Children's Rehabilitative Services (CRS)
Actuarial Memorandum for CYE 2013

I. Purpose

This memorandum presents a discussion of the revision to the capitation rates for the Children's Rehabilitative Services (CRS) program, for the period October 1, 2012 to September 30, 2013. The purpose of this actuarial memorandum is to demonstrate that the updated capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

Arizona Health Care Cost Containment System (AHCCCS) intends to update these capitation rates for January 1, 2013 to include changes to the physician fee schedule resulting from mandated Health Care Reform requirements and any other necessary changes.

II. Overview of Rate Setting Methodology and Base Period Experience

The contract year ending 2013 (CYE13) rates were developed as a rate rebase from the contract year ending 2012 (CYE12) capitation rates previously approved by CMS. The CYE13 rates cover the twelve month contract period of October 1, 2012 through September 30, 2013.

Since CRS has a relatively small membership base, multiple years and sources of data were used to increase the statistical credibility. For CYE13 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 is the 2009, 2010 and 2011 federal fiscal year encounter data. 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 CYE11 and CYE12, year-to-date, was used to estimate the CYE13 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, anticipated AHCCCS Fee-For-Service rate changes, anticipated Arizona Department of Health Services (ADHS) transportation increases, programmatic changes, and BLS statistics on medical inflation.

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 leads to a more actuarially sound rate than creating additional rate cells.

The experience only includes CRS Medicaid eligible expenses for CRS Medicaid eligible individuals. In addition, the experience includes reinsurance amounts. For CYE13 the CRS capitation rates will be reconciled using a tiered reconciliation methodology. See Section X CMS Rate Setting Checklist for additional information. There are no other incentives or risk sharing arrangements.

In general, the base period claim PMPMs are trended to the midpoint of the effective period or April 1, 2013. The next step involves adjusting for program and other changes. In the final step, the projected administrative expenses, risk/contingency margin, reinsurance offset and premium tax are added to the projected claim PMPMs to obtain the capitation rates. Each step is described in the sections below.

III. Projected Trend Assumptions

Utilization and unit cost trend rates were calculated from the encounter data experience for CYE09, CYE10 and CYE11 dates of service. Financial statements for the same time periods, and CYE12 (YTD) financials, were used to validate the encounter data and trends.

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

Table I: Average Trend Rates

Service Category	Utilization Trend	Unit Cost Trend	PMPM Trend
Inpatient	-4.61%	-4.61%	-9.00%
Outpatient	-7.78%	10.94%	2.31%
Physician	5.00%	0.65%	5.68%
Pharmacy	-7.15%	6.25%	-1.35%
DME	12.73%	6.85%	20.45%
Non-Physician Professional	14.81%	8.00%	23.99%
Lab/Radiology	-6.21%	9.53%	2.73%
Clinic	N/A	N/A	N/A
Dental	-13.36%	-2.01%	-15.10%
Other	-29.32%	25.18%	-11.52%
Total	2.70%	-1.89%	0.75%

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 2010, encounter-reported COB cost avoidance grew from $34,000 to $889,000 (no data is available for SFY 2011 as it was reported under the Acute or ALTCS program based on the members' enrollment). Additionally, the CRS Contractor cost-avoided $1.2 million in SFY 2011 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.

IV. Projected Gross Claim PMPM

The claims PMPMs were trended from the midpoint of the base claims period to the midpoint of the projected claims period. The midpoint of the projected claims period is April 1, 2013. The midpoint of the base claims period is April 1, 2010.

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

Clinic Fees
The projected cost for clinic fees includes an adjustment of $5.14 PMPM to reflect movement of clinic services from St. Joseph's Hospital to a new clinic in Maricopa County. The new clinic will be active beginning October 1, 2012. The contracted clinic fee per visit with DMG is higher than that currently paid to St. Joseph's. The impact is an increase of approximately $1,575,720.

340B Pharmacy Pricing
Effective April 2012, all Contractors are required to reimburse claims for 340B drugs consistent with the requirements in AHCCCS Rule A.A.C. R9-22-710 C. In general, this provision requires that claims for drugs identified on the 340B pricing file dispensed by FQHCs and FQHC Look Alike pharmacies be reimbursed at the lesser of: 1) the actual acquisition cost or 2) the 340B ceiling price, plus a dispensing fee listed in the AHCCCS capped Fee-For-Service (FFS) schedule. For more detail regarding reimbursement of 340B drugs, please refer to the AHCCCS Rule. The estimated statewide savings to the CRS program was immaterial.

Claims Processing Standards
Effective January 1, 2012, Contractors were required to adjust their claims processing systems to recognize two cost-saving standards including multiple surgery occurrences and bundled services. When multiple surgeries occur on the same day, the surgery with the lowest cost is valued at 50% of the standard allowed amount for that surgery. Encounter data identified with status code B reflects bundled services where no additional payment is allowed for certain services that are performed together (e.g. anesthesia provided during an outpatient surgery). The estimated statewide savings to the CRS program was immaterial.

VI. Projected Net Claim PMPM

The CYE12 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 CYE13 utilization, unit costs and net claims' PMPMs.

VII. Projected Reinsurance Offsets

The CYE12 reinsurance offsets were reviewed by AHCCCS for appropriateness and reasonableness using reinsurance encounter and payment information. Appropriate adjustments were made to the reinsurance offsets based upon this review.

VIII. Administrative Expenses and Risk Contingency

The administrative expense remains at 9.64% for general administration, which was determined to be appropriate to cover the contractors' average expenses. The risk contingency load also remains the same at 2%.

IX. 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) and the projected administrative expenses and risk contingency PMPM (in section VIII), divided by one minus two percent for premium tax. Table II below summarizes the changes from the current approved CYE12 capitation rates and the estimated budget impact, effective for CYE13 on a statewide basis.

Table II. Proposed Capitation Rates and Budget Impact

	Based on Projected Member Months October 1, 2012 - September 30, 2013	CYE12 Current Rate	CYE13 Updated Rate	Based on Projected Member Months October 1, 2012 - September 30, 2013	
				Estimated CYE12 Current Capitation	Estimated CYE13 Updated Capitation
Statewide Totals	306,617	$ 424.10	$ 369.61	$130,036,270	$113,328,709
Dollar Impact					($16,707,560)
Percentage Impact					-12.85%

X. CMS Rate Setting Checklist

1. Overview of rate setting methodology

AA.1.1: Actuarial certification

Please refer to Section XI.

AA.1.2: Projection of expenditure

Please refer to Section IX.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Sole Source 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 MCO Profit
<=3%	100%	0%	3%
>3% and <=5%	75%	25%	1.5%
>5% and <=7%	50%	50%	1.0%
>7% and <=9%	25%	75%	0.5%
>9%	0%	100%	0%
Total			6.0%

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

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 VIII.

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 Contractors specifies that Contractors 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 and III.

AA.3.1 Benefit differences

There are no changes to the covered benefits. Therefore, no adjustment was made.

AA.3.2 Administrative cost allowance calculation

Please refer to Section VIII.

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. See Section III.

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 FFY11 encounter data was assumed to be 95% complete; therefore a completion factor was added.

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 a reconciliation for the CRS population.

7. Incentive Arrangements

At this time there are no incentive arrangements.

XI. 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, 2012.

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.

Matthew C. Varitek — 08.29.2012

Matthew C. Varitek — Date

Fellow of the Society of Actuaries
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