

Children’s Rehabilitative Services (CRS) Actuarial Memorandum for CYE 2014

I. Purpose

The purpose of this actuarial memorandum is to demonstrate that the Children’s Rehabilitative Services (CRS) capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

The Affordable Care Act (ACA) places an annual fee on the health insurance industry nationwide including most Medicaid health plans effective January 1, 2014. The fee will be allocated to health insurers based on their respective market share of premium revenue in the previous year. Due to the uncertainty of the actual fees and other unknowns, AHCCCS will not be adjusting the capitation rates for this fee at this time, but intends to make a revision once the impacts are known.

The historical CRS carve-out program provides specialty services to children with special health care needs. Children qualify for CRS based on particular diagnoses, and currently a CRS member receives services specific to the health condition that qualifies him/her for CRS through the sole CRS Contractor. However, that same member may currently receive other acute care services through a different Contractor or through the American Indian Health Plan (AIHP), they may receive long-term care services through a different Contractor or the American Indian Fee-for-Service environment, and they may receive behavioral health services through a Regional Behavioral Health Authority (RBHA) or a Tribal Regional Behavioral Health Authority (TRBHA).

Beginning October 1, 2013, AHCCCS is integrating all services for most Acute Care Program children with CRS conditions through one CRS Contractor with the goals of improved member outcomes, reduced member confusion, improved care coordination, and streamlined administration. At the same time, children with CRS conditions who are enrolled in the long term care program, and who today have integrated acute and long term care services, will begin to receive their CRS related services through the Arizona Long Term Care System (ALTCS) Contractors.

II. Overview of Bid, Rate Setting Methodology and Base Period Experience

Contract year ending 2014 (CYE 14) is the first year of a new cycle for the CRS contract. The medical component of the contract year ending 2014 (CYE 14) rates were developed as a rate rebase in order to include experience data for acute care and behavioral health services received by CRS members. The administrative component of the CYE 14 rates are the rates awarded as part of the competitive bid process for the CYE 14 Request for Proposal (RFP). The CYE 14 rates cover the twelve month contract period of October 1, 2013 through September 30, 2014.

There are four permutations of the program enrollment, hereafter called “coverage types” and described as follows:

- A Fully Integrated member will receive acute care, behavioral health, and specialty care for CRS conditions through the sole CRS contractor.
- A Partially Integrated-BH member will receive behavioral health and specialty care through the sole CRS contractor. These members are typically enrolled with the Developmentally Disabled (DD) or the Comprehensive Medical and Dental Program (CMDP) for their acute care services.
- A Partially Integrated-Acute member will receive acute care and specialty care through the sole CRS contractor. These members are typically Native Americans receiving behavioral health services through a TRBHA.
- A CRS Only member will only receive specialty care through the sole CRS contractor. These members are typically enrolled in the American Indian Health Plan (AIHP), receiving acute care in a fee-for-service environment, and receiving behavioral health services through a TRBHA.

Since CRS has a relatively small membership base, multiple years and sources of data were used to increase the statistical credibility. For CYE 14 rate development, CRS' encounter data was found to be appropriate for all service categories, except clinic fees. For all categories other than clinic fees the base year experience includes encounters with dates of service between October 1, 2009 and March 31, 2012. Completion and credibility factors were added to the encounter data. CRS did not begin encountering clinic fees until January 2011 thus limited encounter data is available for these expenses. Consequently, financial statement data for CYE 09 through CYE 12 was used to estimate the CYE 14 clinic expenses. That forecast also incorporates anticipated changes to clinic reimbursement due to a location and administrative change for the Maricopa County clinic. The per member per month (PMPM) claim costs observed for all categories of service were then adjusted to reflect program changes and reimbursement reductions that were effective subsequent to the experience periods used.

The assumed trend rates were developed from an internal data extract ("databook") that tracks historical enrollment, as well as utilization counts and unit costs for encounters adjudicated by AHCCCS. Other data sources include Contractor financial statements, AHCCCS Fee-For-Service rate changes, anticipated Arizona Department of Health Services (ADHS) transportation increases, programmatic changes, and CMS statistics on national health expenditures (NHEs).

Because of the relatively small membership base and statewide disbursement of members, segregating the CRS population into different rate cells with similar risk characteristics would lead to a statistical credibility problem. Therefore, AHCCCS believes that a single CRS capitation rate for each coverage type leads to a more actuarially sound rate than creating additional rate cells.

The experience includes all Medicaid eligible expenses for CRS Medicaid eligible individuals. In addition, the experience includes reinsurance amounts. For CYE 14 the CRS capitation rates will be reconciled using a tiered reconciliation methodology. See Section XI for additional information. There are no other incentives or risk sharing arrangements.

The base period claim PMPMs for each of the acute, behavioral, and specialty components are built up from utilization and unit cost data for the experience period, adjusted for completion estimates, adjusted for programmatic and AHCCCS Fee-For-Service (FFS) provider rate changes, and trended to the midpoint of the effective period, April 1, 2014. The trended PMPMs for each component are added together as appropriate for each of the four coverage types described in this Section. The administrative expense from the successful Offeror, risk/contingency, reinsurance offset and premium tax are then added to the projected claim PMPMs to obtain the capitation rates. Each step is described in the sections below.

III. Projected Trend Assumptions

PMPM trend rates were calculated from the encounter data experience for CYE 09, CYE 10, CYE 11 and CYE 12 dates of service. Financial statements for the same time periods were used to validate the encounter data and trends. The trend rates shown below in Table I do not include AHCCCS FFS provider rate changes.

The trend rates used in projecting the claim costs are as follows:

Table I: Annual Trend Rates by Program Component and Service Category

Program Component	Service Category	PMPM Trend
Acute Care	Inpatient	1.5%
Acute Care	Outpatient	6.5%
Acute Care	Professional	4.9%
Acute Care	Pharmacy	0.1%
Acute Care	Long-Term Care	-4.7%
Acute Care	Dental	2.7%
Behavioral Health	Inpatient	-2.2%
Behavioral Health	Professional	4.8%
Behavioral Health	Pharmacy	2.4%
Specialty Care	Inpatient	-2.2%
Specialty Care	Outpatient	1.6%
Specialty Care	Professional	3.5%
Specialty Care	Pharmacy	-3.2%
Specialty Care	Long-Term Care	0.3%
Specialty Care	Dental	-2.2%

IV. Projected Gross Claim PMPM

The claims PMPMs for each contract year in the experience period were trended from the midpoint of the contract year to the midpoint of the rating period. The midpoint of the rating period is April 1, 2014.

V. State Mandates, Court Ordered Programs, Program Changes and Other Changes

Provider Rate Changes

Effective October 1, 2013, AHCCCS is increasing FFS provider rates for certain providers based either on access to care needs, Medicare or ADHS fee schedule rates, legislative mandates, or cost of living adjustments. The unit cost (inflation) trends were adjusted appropriately for these changes. The estimated statewide impact is an increase of approximately \$1.9 million.

Primary Care Provider (PCP) Payment Increase

Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act, requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. The AHCCCS managed care model, with strict requirements regarding actuarially-sound capitation rates, necessitates that Contractors be funded for expected cost increases due to primary care rate parity. AHCCCS proposes to provide Contractors the necessary funds to increase primary care payments by using Model 3: Non-risk Reconciled Payments for Enhanced Rates as referenced in the *Medicaid Managed Care Payment for PCP Services in 2013 and 2014, Technical Guidance and Rate Setting Practices* (Technical Guidance) document released by CMS.

In summary, under Model 3, prospective capitation rates would not be adjusted for the enhanced primary care payments. Rather, AHCCCS would query actual encounter data on a quarterly basis to calculate the total payments that eligible providers were paid for eligible services in order to reach the mandated enhanced payment rates. Once the data on this report is verified, AHCCCS would pay the Contractors the calculated additional payment amounts. A more detail explanation of the process and methodology can be found in the Actuarial Certification submitted to CMS for approval of AHCCCS methodology. There is no impact to the CYE 14 capitation rates.

In-Lieu of Services

Included in the base rates is funding for "in lieu of" services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. State approved FFS rates at inpatient non-specialty hospitals are approximately 93.5% more expensive than those provided in alternative inpatient settings. The proposed capitation rates allow for the provision of services in alternative inpatient settings that are licensed by ADHS/Arizona Licensing Services/Office of Behavioral Health License, in lieu of services in an inpatient non-specialty hospital, thus no increase to cap rates is included.

VI. Projected Net Claim PMPM

The base period utilization, unit costs, and net claims' PMPMs are trended forward and adjusted for AHCCCS fee schedule changes, state mandates, court ordered programs and program changes to arrive at the CYE 14 utilization, unit costs and net claims' PMPMs.

VII. Projected Reinsurance Offsets

The projected CYE 14 reinsurance offsets were developed using CYE12 encounter data and reinsurance payment information. The projected CYE 14 reinsurance offsets take into consideration that a single threshold for reinsurance will apply to the total encounters incurred under all of the program components for which each member is enrolled.

VIII. Coordination of Benefits

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors' Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 to SFY 2013, encounter-reported COB cost avoidance grew from \$34,000 to \$7.7 million. Additionally, in CYE 13 the CRS Contractor cost-avoided \$667,000 in the nine months ending March 31, 2013, in claims for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

IX. Administrative Expenses and Risk Contingency

The administrative expense PMPM bid by the successful Offeror was adjusted by AHCCCS to cover additional administrative responsibility and is built into the rates. The risk contingency load is set at 1%.

X. Proposed Capitation Rates and Their Impact

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VI) less the reinsurance offsets (in section VII), the awarded administrative expenses, and the risk contingency PMPM (in section IX), divided by one minus two percent for premium tax. Table II below summarizes the projected member months, proposed capitation rates, and estimated total capitation by coverage type and in total on a statewide basis.

Table II: Proposed Capitation Rates by Coverage Type

	Projected Member Months October 1, 2013 - September 30, 2014	CYE 14 Proposed Rate	Estimated CYE 14 Capitation
Fully Integrated	213,069	\$741.22	\$157,930,542
Partially Integrated/BHS	75,943	\$478.75	\$36,357,592
Partially Integrated/Acute	1,895	\$656.43	\$1,243,769
CRS Only	13,955	\$393.96	\$5,497,521
Statewide Total	304,861		\$201,029,424

XI. CMS Rate Setting Checklist

1. Overview of rate setting methodology

AA.1.1: Actuarial certification

Please refer to Section XII.

AA.1.2: Projection of expenditure

Please refer to Section X.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Competitive Procurement contracting method.

AA.1.5: Risk contract

The contract is an at risk contract, however there are some provisions for reconciliations and reinsurance. The reconciliation is as follows:

Profit	MCO Share	State Share	Maximum Contractor Profit
<=3%	100%	0%	3.0%
>3% and <=6%	50%	50%	1.5%
>6%	0%	100%	0%
Total			4.5%

Loss	MCO Share	State Share	Maximum Contractor Loss
<=3%	100%	0%	3.0%
>3%	0%	100%	0%
Total			3.0%

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to providers, except for DSH, GME, and Critical Access Hospitals. GME is paid in accordance with state plan. DSH and Critical Access Hospital payments are paid in accordance with the Waiver Special Terms and Conditions. None of the additional payments to providers were included in the capitation calculation.

AA.1.7: Rate modification

Please refer to Sections II, III, V, VII and IX.

2. Base Year Utilization and Cost Data

AA.2.0: Base year utilization and cost data

Please refer to Section II.

AA.2.1: Medicaid eligibles under the contract

The data includes only those members eligible for managed care.

AA.2.2: Spenddown

Not applicable, not covered under this contract.

AA.2.3: State plan services only

The contract between AHCCCS and the Contractor specifies that the Contractor may cover additional services. Non-covered services were not included in the encounter data used to set the rates.

AA.2.4: Services that can be covered by a capitated entity out of contract savings.

Same as AA.2.3

3. Adjustments to the Base Year Data

AA.3.0 Adjustments to base year data

Please refer to Section II, III, V and VII.

AA.3.1 Benefit differences

Please refer to Sections I and II for descriptions of the benefits provided under the integrated contract and the four coverage types.

AA.3.2 Administrative cost allowance calculation

Please refer to Section IX.

AA.3.3 Special populations' adjustment

It is anticipated that the risk characteristics of this population will not change materially from the base period to the effective period of the capitation rates. Therefore, no adjustment was made.

AA.3.4 Eligibility Adjustments

No adjustment was made.

AA.3.5 DSH Payments

No DSH payments were included in the capitation development

AA.3.6 Third party Liability (TPL)

This is a contractual arrangement between AHCCCS and the Contractors.

AA.3.7 Copayments, coinsurance and deductible in the capitated rates

Not applicable, member cost sharing is not required.

AA.3.8 Graduate Medical Education (GME)

The experience excludes any payments for GME.

AA.3.9 FQHC and RHC reimbursement

The experience excludes any additional payments that FQHCs may receive from the State.

AA.3.10 Medical cost/ trend inflation

Please refer to Section III.

AA.3.11 Utilization adjustment

Other than trend, no specific adjustment was made to utilization.

AA.3.12 Utilization and cost assumptions

Not applicable, since actual experience was used.

AA.3.13 Post-eligibility treatment of income (PETI)

Not applicable, not required to consider PETI.

AA.3.14 Incomplete data adjustment.

The encounter data was not fully complete. AHCCCS applied completion factors by form type and contract year to the encounter data.

4. Establish Rate Category Groupings

AA.4.0: Establish rate category groupings

Please refer to Section II.

AA.4.1: Age

Please refer to Section II.

AA.4.2: Gender

Please refer to Section II.

AA.4.2: Locality/region

Please refer to Section II.

AA.4.2: Eligibility category

Please refer to Section II.

5. Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0: Data smoothing

Please refer to Section II.

AA.5.1: Special populations and assessment of the data for distortions

Data was not adjusted for special populations.

AA.5.2: Cost-neutral data smoothing adjustments

There was no cost-neutral data smoothing adjustments

AA.5.3: Risk-adjustment

There is no other risk adjustment, except for reconciliation and reinsurance.

6. Stop Loss, Reinsurance, or Risk-Sharing arrangements

AA.6.1: Commercial reinsurance

There is no commercial reinsurance.

AA.6.2: Simple stop loss program

AHCCCS has a reinsurance program. Please refer to Section VII.

AA.6.3: Risk corridor program

There is the stop loss program (i.e. Reinsurance) and a reconciliation for the CRS population.

7. Incentive Arrangements

At this time there are no incentive arrangements.

XII. Actuarial Certification of the Capitation Rates

I, Matt Varitek, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board.

The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the twelve month period beginning October 1, 2013.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the health plan and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the health plan auditors and other AHCCCS employees for the accuracy of the data.

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.

This certification letter assumes the reader is familiar with the CRS program, Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

Matthew C. Varitek

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08.23.2013

Date

Fellow of the Society of Actuaries
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