	1.0050	1.0050	1,473.6	$ 202.83	$ 24.91
Surgery	216.8	661.15	11.94	1.5010	1.1000	1.0200	1.0050	1.0050	329.6	751.43	20.64
General	526.1	363.80	15.95	1.0000	1.0000	1.0200	1.0050	1.0050	532.9	375.89	16.69
End-Stage Renal Disease	353.2	1,665.30	49.02	1.0000	1.0000	1.0200	1.0050	1.0050	357.8	1,720.64	51.30
Subtotal	2,660.4	$ 458.99	$ 101.76						2,693.9	$ 505.78	$ 113.54
Ancillaries											
Pharmacy	106,770.8	$ 69.53	$ 618.63	0.9790	0.9361	0.9500	1.0148	1.0150	108,566.1	$ 64.25	$ 581.30
Transportation	78,811.1	11.52	75.69	0.7207	1.0000	1.0000	1.0050	1.0000	57,538.5	11.52	55.26
DME/Prosthetics/Orthotics	4,642.9	88.20	34.13	1.0000	1.0000	1.0000	1.0050	1.0000	4,703.1	88.20	34.57
Home Health/Hospice	606.3	259.57	13.11	1.0000	1.0000	1.0000	1.0050	1.0000	614.1	259.57	13.28
Dental	694.4	38.29	2.22	1.0000	1.0000	1.0200	1.0050	1.0000	703.4	39.06	2.29
Other Ancillary	2,775.1	20.70	4.79	1.0000	1.0000	1.0000	1.0050	1.0000	2,811.1	20.70	4.85
Subtotal	194,300.6	$ 46.23	$ 748.56						174,936.3	$ 47.44	$ 691.55
Physician											
Surgery	1,396.2	$ 162.27	$ 18.88	0.9492	1.0344	1.0200	1.0100	1.0000	1,359.8	$ 171.21	$ 19.40
Anesthesia	251.5	196.23	4.11	1.0000	1.0000	1.0200	1.0100	1.0000	258.0	200.15	4.30
Hospital Inpatient Visits	23,815.9	30.41	60.36	0.8530	1.0300	1.0200	1.0100	1.0000	20,843.9	31.95	55.50
Office Visits/Consults	2,217.0	45.35	8.38	1.0320	1.0000	1.0200	1.0100	1.0000	2,347.5	46.26	9.05
Office Administered Drugs	363.5	382.14	11.58	1.0000	1.0000	1.0200	1.0100	1.0000	373.0	389.78	12.12
Physical Exams	26.2	93.65	0.20	3.0000	1.0000	1.0200	1.0100	1.0000	80.6	95.53	0.64
Emergency Room Visits	1,406.1	56.52	6.62	0.9300	1.0100	1.0200	1.0100	1.0000	1,341.7	58.23	6.51
Clinic Visit/Services	330.3	199.90	5.50	1.0000	1.0000	1.0200	1.0100	1.0000	338.9	203.90	5.76
Radiology	4,526.9	34.02	12.83	0.9650	1.0000	1.0200	1.0100	1.0000	4,482.2	34.70	12.96
Pathology	56,585.1	5.92	27.93	0.9300	1.0000	1.0200	1.0100	1.0000	53,994.4	6.04	27.18
Outpatient Behavioral Health	9,596.4	36.81	29.44	0.6965	1.0000	1.0200	1.0100	1.0000	6,858.1	37.55	21.46
DMHDD Rehabilitation Option Services	5,760.9	39.21	18.82	1.0000	1.0000	1.0200	1.0100	1.0000	5,910.9	39.99	19.70
Mental Health	5,809.6	51.92	25.13	0.6965	1.0000	1.0200	1.0100	1.0000	4,151.9	52.95	18.32
Other Professional	17,894.3	10.31	15.38	1.0000	1.0000	1.0200	1.0100	1.0000	18,360.2	10.52	16.10
Subtotal	129,979.9	$ 22.64	$ 245.18						120,701.3	$ 22.77	$ 229.01
Service Package I Medical Cost	334,530.7	$ 63.95	$ 1,782.87	0.9135	0.9942	0.9904	1.0072	1.0036	304,858.3	$ 64.76	$ 1,645.13
Service Package II Transition Cost	-	$ 0.00	$ 0.00	-	-	-	-	-	-	-	-
									Copay Adjustment		(13.58)
									Variable Admin	6.0%	97.89
									Fixed Admin		40.00
									PCP Fee		4.00
									Service Package I Capitation Rate		$ 1,773.44

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development

Region: All Program Counties **SFY 2011 FFS Member Months:** 43,059 **Contract Period MCO Estimated Member Months:** 35,986
Population: Other Waiver

	Base Adjusted/Blended/Trended to SFY 2011								March 2013 - December 2013		
Type of Service	**Utilization Per 1,000**	**Cost per Service**	**PMPM**	**MC Adj Util**	**Intensity Adj Cost**	**Contracting Adj Cost**	**Annual Trend Util**	**Annual Trend Cost**	**Utilization Per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital											
Medical/Surgical	5,361.5	$ 1,507.07	$ 673.35	0.8722	1.0457	1.0100	1.0000	0.9950	4,676.2	$ 1,571.20	$ 612.27
Psychiatric/Substance Abuse	415.0	566.60	19.60	0.8481	1.0089	1.0100	1.0000	0.9950	352.0	569.95	16.72
Service Package 1 Nursing Facility	1,038.4	140.80	12.18	1.0929	1.0000	1.0100	1.0000	0.9950	1,134.8	140.37	13.28
Other	16.5	3,351.23	4.60	0.9182	1.0217	1.0100	1.0000	0.9950	15.1	3,413.80	4.30
Subtotal	6,831.4	$ 1,246.71	$ 709.73						6,178.1	$ 1,255.84	$ 646.57
Outpatient Hospital											
Emergency Room	2,000.0	$ 189.79	$ 31.63	0.8950	1.0400	1.0200	1.0098	1.0200	1,835.7	$ 211.89	$ 32.41
Surgery	306.8	941.66	24.08	1.2920	1.0700	1.0200	1.0098	1.0200	406.6	1,081.67	36.65
General	1,360.6	324.14	36.75	1.0000	1.0000	1.0200	1.0098	1.0200	1,395.4	347.98	40.46
End-Stage Renal Disease	366.4	1,512.32	46.18	1.0000	1.0000	1.0200	1.0098	1.0200	375.8	1,623.53	50.84
Subtotal	4,034.0	$ 412.43	$ 138.65						4,013.4	$ 479.49	$ 160.37
Ancillaries											
Pharmacy	65,912.5	$ 76.65	$ 421.01	0.9790	0.9576	0.9500	1.0148	1.0150	67,020.8	$ 72.47	$ 404.73
Transportation	18,934.2	15.61	24.62	0.9571	1.0000	1.0000	1.0100	1.0000	18,593.3	15.61	24.18
DME/Prosthetics/Orthotics	12,459.6	130.92	135.93	1.0000	1.0000	1.0000	1.0100	1.0000	12,784.0	130.92	139.47
Home Health/Hospice	4,950.0	104.92	43.28	1.0000	1.0000	1.0000	1.0100	1.0000	5,078.9	104.92	44.41
Dental	483.2	38.56	1.55	1.0000	1.0000	1.0200	1.0100	1.0000	495.8	39.33	1.62
Other Ancillary	458.0	31.30	1.19	1.0000	1.0000	1.0000	1.0100	1.0000	469.9	31.30	1.23
Subtotal	103,197.4	$ 72.98	$ 627.59						104,442.6	$ 70.73	$ 615.64
Physician											
Surgery	1,402.9	$ 225.05	$ 26.31	0.9486	1.0390	1.0200	1.0200	1.0000	1,400.7	$ 238.51	$ 27.84
Anesthesia	329.6	211.36	5.81	1.0000	1.0000	1.0200	1.0200	1.0000	346.9	215.59	6.23
Hospital Inpatient Visits	11,070.2	39.08	36.06	0.8670	1.0300	1.0200	1.0200	1.0000	10,101.6	41.06	34.57
Office Visits/Consults	6,332.6	48.76	25.73	1.0240	1.0000	1.0200	1.0200	1.0000	6,824.9	49.73	28.28
Office Administered Drugs	1,197.1	328.87	32.81	1.0000	1.0000	1.0200	1.0200	1.0000	1,259.9	335.45	35.22
Physical Exams	76.3	86.22	0.55	3.0000	1.0000	1.0200	1.0200	1.0000	240.8	87.95	1.77
Emergency Room Visits	1,925.5	54.45	8.74	0.8950	1.0100	1.0200	1.0200	1.0000	1,813.8	56.10	8.48
Clinic Visit/Services	2,927.0	79.07	19.29	1.0000	1.0000	1.0200	1.0200	1.0000	3,080.6	80.65	20.70
Radiology	6,278.2	34.65	18.13	0.9650	1.0000	1.0200	1.0200	1.0000	6,376.4	35.35	18.78
Pathology	43,323.8	5.26	18.99	0.9300	1.0000	1.0200	1.0200	1.0000	42,405.9	5.37	18.96
Outpatient Behavioral Health	936.9	35.81	2.80	0.9300	1.0000	1.0200	1.0200	1.0000	917.0	36.53	2.79
DMHDD Rehabilitation Option Services	1,925.8	59.39	9.53	1.0000	1.0000	1.0200	1.0200	1.0000	2,026.9	60.58	10.23
Mental Health	296.3	82.00	2.02	0.9300	1.0000	1.0200	1.0200	1.0000	290.0	83.64	2.02
Other Professional	8,742.9	20.70	15.08	1.0000	1.0000	1.0200	1.0200	1.0000	9,201.8	21.11	16.19
Subtotal	86,765.1	$ 30.68	$ 221.84						86,287.5	$ 32.27	$ 232.07
Service Package I Medical Cost	200,827.9	$ 101.45	$ 1,697.80	0.9398	1.0108	0.9960	1.0083	1.0033	200,921.7	$ 98.82	$ 1,654.64
Service Package II Transition Cost	-	$ 0.00	$ 0.00	-	-	-	-	-	-	-	-
									Copay Adjustment		(10.69)
									Variable Admin	6.0%	98.64
									Fixed Admin		40.00
									PCP Fee		4.00
									Service Package I Capitation Rate		$ 1,786.59

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Rate Development

Region: Collar Counties **SFY 2011 FFS Member Months:** 3,126 **Contract Period MCO Estimated Member Months:** 1,477
Population: State Operated Facility

	Base Adjusted/Blended/Trended to SFY 2011								March 2013 - December 2013		
Type of Service	**Utilization Per 1,000**	**Cost per Service**	**PMPM**	**MC Adj Util**	**Intensity Adj Cost**	**Contracting Adj Cost**	**Annual Trend Util**	**Annual Trend Cost**	**Utilization Per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital											
Medical/Surgical	889.7	$ 1,054.34	$ 78.17	0.8577	1.0225	1.0100	1.0000	0.9950	763.1	$ 1,074.88	$ 68.36
Psychiatric/Substance Abuse	-	-	-	0.8386	1.0097	1.0100	1.0000	0.9950	-	-	-
Service Package 1 Nursing Facility	-	-	-	1.1878	1.0000	1.0100	1.0000	0.9950	-	-	-
Other	-	-	-	1.0000	1.0000	1.0100	1.0000	0.9950	-	-	-
Subtotal	889.7	$ 1,054.34	$ 78.17						763.1	$ 1,074.88	$ 68.36
Outpatient Hospital											
Emergency Room	7.7	$ 310.14	$ 0.20	0.9300	1.0300	1.0200	1.0000	1.0050	7.2	$ 330.06	$ 0.20
Surgery	-	-	-	1.0000	1.2600	1.0200	1.0000	1.0050	-	-	-
General	-	-	-	1.0000	1.0000	1.0200	1.0000	1.0050	-	-	-
End-Stage Renal Disease	-	-	-	1.0000	1.0000	1.0200	1.0000	1.0050	-	-	-
Subtotal	7.7	$ 310.14	$ 0.20						7.2	$ 330.06	$ 0.20
Ancillaries											
Pharmacy	14.0	$ 15.50	$ 0.02	0.9790	1.0000	0.9500	1.0196	1.0200	14.4	$ 15.50	$ 0.02
Transportation	225.2	80.71	1.51	0.9390	1.0000	1.0000	1.0050	1.0000	214.2	80.71	1.44
DME/Prosthetics/Orthotics	7.7	15.21	0.01	1.0000	1.0000	1.0000	1.0050	1.0000	7.8	15.21	0.01
Home Health/Hospice	-	-	-	1.0000	1.0000	1.0000	1.0050	1.0000	-	-	-
Dental	15.7	39.31	0.05	1.0000	1.0000	1.0200	1.0050	1.0000	15.9	40.10	0.05
Other Ancillary	-	-	-	1.0000	1.0000	1.0000	1.0050	1.0000	-	-	-
Subtotal	262.5	$ 72.85	$ 1.59						252.3	$ 72.42	$ 1.52
Physician											
Surgery	98.9	$ 294.88	$ 2.43	0.9474	1.0404	1.0200	1.0100	1.0000	96.1	$ 312.93	$ 2.51
Anesthesia	79.8	204.22	1.36	1.0000	1.0000	1.0200	1.0100	1.0000	81.9	208.31	1.42
Hospital Inpatient Visits	1,243.5	44.59	4.62	0.8530	1.0100	1.0200	1.0100	1.0000	1,088.4	45.94	4.17
Office Visits/Consults	391.7	42.22	1.38	1.0100	1.0000	1.0200	1.0100	1.0000	405.9	43.07	1.46
Office Administered Drugs	-	-	-	1.0000	1.0000	1.0200	1.0100	1.0000	-	-	-
Physical Exams	-	-	-	1.0000	1.0000	1.0200	1.0100	1.0000	-	-	-
Emergency Room Visits	68.4	78.26	0.45	0.9300	1.0100	1.0200	1.0100	1.0000	65.3	80.62	0.44
Clinic Visit/Services	11.4	-	-	1.0000	1.0000	1.0200	1.0100	1.0000	11.7	-	-
Radiology	802.4	28.11	1.88	0.9650	1.0000	1.0200	1.0100	1.0000	794.5	28.67	1.90
Pathology	3,194.4	4.58	1.22	0.9300	1.0000	1.0200	1.0100	1.0000	3,048.1	4.67	1.19
Outpatient Behavioral Health	-	-	-	0.9300	1.0000	1.0200	1.0100	1.0000	-	-	-
DMHDD Rehabilitation Option Services	-	-	-	1.0000	1.0000	1.0200	1.0100	1.0000	-	-	-
Mental Health	-	-	-	0.9300	1.0000	1.0200	1.0100	1.0000	-	-	-
Other Professional	251.0	26.54	0.56	1.0000	1.0000	1.0200	1.0100	1.0000	257.5	27.07	0.58
Subtotal	6,141.5	$ 27.13	$ 13.89						5,849.4	$ 28.01	$ 13.65
Service Package I Medical Cost	7,301.4	$ 154.24	$ 93.85	0.8700	1.0204	1.0113	1.0016	0.9958	6,871.9	$ 146.21	$ 83.73
Service Package II Transition Cost	-	$ 0.00	$ 0.00	-	-	-	-	-	-	-	-
									Copay Adjustment		(0.09)
									Variable Admin	6.0%	5.02
									Fixed Admin		25.00
									PCP Fee		4.00
									Service Package I Capitation Rate		$ 117.66

ATTACHMENT 5

State of Illinois
Department of Healthcare and Family Services
Integrated Care Program for the Aged, Blind and Disabled - Capitation Rates
March 1, 2013 to December 31, 2013 Contract Period
SMART Policy and Program Changes Effective April 1, 2013

Rate Cell/Region	Projected 2013 Member Months	Current Capitation Rate	Current Expenditures	Proposed Capitation Rate	Proposed Expenditures	% Change	$ Change
Service Package I							
Community - Collar Counties	281,631	$ 985.35	$ 277,500,000	$ 890.59	$ 250,820,000	(9.6%)	$ (26,680,000)
DD Waiver - Collar Counties	17,730	753.06	13,350,000	655.70	11,630,000	(12.9%)	(1,720,000)
ICFMR - Collar Counties	2,893	891.55	2,580,000	832.52	2,410,000	(6.6%)	(170,000)
Nursing Facility - Collar Counties	9,174	2,146.33	19,690,000	1,773.44	16,270,000	(17.4%)	(3,420,000)
Other Waiver - Collar Counties	29,158	1,726.74	50,350,000	1,786.59	52,090,000	3.5%	1,740,000
State Operated Facility - Collar Counties	1,477	269.71	400,000	117.66	170,000	(56.4%)	(230,000)
Collar County Composite SPI	*342,064*	*$ 1,063.76*	*$ 363,870,000*	*$ 974.65*	*$ 333,390,000*	*(8.4%)*	*$ (30,480,000)*
Community - Expansion Counties	29,955	-	-	$ 890.59	$ 26,680,000		
DD Waiver - Expansion Counties	1,628	-	-	655.70	1,070,000		
ICFMR - Expansion Counties	670	-	-	832.52	560,000		
Nursing Facility - Expansion Counties	384	-	-	1,773.44	680,000		
Other Waiver - Expansion Counties	6,927	-	-	1,786.59	12,380,000		
State Operated Facility - Expansion Counties	-	-	-	117.66	-		
Expansion County Composite SPI	*39,565*	*$ 0.00*	*$ 0*	*$ 1,044.61*	*$ 41,340,000*		