



January 31, 2012

Mr. Jed Ziegenhagen
Rates Section Manager
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

RE: FINAL APRIL 1, 2012 - DECEMBER 31, 2012 CAPITATION RATE CERTIFICATION

Dear Jed:

The State of Colorado Department of Health Care Policy and Financing (Department) has developed Medicaid managed care capitation rates for the period April 1, 2012 through December 31, 2012. The Department contracted with The Lewin Group (Lewin) to review the proposed capitation rates and their development, and to certify that they are actuarially sound for the purpose of seeking rate approval by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 438.6(c). Certification of these capitation rates by Lewin will also fulfill all applicable state statutes.

This letter documents the methodologies used by the Department in developing the April 1, 2012 through December 31, 2012 managed care capitation rates as well as the processes used by Lewin in reviewing the actuarial soundness of the rates.

PROGRAM BACKGROUND

The General Assembly adopted House Bill 1346, which makes certain changes to the Medicaid managed care program, including removal of the upper limit on the Department's calculation of managed care capitated rates. Previously, rates set by the Department had been no greater than 95% of relative fee-for-service costs. However, Colorado Revised Statutes at 25.5-5-408 (9) contain a requirement that managed care plans submit rate proposals to the Department, and House Bill 07-1346 requires the managed care rate proposal to not exceed 100% of fee-for-service costs. Lewin, as explained below, has established an actuarially sound rate range for the managed care rates, in compliance with federal regulations and guidance concerning setting capitation rates for managed care organizations. Also, Lewin has certified a state statute payment maximum that is equal to the 100% of the expected fee-for-service cost of the managed care organization's anticipated enrollees.

The capitation rates being reviewed and certified are those under the managed care program for physical health, acute care Managed Care Organizations (MCO). There is currently one MCO for which rates are developed - Denver Health and Hospital Authority (DHHA). This certification letter only applies to DHHA.

APRIL 1, 2012 THROUGH DECEMBER 31, 2012 Methodology

Colorado Revised Statute (C.R.S.) Section 25.5-5-408 (8) states: "For capitation payments effective on and after July 1, 2003, the state department shall recalculate the base calculation every three years.



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The three-year cycle for the recalculation of the base calculation shall begin with capitation payments effective for fiscal year 2003-04. In the years in which the base calculation is not recalculated, the state department shall annually trend the base calculation after consulting with the MCOs. The state department shall take into consideration when trending the base calculation any public policy changes that affect reimbursement under the 'Colorado Medical Assistance Act'."

The capitation rates developed and certified for April 1, 2012 through December 31, 2012 were not rebased per the statute. Details regarding the following items are found in the body of this document.

- April 1, 2012 through December 31, 2012 trend rates are developed and applied to the existing base.
- Policy Changes for FY 05-06 through FY 11 -12 are applied to the existing base.
- A Health Status Based Risk Adjustment Case Mix Index was developed with enrollment and claims data using the Chronic Illness and Disability Payment System (CDPS) and is discussed in the Voluntary Risk Assessment section.

Aid Categories

For DHHA, the aid categories that are covered are:

- Categorically Eligible Low Income Adults (AFDC-A)
- Expansion Adults
- Baby Care Program Adults
- Eligible Children Over Age One (AFDC-C and BCKC-C)
- Eligible Children Under Age One (AFDC-U and BCKC-U)
- Foster Care
- Adults 65 and Older (OAP-A)
- Disabled Adults 60-64 (OAP/B-SSI)
- Disabled Individuals to 59 (AND/AB-SSI)

Note that the managed care programs do not cover the Partial Dual Eligibles such as Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualified Disabled and Working Individuals. Furthermore, the managed care programs do not cover participants in the state funded Old Age Pension Health and Medical program.

Covered Services

The MCO is responsible for providing a range of services to their enrolled members, summarized here by Categories of Service:



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- Inpatient Hospital
- Outpatient Hospital
- Physician
- Laboratory and X-Ray
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Family Planning
- Home Health (Acute Care services only)
- Durable Medical Equipment (DME)
- Emergency Transportation
- Prescription Drugs
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)

Rate Cells

The capitation payments received by the MCO are based on their enrollment by rate cell. The purpose of the rate cells is to group homogeneous, credible populations in a reasonable manner. While these rate cells generally follow the aid categories, there are some differences:

- Both disabled aid categories (OAP/B-SSI and AND/AB-SSI) have in common a Medicaid eligibility determination process that requires a formal disability determination. Those categories of eligibility are therefore combined together into an OAP-B/AND-SSI rate cell and refined to account for Institutional and third party liability (TPL) status:
 - Institutional/TPL (IT)
 - Institutional/Medicaid Only (IN)
 - Non-Institutional/TPL (NT)
 - Non-Institutional/Medicaid Only (NN)
- The Adults 65 and over (OAP-A) category is split only by institutional status. Previous analysis found that the TPL split for this aid category was temporary, and non credible, for most eligibles.
- The BCKC-C and AFDC-C subsets of Eligible Children Over Age One are combined together into one rate cell - CHILD-C. The Department previously performed a statistical analysis that showed that differences in cost between these groups of eligible children are not significant. Also, combining these aid categories into one rate cell is consistent with the Department's practice for budgeting and reporting financials. Similarly, the BCKC-U and AFDC-U (Eligible Children Under Age One) are combined together into one rate cell - CHILD-U.
- The Department calculated separate rate cells by sex within the AFDC eligibility

category. The Department examined the claims experience of the FFS eligible adult males and determined that expenditure differences were material enough and significant enough to warrant a separate set of rates.

- The claim and member month data for the Refugee Medical Assistance (RMA) category of eligibility, formerly known as Non-Categorical Refugee Assistance (NCRA), is grouped into the income eligible, non-disabled categories based on age. Given the risk characteristics and relatively small size of the refugee categories, this combination was determined to be the best course of action.
- A risk adjustment payment is made for maternity services. This risk adjustment payment includes facility and professional service costs for the delivery and post partum care. Prenatal and neonatal expenses are paid through the standard acute care MCO capitation payment. A single payment is made for each delivery regardless of the number of births.

BASE UTILIZATION AND UNIT COST DATA

Data Source

The April 1, 2012 through December 31, 2012 capitation rates are developed using direct health care FFS (PCP and Traditional FFS or Unassigned) claims and member month data from State FY 05-06 (July 1, 2005 - June 30, 2006) through state FY 07-08 (July 1, 2007 - June 30, 2008), hereinafter referred to as "base data". Lewin did not receive raw claims data. The summarization of claims and enrollment data was completed by the Department and the results were reviewed for reasonableness by Lewin. Lewin relied upon these summaries in drawing conclusions regarding the actuarial soundness of the state April 1, 2012 through December 31, 2012 rates.

Claims

The base data was collected for individuals identified as potentially eligible for the respective Medicaid managed care program and includes only those services that will be covered by the MCO.

The base data was then summarized by fiscal year, rate cell and category of service and then linked to the Department's eligibility file. The counties in the base data are: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson.

The Department compared the base data to the record of expenditures contained within the Colorado Financial and Reporting System (COFRS), the information system used for accounting throughout state government, in order to verify the accuracy of the paid data. This reconciliation showed that the differences between claims contained in the base data and the records of expenditures in the state accounting system were small and largely explicable.



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Maternity Delivery Risk Adjustment Payment

The Department calculated a maternity delivery risk adjustment payment to appropriately reimburse its participating MCOs for the risk incurred by a maternity delivery. Maternity deliveries are carved out from the total capitation rate. As a matter of public policy, the Department has adopted this methodology to ensure that MCOs are not at risk for the relative prevalence of pregnancies and deliveries within MCO enrolled populations, but instead are only at risk for the cost for each episode. A well managed MCO may well incur a lower incidence of cesarean deliveries (relative to the total number of deliveries) through well managed prenatal care. As such, the Department has determined that it should retain a single delivery payment for both cesarean and vaginal deliveries to retain the incentive for its contracting MCOs to provide intensive prenatal care. However, claims information was captured separately for cesarean and vaginal deliveries for the purpose of calculating actuarially sound rate ranges. Since the delivery risk adjustment payment only covers the delivery and post partum care, only the facility and professional payments related to these services were used in the payment development.

Medicare Coinsurance and Deductibles

Medicare co-insurance and deductibles, to the extent they are covered benefits of the managed care program, are included in the base data as well as the claims data used to develop trend rates. Incorporation of such "cross-over claims" results in their inclusion in the capitation rates.

DATA EXCLUSIONS

The Department modified the FFS data in order to develop rates that reflect MCO covered services and costs. Since these items are not part of the MCO benefit package, the claims are removed from the rate setting process. Some of the exclusions to the data that require the Department to take a more granular approach in order to remove them from the base data include:

- Inpatient Graduate Medical Education (GME)
- Outpatient Graduate Medical Education (GME)
- Mental Health Exclusion
- Indian Health Services Exclusion
- Substance Abuse Exclusion
- Medicare Modernization Act "Part D" Pharmacy Benefit Exclusion
- Oxygen (DME) Exclusion

AGE ADJUSTMENT FOR CHILDREN UNDER 1 YEAR

The Age Adjustment for the Child-U rate cell measures the relative cost of members in this



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eligibility category within the FFS population versus members in this category within the MCO population. For instance, FFS Medicaid incurs a disproportionate share of the earliest months in a newborn baby's Medicaid eligibility. These months are disproportionately expensive compared to later months. The capitation rates were adjusted based on the relative expected cost of the MCO compared to FFS.

A relative cost curve for the Child-U eligibility category was developed based on FFS claims data in fiscal years 2006 through 2008 to determine the relative health care costs of Child-U enrollees separately for the following four age categories: first month of life, age 1 month, age 2 months, and ages 3 through 12 months. FY11 DHHA enrollment information was used to develop a distribution of their Child-U enrollees, and the same was done for the FFS population. Those distributions were applied to the relative cost curve, and it was determined that the DHHA Child-U population is expected to be approximately 31% lower cost than the FFS Child-U population, purely based on age characteristics. DHHA's capitation rate for Child-U has been adjusted accordingly.

DATA CONSIDERATIONS/MODIFICATIONS

IBNR Claim Adjustment

Incurred but Not Reported (IBNR) claim adjustments were applied to the base data and the trend data. The IBNR adjustments applied to the trending data were developed using incurred data from FY 05-06 to FY 09-10, paid through October 31, 2010.

Federally Qualified Health Center Reimbursement

Amounts paid to Federally Qualified Health Centers (FQHCs) in excess of the standard Medicaid fee allowance are excluded from the base rates and are paid separately. That is, the Department adjusts FQHC claims (by category of eligibility) down to the average primary care provider level. Under this methodology, each MCO is reimbursed for a percentage of the FQHC costs in their capitation payment.

Since the Department is responsible for reimbursing the FQHCs at 100% of their reasonable costs, the Department makes an additional 'wrap-around' payment to each MCO for the portion of the FQHC payment obligation that is not covered in the monthly capitation payment. The Department's contract with the MCO contains a provision stating that the MCO is then obliged to ensure that its contracted FQHCs are paid at the "100% of reasonable cost" rate. This wraparound payment is determined by taking the product of the FQHC encounter rate (by FQHC), the percent of FQHC costs not covered in the capitation (by category of eligibility), and the number of encounters.



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FORECAST OF CY 12 EXPERIENCE

Prospective Policy Changes

Policy change adjustments are made to account for budget actions through statutory changes by the General Assembly of the State of Colorado. These projected changes in expenditures are due to rate, benefit, or eligibility changes occurring after the base period. The factors used to adjust the rates were calculated by the Department, and represent changes in the price and copayments of the services as described.

The following table shows public policy adjustments:

Category of Service	FY07	FY07-Effective Apr 1 2007	FY08	FY09	FY10	FY10-Effective Sep 1 2009	FY10 - Effective Dec 1 2009	FY10 - Effective Jan 1 2010	FY 11-Effective Jul 1 2010	FY12-Effective Jul 1 2011
DME	3.25%	0.00%	0.83%	0.71%	-2.00%	-1.50%	-1.00%	0.00%	-1.69%	-1.76%
Drugs	0.00%	0.00%	0.00%	-0.70%	-0.87%	-3.79%	0.00%	0.00%	-1.11%	-0.81%
Emergency Transport	0.00%	0.00%	7.58%	0.00%	-2.00%	-1.50%	-1.00%	0.00%	-1.00%	-0.75%
EPSDT	3.25%	0.00%	0.00%	0.00%	-2.00%	-1.50%	-1.00%	0.00%	-1.00%	-0.75%
Family Planning	0.00%	0.00%	17.84%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FQHC & Rural Health	3.25%	0.00%	3.78%	7.20%	-4.54%	-1.50%	-1.00%	0.00%	-1.00%	0.00%
FQHC (Children)	3.25%	0.00%	3.78%	11.72%	-4.54%	-1.50%	-1.00%	0.00%	-1.00%	0.00%
Home Health	0.00%	7.00%	0.00%	1.50%	-2.34%	-1.50%	-1.00%	0.00%	-1.00%	-0.75%
Inpatient Hospital	3.25%	0.00%	1.46%	1.50%	-2.39%	-1.50%	-1.00%	0.00%	-1.00%	-1.47%
Laboratory and X-Ray	3.25%	0.00%	0.00%	10.37%	-2.00%	-1.50%	-1.00%	0.00%	-1.00%	-0.75%
Outpatient Hospital	0.00%	0.00%	0.93%	0.00%	-2.00%	-1.50%	0.00%	-1.01%	-1.00%	-0.84%
Physician	3.25%	0.00%	3.78%	7.20%	-4.54%	-1.50%	-1.00%	0.00%	-1.00%	-0.88%
Physician (Children)	3.25%	0.00%	3.78%	11.72%	-4.54%	-1.50%	-1.00%	0.00%	-1.00%	-0.88%



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Voluntary Risk Assessment

This adjustment is intended to account for the difference in health status between members that enroll in the managed care program and members that enroll in the traditional FFS or PCP programs.

Because enrollees may voluntarily elect to participate in either the PCP or Medicaid managed care program, the health risk of those who participate in the Medicaid managed care program may vary from the risks underlying the base data (PCP and unassigned). When individuals have a choice between an MCO and the FFS program, the enrollment of individuals into an MCO will most likely not reflect the exact same risk as enrollment in the FFS program. The impact of this voluntary selection inherent in the FFS base data is measured using a prospective risk adjustment model, the Chronic Illness and Disability Payment System (CDPS).

The CDPS model is used to identify the risks assumed by the MCOs relative to the risk inherent in the FFS base data for all aid categories except Eligible Children Under Age One, Baby Care Program Adults, Foster Care, and Adults 65 and Older.

The FY06, FY07, and FY08 FFS CMI's were calculated based on FFS and MCO claims data incurred within those twelve-month periods, for FFS members who had a minimum of six months of eligibility during each of the fiscal years. In order to be consistent with the development of the MCO CMI's, claim run-out for each fiscal year's analysis was capped at four months of paid claims after each fiscal year (i.e., through October 31). To obtain an average FFS CMI, the members' risk scores were weighted by their enrollment spans within FFS during the fiscal year.

The MCO CMI's were calculated based on the risk scores of their clients enrolled June 2010. FY10 FFS and MCO medical claims data for these MCO enrollees was utilized, with claims paid through October 31, 2010. Only those clients who had a minimum of six months of eligibility during FY10 were considered in the risk adjustment calculation.

Because the MCO CMI's were calculated for members enrolled in June 2010, an adjustment was applied because the MCO CMI's did not consider risk scores for people who died, transitioned to a different rate cell, became institutionalized prior to June 2010, or were deemed Medicaid-ineligible; these issues all affected the FFS CMI's. This adjustment increased the MCO CMI's in the OAP-B/AND-AB eligibility category and reduced the MCO CMI's in the other risk-adjusted rate cells.

The adjusted CMI's for the MCOs were compared to the FFS CMI's within the three years of base data used for rate setting. The ratio between the case mix index values shows the relative difference in expected acuity between the FFS eligibles and the MCO enrollees. These case mix ratios were developed independently by aid category.



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Additional Data Considerations/Modifications

Additionally, modifications have been made to the data to reflect pharmacy rebates, 'pay-and-chase' TPL recoveries, unspecified adjustments and Colorado Financial Reporting System (COFRS) payments. Since these adjustments are not attributable to individuals, they are applied as applicable and across the board.

CY 12 Trends

Trend rates were developed by Lewin using summarized FY 05-06 to FY09-10 adjusted claims data paid through October 2010 and corresponding enrollment data. Data was split by Metro and Non-Metro areas, and trend was developed for Metro areas only. The Department provided summarized per member per month (PMPM) data, adjusted for incurred but not reported (IBNR) claims and normalized for historic Public Policy Adjustments. The trend data was normalized for risk factors. The data was partitioned by category of eligibility and category of service. IBNR factors were calculated by Lewin using the most recent data available. We calculated two distinct trends for rate setting: a retrospective trend, which is based only on historical experience and a prospective trend, which is based on both historical experience and actuarial judgment.

The following modifications were made in the trend rate development:

- All OAP-A categories were combined for trend calculation.
- The trend data was normalized for risk factors.
- The Adult Expansion/Eligible male and female and the Baby Care Program Adult rate cells have been combined for all types of service to create a larger group of similar coverages for additional trend credibility.
- Disabled categories were combined as follows:
 - Disabled Non Institutional/Non Third Party Liability and Disabled Institutional/Non Third Party Liability Combined
 - Disabled Non Institutional/ Third Party Liability and Disabled Institutional/ Third Party Liability Combined
- Within each aid category, trend rates for EPSDT, FQHC and Rural Health, Family Planning, and Physician were calculated by combining data for all of these categories of service. The resulting trend rate was used for each of these service categories.
- Within each aid category, data was combined for the DME and Emergency Transport service categories. The resulting trend rate was used for both of these service categories.
- Actuarial judgment was used where historic data fluctuation was observed, as allowed under 42 CFR 438.6(c).



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MANAGED CARE RATE RANGE DEVELOPMENT

Actuarial certification is no longer based on the managed care savings assumption implicit in setting rates relative to the federal upper payment limit (UPL), as was permitted by CMS through its November 1, 2000 checklist. To comply with the Balanced Budget Act (BBA) regulations for August 13, 2003 implementation, actuarially sound assessments were performed independently for each rate cell based on the development of a rate range (see below). To further comply with the BBA regulations, the actuarial certification is based on FFS cost experience that is gross of copayments.

In order to develop rate ranges as required by the BBA, two sets of managed care and administrative assumptions were developed using related data. The lower bound represents an amount commensurate with what a very efficient MCO, with typical utilization and administrative levels, could achieve without denying medically necessary services. The upper bound represents the least amount of efficiency a state may be willing to purchase.

For Colorado, the upper bound of the rate range is calculated without consideration of Colorado's state UPL (MCO payment proposals cannot exceed 100% percent of the direct health care cost). Additionally, the following were considered:

DSH Payments

Pursuant to Item AA.3.5 of the CMS Rate Checklist, DSH payments were not included in the rate setting.

Third Party Liability (TPL) Payments

Pursuant to Item AA.3.6 of the CMS Rate Checklist, TPL recoveries were captured in the base data, and since the MCO collects and keeps their own TPL there was not an additional amount added back into the rates.

Inclusion of Value of Copayments

Pursuant to Item AA.3.7 of the CMS Rate Checklist, an amount equal to the value of copayments collected from Medicaid enrollees through the FFS program has been included in the FFS base data for development of capitation rate range endpoints. Because extracted paid claims data is net of copayments, an amount equal to the value of copayments has been added to the rate range base data.

Graduate Medical Education (GME)

Pursuant to Item AA.3.8 of the CMS Rate Checklist, GME was removed from the base data.



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FQHC and RHC Reimbursement

Pursuant to Item AA.3.9 of the CMS Rate Checklist, the cap rates only include standard Medicaid reimbursement for the services rendered at FQHCs and RHCs.

Rate Range Assumptions

Two sets of managed care adjustments were developed and applied to account for variations in the health care delivery patterns between the managed care and FFS setting. The adjustments are based upon relevant managed care data, which are consistent with historical assumptions.

In the managed care adjustments, utilization reductions were assumed for hospital inpatient, hospital outpatient, laboratory and x-ray, and pharmacy. Net increases in physician utilization were assumed.

For the maternity delivery payment lower bound, reduction in unit cost was assumed that would result from an MCO directing care to facilities with lower than average costs.

Also pursuant to CMS requirements, capitation rates must provide some amount for plan administration. The range of administrative loading used in the rate range development is based upon plan financial reports for the participating plans as well as external sources. From this analysis, a combined administrative and underwriting profit load has been developed. For the lower end of the range, the load is 9.0% of premium for the monthly capitation payments and 1.0% for the maternity delivery payment. For the upper end of the range, the load is 20.0% of premium for the monthly capitation payments and 2.0% for the maternity delivery payment. These administrative and underwriting profit loads are based on rate filings of Colorado MCOs as of June 30, 2008.

RATE CERTIFICATION

The Department has developed, and Lewin has reviewed, April 1, 2012 through December 31, 2012 Medicaid managed care capitation rates. Lewin further, and separately, developed Medicaid managed care rate ranges for April 1, 2012 through December 31, 2012 as required by the BBA. For Denver Health, the attached exhibits summarize the April 1, 2012 through December 31, 2012 State capitation rate range and the April 1, 2012 through December 31, 2012 Lewin rate range by defined rate cell. To note, health based risk adjustment underlying the capitation rates, rate ranges, and final rate ranges shown in the exhibit below are specific to Denver Health.

Lewin developed rate ranges based on data supplied by the Department. Lewin has not audited the data and changes to the data could affect the resulting rates, perhaps even materially. Further, use of these rate ranges for purposes beyond those required by the BBA and Colorado Revised Statute may not be appropriate.

Lewin certifies that the above described rate ranges were developed in accordance with generally



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accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by the Department, as reviewed by Lewin, and rate ranges and trending rates developed by Lewin are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. Lewin has developed these rate ranges on behalf of the State of Colorado to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and certifies that they are in accordance with Colorado Revised Statute (C.R.S.) Section 25.5-5-408 and other applicable laws and regulations. MCOs are advised that the use of these rates and/or rate ranges may not be appropriate for their particular circumstance, and Lewin disclaims any responsibility for the use of these rate ranges by MCOs for any purpose. Lewin recommends that any MCO considering contracting with the State of Colorado should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the State. Use of these rate ranges for any purpose beyond that stated may not be appropriate. Furthermore, as outlined in C.R.S. Section 25.5-5-404, each MCO must certify the following: first, per C.R.S. Section 25.5-5-404(k) "the MCO shall certify...that the capitation payments set forth in the contract...are sufficient to assure the financial stability of the MCO;" second, per C.R.S. Section 25.5-5-404(l) "the MCO shall certify, through a qualified actuary retained by the MCO, that the capitation payments set forth in the contract...comply with all applicable federal and state requirements."

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If you have any questions regarding this letter, please contact Tom Carlson at 952-833-8244.

Sincerely,

A handwritten signature in cursive script that reads "Thomas P. Carlson".

Thomas Carlson, FSA, MAAA



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RATES EXHIBIT

State of Colorado Department of Health Care Policy and Financing
 April 1, 2012 - December 31, 2012 PMPM HMO Capitation Rates

Denver Health

	Metro			
	HCPF CY12 100% Base			
	Rate	Rate Min	Rate Max	Final Rate
AFDC-A F (RA CMI)	\$230.48	\$219.57	\$272.36	\$230.48
AFDC-A M (RA CMI)	\$169.96	\$157.84	\$189.75	\$169.96
BCKC-A	\$285.42	\$266.45	\$332.12	\$285.42
CHILD-C (RA CMI)	\$77.64	\$73.29	\$87.33	\$77.64
CHILD-U	\$214.51	\$191.59	\$228.98	\$214.51
FC	\$246.51	\$227.26	\$272.33	\$246.51
OAP-A				
Non-Institutional/MK Only	\$174.24	\$155.99	\$191.83	\$174.24
Non-Institutional/TPL	\$174.24	\$155.99	\$191.83	\$174.24
Institutional/MK Only	\$58.28	\$52.88	\$63.36	\$58.28
Institutional/TPL	\$58.28	\$52.88	\$63.36	\$58.28
OAP-B,AND/AB				
Non-Institutional/MK Only	\$726.72	\$650.63	\$799.55	\$726.72
Non-Institutional/TPL	\$164.83	\$153.92	\$189.02	\$164.83
Institutional/MK Only	\$1,365.80	\$1,197.75	\$1,463.66	\$1,365.80
Institutional/TPL	\$115.10	\$111.70	\$131.11	\$115.10

	HCPF CY12 100% Base			
	Rate	Rate Min	Rate Max	Final Rate
Delivery	\$4591.24	\$4,432.39	\$4,760.89	\$4591.24