Comprehensive Medical and Dental Program (CMDP)
Actuarial Memorandum

I. Purpose

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.

This memorandum presents a discussion of the revision to the CMDP capitation rates which were developed as a rate rebase. These capitation rates represent the twelve month contract period from July 1, 2015 through June 30, 2016 (SFY 16). CMDP is a division of the state's Department of Child Safety (DCS) and thus operates on the state fiscal year period.

II. General Program Information

CMDP is a program within the DCS that is responsible for managing the health care needs for children who are: a) placed in a foster home; b) in the custody of DCS and placed with a relative, in a certified adoptive home prior to the final order of adoption, or in an independent living program as provided in A.R.S. §8-512; and c) in the custody of the Arizona Department of Juvenile Corrections (ADJC) or the Administrative Office of the Courts/Juvenile Probation Office (AOC/JPO) and placed in foster care.

III. Overview of Rate Setting Methodology

SFY 16 actuarially sound capitation rates were developed utilizing the steps outlined as follows:

1. Develop base period data (Section IV)
2. Adjust base period data for subsequent changes to the program benefits and the provider fee schedule, if applicable (Section IV)
3. Develop trend factors (Section V)
4. Apply trend factors to bring base period data forward (Section VI)
5. Adjust trended data for program and provider fee schedule changes, if applicable (Section VII)
6. Add provision for reinsurance and third party liability (Section VIII)
7. Add provision for non-benefit costs (Section IX)
8. Combine for final capitation rates (Section X)

IV. Base Period Experience

CMDP has a relatively small membership base which is located statewide. Ideally, the experience should be analyzed by different rate cells, which are comprised of members with similar risk characteristics; however, segregating the CMDP population into different rate cells would lead to a statistical credibility problem. Therefore, Arizona Health Care Cost Containment System (AHCCCS) believes that having only two rate cells, Prospective and Prior Period Coverage (PPC), is more actuarially sound than creating more rate cells.

Since CMDP has a relatively small membership base, multiple years and sources of data were used to increase the statistical credibility. For SFY 16 rate development, CMDP's encounter data was found to be credible in aggregate, as compared with CMDP financial reporting. The base year experience is the 2012 state fiscal year (SFY 12), 2013 state fiscal year (SFY 13), and 2014 state fiscal year (SFY 14) encounter data for both Prospective and Prior Period Coverage (PPC) CMDP members. The PMPM claim costs observed for all categories of service were completed as appropriate and then adjusted to reflect program changes and reimbursement reductions that were effective subsequent to the experience periods used.

The experience only includes CMDP Medicaid eligible expenses for CMDP Medicaid eligible individuals. In addition, the experience includes reinsurance amounts. PPC rates are reconciled to a maximum of 2% profit or loss. There are no other incentives or risk sharing arrangements.

V. Projected Trend Rates

The trend analysis includes encounter experience from July 2011 through June 2014 (state fiscal years 12-14). In addition to using encounter data, AHCCCS used information from CMS National Health Expenditure (NHE) Report estimates. The trend analysis considered historical changes in AHCCCS' Professional and Outpatient Fee Schedules, Dental Fee Schedule, Transportation Schedule, and estimates of the impact of various changes to benefits and reimbursement levels. AHCCCS developed PMPM trend estimates using the encounter data. These trends were calculated by category of service (COS) and weighted to an overall medical expense trend. The PMPM trends calculated from experience data for the Inpatient and Pharmacy COS do not appear reasonably predictive of future expenditures. More recent experience suggests the large negative PMPM trend observed during the base period on inpatient services, and the large positive PMPM trend observed on pharmacy services, are not expected to continue in future years. As such, AHCCCS is using the NHE estimates of Medicaid expenditures for 2015 and 2016 to develop the trend assumptions for those COS. For the remaining COS, several of which are small and volatile, AHCCCS calculated a single trend assumption to apply to each COS. The single trend rate for the remaining COS, weighted with the NHE-based trends for Inpatient and Pharmacy, combines to the overall PMPM trend rate calculated from the experience data prior to any COS adjustments. As noted in Section IV, this overall trend rate was deemed reasonable when compared with results from financial reporting and past years' trend assumptions.

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

Table I :Prospective and PPC Average Annual Trend Rate

Service Category	Average Annual Trend	
	Prospective	PPC
Hospital Inpatient	1.8%	1.8%
Physician	4.2%	-4.9%
Emergency Services	4.2%	n/a
Pharmacy	3.6%	n/a
Lab, X-ray, & med image	4.2%	n/a
Outpatient Facility	4.2%	n/a
Durable Med Equip	4.2%	n/a
Dental	4.2%	n/a
Transportation	4.2%	n/a
NF, Home HC	4.2%	n/a
PT, Other Prof, Misc Med	4.2%	-4.9%

VI. Projected Gross Claim PMPM

The claims PMPMs were trended from the weighted midpoint of the base claims period to the midpoint of the projected claims period. The midpoint of the projected claims period is January 1, 2016. In developing the average claims PMPM for the base period, more weight was given to the PMPM for state fiscal year 2014 and less weight was given to the PMPM for state fiscal year 2012. Thus the weighted midpoint of the base claims period is May 1, 2013.

VII. Programmatic Changes

No program changes will take effect at this time. AHCCCS intends to review and possibly update the CMDP capitation rates effective October 1, 2015 to include changes to various acute care categories of service. This capitation rate update for July 1, 2015 does not include adjustments for anticipated reimbursement changes or program changes with effective dates after July 1, 2015. If appropriate, AHCCCS will include these adjustments in the capitation rates updated effective October 1, 2015.

VIII. Projected Net Claim PMPM

The projected gross claim PMPMs were adjusted for the reinsurance offset and third party liability to obtain the net claim PMPM. For PPC, all categories of service other than Physician and Hospital Inpatient are rolled up into one line for credibility purposes. There is no reinsurance offset or third party liability for PPC. For Prospective, the estimated reinsurance offset and third party liability is $6.56 PMPM. The projected net claim PMPMs are as follows:

Table II: Projected Net Claim PMPM

Service Category	Projected SFY 16 Claim Cost PMPM	
	Prospective	PPC
Hospital Inpatient	$24.16	$217.96
Physician	$59.10	$74.51
Emergency Services	$13.44	$0.00
Pharmacy	$27.85	$0.00
Lab, X-ray, & med image	$5.86	$0.00
Outpatient Facility	$33.55	$0.00
Durable Med Equip	$14.70	$0.00
Dental	$36.04	$0.00
Transportation	$4.80	$0.00
NF, Home HC	$0.22	$0.00
PT, Other Prof, Misc Med	$0.92	$68.48
Total	$220.66	$360.94
Less Reinsurance & TPL	($6.56)	$0.00
Net Claim Cost	$214.10	$360.94

IX. Administrative Expenses

The PMPM administrative expense decreased from $32.55 to $32.46. The proposed administrative expense is based on actual and projected administrative data provided by CMDP as well as financial statement data and expected future administrative expenses.

X. Proposed Capitation Rates and Their Impacts

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VIII) and the projected administrative expenses PMPM (in section IX), divided by one minus the two percent premium tax. Table III below shows the current and proposed capitation rates and the budget impact from SFY 15 (04/01/15 capitation rate) to SFY 16 using the same projected membership base.

Table III: Proposed Capitation Rates and Budget Impact

Rate Cell	Prospective	PPC	Total
Projected SFY 16 Member Months	200,770	5,711	
SFY 15 Rate (4/1/15 - 6/30/15)	$248.27	$471.05	
SFY 16 Rate	$251.59	$401.43	
Estimated SFY 15 Capitation	$49,845,188	$2,690,356	$52,535,544
Estimated SFY 16 Capitation	$50,511,744	$2,292,728	$52,804,472
Dollar Impact	$666,556	($397,628)	$268,928
Percentage Impact	1.3%	-14.8%	0.5%

XI. Coordination of Benefits

While this section does not directly impact the capitation rate development it is important to note the efforts made by the State and the Contractors when it comes to coordination of benefits. 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, the Contractors submit encounters for these amounts. From state fiscal year (SFY) 2008 through SFY 2014, encounter-reported Coordination of Benefits (COB) cost avoidance grew from $7,500 to $179,000. AHCCCS continues to emphasize the importance of COB activities with the Contractor.

XII. CMS Rate Setting Checklist

1. Overview of rate setting methodology

AA.1.1: Actuarial certification

Please refer to Section XIII.

AA.1.2: Projection of expenditure

Please refer to Section X.

AA.1.3: Procurement, prior approval and rate setting

This is a sole source contracting method, between AHCCCS and CMDP.

AA.1.5: Risk contract

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

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 Section VIII.

2. Base Year Utilization and Cost Data

AA.2.0: Base year utilization and cost data

Please refer to Section IV.

AA.2.1: Medicaid eligibles under the contract

There are no dual eligibles.

AA.2.2: Spenddown

Not applicable, not covered under this contract.

AA.2.3: State plan services only

The contract between AHCCCS and CMDP specifies that CMDP may cover additional services. Non-covered services were excluded from the base data and not included in 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 IV.

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 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)

Please refer to Section VIII.

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 V.

AA.3.11 Utilization adjustment

Other than trend, no specific adjustment was made to utilization. Furthermore, the experience was not broken down into utilization rate and cost per unit.

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.

Completion factors were applied to encounter data as appropriate.

4. Establish Rate Category Groupings

AA.4.0: Establish rate category groupings

Please refer to Section IV.

AA.4.1: Age

Please refer to Section IV.

AA.4.2: Gender

Please refer to Section IV.

AA.4.3: Locality/region

Please refer to Section IV.

AA.4.4: Eligibility category

Please refer to Section IV.

5. Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0: Data smoothing

Please refer to Section IV and V.

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

Please refer to Section IV.

AA.5.2: Cost-neutral data smoothing adjustments

Please refer to Section V.

AA.5.3: Risk-adjustment

There is no other risk adjustment, except for PPC reconciliation.

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

Please refer to Section VIII.

AA.6.3: Risk corridor program

There is no risk sharing between AHCCCS and CMDP, except the stop loss program and PPC reconciliation. CMDP assumes all other risks.

7. Incentive Arrangements

There is no incentive arrangement between AHCCCS and CMDP.

XIII. Actuarial Certification of the Capitation Rates

I, Matthew C. 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 capitation rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The capitation 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 capitation rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The capitation 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 July 1, 2015.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by CMDP and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the CMDP 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 CMDP program, Medicare and Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS, CMDP 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.

Signature on File	May 15, 2015
Matthew C. Varitek	Date

Fellow of the Society of Actuaries
Member, American Academy of Actuaries