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**State of New Hampshire  
Department of Health and Human Services  
Request for Proposals # 12-DHHS-CM-01  
For Medicaid Care Management Services**

**Cost Proposal Instructions and Data Book**

Prepared for:  
**New Hampshire Department of Health and Human Services**

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## I. INTRODUCTION

The State Legislature passed SB 147 that directed the Department of Health and Human Services (DHHS) to develop a comprehensive statewide care management program for all Medicaid enrollees. The program is to focus on improving the value, quality, and efficiency of services provided in the Medicaid program, stimulate innovation and generate savings for the Medicaid program. SB 147 called for DHHS to select fully at risk Bidders to provide managed care services and set the target date of July 1, 2012 for the launch of the new Care Management Program.

The cost proposal instructions and data book included herein present a summary of the bidding instructions as well as historical costs, utilization, and eligibility data for the Medicaid recipients eligible to enroll in and services to be covered by managed care organizations (MCOs) in the New Hampshire Medicaid Care Management Program.

The data book provides background information to enable interested bidders to prepare their bids to DHHS.

The sections of the cost proposal instructions and data book and their contents are as follows:

- > Section I provides an introduction and some background on the proposed program,
- > Section II describes the rate cell definitions used to develop the data book,
- > Section III provides bidding instructions,
- > Section IV presents information to be used in the development of the cost proposal, including the historical costs, utilization, and eligibility data, and
- > Section V includes a summary of the risk adjustment process that will be used for the July 2012 – June 2013 rate period.

Selected MCOs will be paid a monthly capitation rate that will be determined as part of contract negotiations, any best and final offer process, and the DHHS actuary's soundness certification. Please refer to Section 7 of the RFP for more details on the capitation payments to MCOs.

All questions related to the cost proposal instructions and data book should be prepared and submitted in accordance with Section 5.3 of the RFP. Cost proposal questions may be submitted in writing via fax or e-mail until November 14, 2011. A non-mandatory cost proposal conference will be held on November 17, 2011 for vendors who have submitted a letter of intent according to Section 5.2 of the RFP.

## II. RATE CELL DEFINITIONS

This section of the cost proposal instructions and data book provides information on the various rate cells that have been established for the New Hampshire Medicaid Care Management Program.

As shown in Section 3.1 of the RFP, the following Medicaid recipients will be mandated for enrollment into MCOs, with member opt-outs as noted, as of July 1, 2012 in Step 1 of the program roll-out:

- > Old Age Assistance (OAA)
- > Aid to the Needy Blind (ANB)
- > Aid to the Permanently and Totally Disabled (APTD)
- > Medicaid for Employed Adults with Disabilities (MEAD)
- > TANF / Poverty
- > Foster Care / Adoption (with member opt out)
- > Home Care for Children with Severe Disabilities (HC-CSD), commonly known as Katie Beckett (with member opt out)
- > New Hampshire Healthy Kids Silver (July 1, 2012) Children's Health Insurance Program (CHIP) population, which will transition to Medicaid expansion coverage
- > Populations with third party liability coverage, except for members with Veteran's Administration (VA) benefits
- > Auto eligible and assigned newborns
- > Medicare-Medicaid Dual Eligibles (with member opt out)

The following Medicaid eligible populations will be moved to the Care Management Program in Steps 2 and 3 of the program roll-out:

- > Medicare-Medicaid Dual Eligibles (mandatory enrollment with CMS waiver)
- > Affordable Care Act (ACA) expansion group

The following Medicaid eligible populations will remain in the fee-for-service program:

- > Members with VA benefits
- > Members with Family Planning only benefits
- > Initial part of month and retroactive / PE eligibility segments
- > Spend-down
- > QMB / SLMB only

The various eligibility groups have been further segmented into rate cells developed based on analysis of the per capita costs of various population sub-groups. These sub-groups were defined by age and gender within the covered eligibility categories and grouped into rate cells based on similarities in average costs.

There are a total of 22 rate cells across 11 different eligibility categories. The bidder will be required to prepare a cost proposal for each of the 22 rate cells as detailed in Section III of this document.

Table 1 below shows the definitions we used for the various rate cells presented in this data book.

<b>Table 1                      New Hampshire Department of Health and Human Services                      Medicaid Care Management Program Rate Cell Definitions</b>				
<b>Rate Cell</b>	<b>Age / Gender Categories</b>	<b>Aid Code Categories</b>	<b>Dual Status Code</b>	<b>Other Criteria</b>
Low Income Children and Families	2 - 11 months 1 - 5 6 - 13 14 - 18 female 14 - 18 male 19 - 44 female 19 - 44 male 45+	20, 21, 22, 24, 27, 28, 2E, 2F, 2H, 2U, 2V, 2W, 2X, 61	00	Includes Healthy Kids Silver SCHIP population
Foster Care / Adoption	All	40, 41, 42	00	
Breast and Cervical Cancer Program (BCCP)	All	86	00	
Disabled Children (non-dual / non-NF resident)	All	2B, 2C, 2D, 2K, and 30-32	00	Age <19 for category code 30-32
Disabled Adults (non-dual / non-NF resident)	19 - 44 female 19 - 44 male 45+	30, 31, 32, 50, 51, 52, 70, 71, 72, 80, 81, 82, 83, 84, 85	00	Age 19+ for category code 30-32
OAA (non-dual / non-NF resident)	All	10, 11, 12	00	
Nursing Facility (NF) residents (non-dual)	All	All aid categories	00	Presence of a claim under Fund Code B, C, or E (determined each month)
Nursing Facility (NF) residents (dual)	All	All aid categories	02, 04, 08	Presence of a claim under Fund Code B, C, or E (determined each month)
Dual eligibles (non-NF resident)	0 - 44 45 - 64 65+	All aid categories	02, 04, 08	Medicare coverage (excluding SLMB and QMB)
Newborn Kick Payment		All aid categories	00	First two months of life (e.g., for a baby born on July 15, all costs incurred in July and August)
Maternity Kick Payment		All aid categories	00	Service description below

The Maternity Kick Payment includes all facility and professional claims associated with deliveries. Maternity Kick Payment cases are counted as women who have either a maternity delivery DRG or a physician maternity delivery claim (or both). The Maternity Kick Payment only includes women already enrolled in Medicaid at time of delivery.

The Maternity Kick Payment cases are distributed in the following manner:

- > Both a maternity delivery DRG and a physician claim = 89%
- > A maternity delivery physician claim only = 6%
- > A maternity delivery DRG only = 5%

We used the following criteria to identify claims information to calculate the Maternity Kick Payment. The Maternity Kick Payment includes hospital inpatient delivery services, hospital outpatient, and emergency room delivery services, as well as professional delivery services.

- > Hospital Inpatient providers, with DRG codes of 765 – 768, 774 – 775.
- > Hospital Outpatient providers with a primary diagnosis code of v27.0 – v27.9, 650, and 651.01 - 669.92 (with the 5<sup>th</sup> digit being 1 or 2)
- > For all other providers only delivery and post-partum care services are included (CPT codes 59400, 59409, 59410, 59430, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, 00850, 00857, 00946, 00955, 01960, 01961, 01967, and 01968).

Prenatal services are not included in the Maternity Kick Payment, these services are included in the rate cell corresponding to the person receiving the services. For global reimbursement CPT-4 codes such as 59400, 59510, 59610 and 59618, we allocated the total allowed and paid amount to prenatal and delivery services using RBRVS ratios corresponding to the codes without prenatal care: 59410, 59515, 59614 and 59622 respectively.

### III. BIDDING INSTRUCTIONS

This section of the cost proposal instructions and data book provides instructions on the bidding process and the completion of the Cost Proposal Workbook.

#### BIDDING RULES AND REQUIREMENTS

In order to be considered complete and eligible for the evaluation, bids must fully comply with the following:

- > Bidder must submit its cost proposal using the Cost Proposal Workbook included in Appendix I,
- > Bidder must provide a cost proposal for each of the 22 different rate cells,
- > Bidder cannot make alterations of any kind to the rate cell structure,
- > Bidder must include an actuarial certification, completed and signed by a Member of the American Academy of Actuaries, that the bidder's cost proposal is actuarially sound, and
- > Bidder must submit an actuarial memorandum that contains a description of the data, methodology, and assumptions used to develop the bidder's cost proposal.
- > Throughout the Cost Proposal Workbook, bidder is only to fill out the cells shaded in yellow.

Cost proposals that do not fully comply with the above rules will be disqualified.

#### ADDITIONAL BIDDING INSTRUCTIONS

Cost proposals are to be quoted on a per member per month basis by type of service for a full month of enrollment. The maternity and newborn kick payments are to be quoted as a case rate for services as defined in the rate cell definitions.

Pricing proposals are effective for year one of the program (July 1, 2012 - June 30, 2013).

Cost proposals must provide details by broad type of service according to the Data Book and the Service Category Definition tab of the Cost Proposal Workbook.

Cost proposals are to be quoted assuming a risk score of 1.00 for each rate cell, where a 1.00 risk score represents the average acuity of the population included in the data book. The final capitation rates paid to the MCOs for non-dual eligible rate cells will be risk adjusted as described in Section V of the cost proposal instructions and data book.

Cost proposals for prescription drugs should be net of any supplemental rebates and net of the FFS adult copays that will remain in place under managed care.

Cost proposals are to be quoted assuming FQHC and RHC providers are paid their normal prospective encounter rates.

Cost proposals are to be net of TPL recoveries and reinsurance recoveries and should not reflect premium tax. If premium tax will apply to the Care Management Program rates, it will be added separately to the final capitation rates.

## IV. DATA BOOK INFORMATION

This section of the cost proposal instructions and data book provides information on the development of the data book appendices and other relevant information for the development of the Bidder's cost proposal.

### COVERED SERVICES

As shown in Section 3.1 of the RFP, the covered services include:

- > Maternity and Newborn Kick Payment
- > Inpatient Hospital
- > Outpatient Hospital
- > Inpatient Psychiatric Facility Services Under Age 22
- > Physicians Services
- > Advanced Practice Registered Nurse
- > Rural Health Clinic and FQHC
- > Prescribed Drugs
- > Community Mental Health Center Services
- > Psychology
- > Ambulatory Surgical Center
- > Laboratory (Pathology)
- > X-Ray Services
- > Family Planning Services
- > Medical Services Clinic (mostly methadone clinic)
- > Physical Therapy
- > Occupational Therapy
- > Speech Therapy
- > Audiology Services
- > Podiatrist Services
- > Home Health Services
- > Private Duty Nursing
- > Adult Medical Day Care
- > Personal Care Services
- > Hospice
- > Optometric Services Eyeglasses
- > Furnished Medical Supplies and Durable Medical Equipment
- > Non-Emergency Medical Transportation
- > Ambulance Service
- > Wheelchair Van

We used claim type, service category information, as well as DRG, revenue codes, and CPT-4 codes to summarize the historical fee-for-services claims for covered services into the categories shown in the data book.

### ELIGIBILITY DATA

Member month counts were calculated from eligibility data files extracted from New Hampshire's MMIS system. Each day a beneficiary is eligible for Medicaid coverage is counted and months of eligibility are determined by dividing the total number of eligible days by 30.42. The eligibility category of each

beneficiary and further breakdown in Rate Cells were determined based on the rate cell definitions outlined in Section II of the cost proposal instructions and data book.

We excluded the spend down population and the individuals with VA benefits on a month by month basis based on information supplied by NH DHHS.

## RETROACTIVE ELIGIBILITY AND ENROLLMENT LAG

Recipient enrollment in the fee-for-service program can and does occur retroactively. When an individual applies and qualifies for Medicaid coverage, DHHS reimburses claims which occurred during the retroactive qualification period prior to their application. DHHS backdates the eligibility of the individual to accommodate the retroactive coverage.

There will be a lag between the first date of eligibility and the date of enrollment in an MCO due to the length of time it will take for a Medicaid beneficiary to select and enroll in an MCO. Once a Medicaid beneficiary signs up for an MCO, they will be enrolled on the first day of the subsequent month.

The retroactive enrollment period will not be covered by the MCO. Retroactive exposure and claims were included in the data provided by DHHS. A beneficiary's retroactive eligibility period is not directly retained in the enrollment data, therefore an estimate of the retroactive exposure and claims were removed for the purposes of developing the data book using the following criteria:

- > Newborns of mothers enrolled in an MCO will be enrolled at birth, therefore we included newborn claims and enrollment from the month of birth.
- > Two months of claims and eligibility are removed for all other Medicaid beneficiaries.

## COST AND UTILIZATION DATA

Detailed fee-for-service claims data extracted from New Hampshire's MMIS system were used to produce this data book. Claims with dates of services between January 2008 and December 2010 with dates of payment through August 2011 are included in the attached Appendices.

- > The cost and utilization data presented in the attached exhibits reflect the claim header information for claims paid at the header level and line item detail for claims paid at the detail level.
- > Claims for FQHC and RHC providers reflect their normal prospective per encounter rates.
- > Prescription drug claims do not reflect FFS rebates.
- > Prescription drug claims are net of FFS copays, which will remain in place under managed care.

The only data adjustments that were made to the data included in the data book are as follows:

- > Adjustment to payments to the Coos County Hospital due to enhanced maternity reimbursement. We divided the payment amounts for Billing Provider ID = 3030022 by three to remove the enhanced payments. DHHS will continue to make these enhanced payments outside of the MCO capitation payments.

- > We removed the Indirect Medical Education payments that are in MMIS using the historical multipliers by Provider Codes as shown in Table 2 below.

<b>Table 2</b> <b>New Hampshire Department of Health and Human Services</b> <b>Historical IME DRG Multipliers</b>			
<b>Provider ID</b>	<b>Before 7/1/2009</b>	<b>7/1/2009 – 3/31/2010</b>	<b>4/1/2010 to Present</b>
80300001	1.073510	1.057500	1.000000
30002675	1.073510	1.057500	1.000000
80300003	1.346235	1.217500	1.000000
80300900	1.346235	1.217500	1.000000
40300020	1.019772	1.009500	1.000000
40004799	1.019772	1.009500	1.000000

### INCURRED BUT NOT REPORTED CLAIMS

We developed completion factors (CFs) by eligibility category and major service category for each year of data provided in the data book.

We used Milliman’s *Claim Reserve Estimation Workbook (CREW)* to calculate the completion factors shown in Appendix E. CREW calculates incurred but not reported (IBNR) reserve estimates by blending two different estimation methods: the lag completion method and the projection method.

The lag method reflects the historical average lag between the time a claim is incurred and the time it is paid. In order to measure this average lag, claims are separated by month of incurral and month of payment. Using this data, historical lag relationships are used to estimate ultimate incurred claims (i.e., total claims for a given incurral month after all claims are paid) for a specific incurral month based on cumulative paid claims for each month.

The projection method develops estimates for incurred claims in recent incurral months by trending an average base period incurred cost per unit to the midpoint of the incurred month at an assumed annual trend rate, and applying an additional factor to account for the seasonality of claim costs and the differing number of working days between months. The base period is chosen by selecting a group (usually 12) of recent consecutive months for which the lag completion method provides reasonable results.

The lag completion and projection methods are combined to produce the final incurred claim estimate. Final incurred claim estimates are calculated as a weighted average of these two methods.

Bidders should review Appendix E for estimates of the adjustment factors that should be applied to the data shown in Appendix A to account for IBNR claims.

### LOW INCOME CHILDREN VS. HEALTHY KIDS SILVER RISK SCORES

As listed in Section II of this document, the Healthy Kids Silver (CHIP) population will be covered under the Medicaid managed care program. However, the experience data for the Healthy Kids Silver (CHIP) population was not available for inclusion in this data book. To help bidders in correctly adjusting their bids for the inclusion of the Healthy Kids Silver (CHIP) population, we included risk score summaries showing the average Clinical Risk Group (CRG) risk scores for the Low Income Children (Medicaid) and Healthy Kids Silver (CHIP) population that can be used to adjust for acuity differences between the two populations.

Table 3 below show the average CRG risk score by age and gender groupings consistent with the proposed rate cells.

<b>Table 3</b>						
<b>New Hampshire Department of Health and Human Services</b>						
<b>Low Income Children vs. Healthy Kids Silver (CHIP) Risk Scores</b>						
<b>Age Group</b>	<b>2008</b>		<b>2009</b>		<b>2010</b>	
	<b>Scored Members</b>	<b>Average Risk Score</b>	<b>Scored Members</b>	<b>Average Risk Score</b>	<b>Scored Members</b>	<b>Average Risk Score</b>
<b>Medicaid Low Income</b>						
Age 1 to 5	16,440	0.570	17,974	0.581	20,038	0.552
Age 6 to 13	22,776	0.657	24,495	0.603	27,286	0.570
Age 14 to 18 Female	6,030	0.741	6,337	0.671	7,054	0.643
Age 14 to 18 Male	6,028	0.801	6,510	0.731	7,280	0.674
<b>Total</b>	<b>51,274</b>	<b>0.656</b>	<b>55,316</b>	<b>0.619</b>	<b>61,658</b>	<b>0.585</b>
<b>Healthy Kids Silver (CHIP)</b>						
Age 1 to 5	886	0.448	838	0.439	932	0.457
Age 6 to 13	1,987	0.494	2,049	0.503	2,280	0.485
Age 14 to 18 Female	628	0.553	668	0.565	781	0.598
Age 14 to 18 Male	700	0.502	694	0.510	774	0.512
<b>Total</b>	<b>4,201</b>	<b>0.494</b>	<b>4,249</b>	<b>0.501</b>	<b>4,767</b>	<b>0.502</b>

Appendix B shows the membership break down by month between the Low Income Children and CHIP population for the historical fee-for-service experience period included in this data book.

### **NON-EMERGENCY TRANSPORTATION AND HOSPICE CLAIMS**

Currently non-emergency transportation services are part of DHHS's administrative expenses and therefore not processed through MMIS and are excluded from Appendix A. Non-emergency transportation services are part of the covered services in the Medicaid Care Management Program. The bidder should account for non-emergency transportation expenses in their cost proposal in the "Other Services" line. Historical non-emergency transportation expenses are presented in Appendix F.

A hospice benefit was introduced in July 2010 and is part of the covered services under the Medicaid managed care program. The expenses for the hospice benefit are currently paid manually and therefore outside of the MMIS system. The bidder should account for hospice expenses in their cost proposal in the "Other Services" line. Historical hospice expenses are presented in Appendix G.

### **THIRD PARTY LIABILITY**

MCOs are expected to pursue and collect Third Party Liability (TPL) recoveries from other payers. Table 4 below shows a summary of the TPL recovery amounts that should be used by the bidder to adjust the paid claims data shown in Appendix A. The TPL recoveries in Table 4 are a summary of actual DHHS recoveries that are not already captured in the MMIS system, and therefore are also not reflected in Appendix A. The recoveries reflect both state and federal dollars.

**Table 4**  
**New Hampshire Department of Health and Human Services**  
**Third Party Liability by Calendar Year and Category of Service**

<b>Category of Service</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
Inpatient	\$159,671	\$493,467	\$514,549
Inpatient Crossover	0	48,913	5,340
Outpatient	196,524	389,251	369,007
Outpatient Crossover	71	63,505	1,920
Medical	565,068	571,962	575,939
Professional Crossover	4,369	21,604	3,914
Prescription Drugs	235,521	229,231	389,621
Invalid Claim Type	0	105	0
Not Matched To TCN	13,008	683,598	768
<b>Total</b>	<b>\$1,174,232</b>	<b>\$2,501,636</b>	<b>\$1,861,059</b>
<b>Percent of Paid Claims</b>	<b>0.31%</b>	<b>0.60%</b>	<b>0.45%</b>

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## V. RISK ADJUSTMENT PROCESS

The capitation rates for the following non-dual rate cells will be further adjusted to reflect the acuity level of the population enrolled in each MCO:

- > Low Income Children and Families
- > Foster Care / Adoption
- > Disabled Children
- > Disabled Adults (non-Dual / non-NF resident)
- > OAA (non-Dual / non-NF resident)
- > Nursing Facility Residents (Medicaid only)

Capitation payments will be risk adjusted using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx). The CDPS + Rx risk adjuster will be used to adjust for the acuity differences of the Care Management Program population compared to the FFS population as well as acuity differences among the enrolled populations of each MCO.

An MCO's capitation rate will be determined based upon the following formula:

$$\text{MCO Capitation Rate} = \text{Base Capitation Rate} \times \text{MCO Adjusted Risk Factor}$$

The Base Capitation Rates are the final negotiated capitation rates for each MCO.

The MCO Adjusted Risk Factor will equal the average risk factor across all beneficiaries that a MCO enrolls divided by the average risk factor for the entire population that is eligible to enroll in the Care Management Program (FFS eligibles + MCO enrollees).

### Risk Adjustment in Year 1

Risk adjustments for July 2012 through December 2012 capitation payments will be based on calendar year 2011 FFS data. Risk adjustment for January 2013 through June 2013 capitation payments will be based on SFY 2012 FFS data.

A beneficiary must have at least six months of eligibility in the data year to be scored. If a beneficiary does not have enough data, they will receive a score equal to the average of those beneficiaries with scores in each cohort (i.e., the MCO-specific average or the FFS average). We will monitor the percentage of MCO and FFS enrollees who are not scored and adjust the methodology if necessary.

Each MCO's Adjusted Risk Factor will be set to 1.00 for payments in the first quarter of the Care Management Program. At the end of the first quarter, we will calculate retrospective settlements based on the risk scores of each MCO's actual beneficiaries enrolled during the first quarter. The most current available month's enrollment will then be used to establish each MCO's Adjusted Risk Factor at the beginning of each of the following three quarters. Again, retrospective settlements will be made at the end of each quarter throughout the first year of the program. This process is being used to protect both DHHS and the MCOs from volatility in membership that can be expected in the first year of the program.

Risk Adjustment in Year 2

In the second year of the program, we expect that enrollment will stabilize. As such, no retrospective settlements will be provided in the second year. Also, each MCO's Adjusted Risk Factor will only be calculated at the beginning of the 5<sup>th</sup> and 7<sup>th</sup> quarter of the program. However, we do anticipate updating the risk factor weight calculation for the second year using calendar year 2012 (for the 5<sup>th</sup> and 6<sup>th</sup> quarter adjustments) and SFY 2013 (for the 7<sup>th</sup> and 8<sup>th</sup> quarter adjustments) FFS claims data and MCO encounter data.

A schedule indicating risk score calculation and settlements is shown in Table 5.

<b>Table 5</b> <b>MCO Capitation Rate Risk Adjustment Schedule</b> <b>Years 1 and 2 of New Hampshire Care Management Program</b>		
<b>Program Quarter</b>	<b>MCO Risk Factor Based on Enrollment in</b>	<b>Retrospective Settlement Based on Enrollment in</b>
1	Set = 1.00 at program start	7/12 – 9/12
2	8/12	10/12– 12/12
3	11/12	1/13 – 3/13
4	2/13	4/13 – 6/13
5 and 6	5/13	None
7 and 8	11/13	None