MERCER

Mike Nordstrom, ASA, MAAA
Partner

Government Human Services Consulting
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 6500
mike.nordstrom@mercer.com
www.mercer.com

Mr. David Reese
Chief Financial Officer
Arizona Department of Health Services
Division of Behavioral Health Services
150 N. 18th Avenue, Suite 200
Phoenix, AZ 85007

April 15, 2011

Subject: Behavioral Health Services State Fiscal Year 2012 Capitation Rates for the Title XIX Program

Dear Mr. Reese:

The State of Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rates for each of its Regional Behavioral Health Authorities (RBHAs) for State Fiscal Year 2012 (SFY12). Rates were developed for the Title XIX program.

Provider reimbursement and other population and benefit adjustments

AHCCCS is anticipating implementation of significant reductions to provider reimbursement via rate reductions, and several population and benefit adjustments, effective October 1, 2011. Many of these adjustments are likely to impact behavioral health capitation rates as well. For clarity, none of the potential adjustments described within this paragraph are included in what follows.

I. Introduction/Background

There are four RBHAs for which actuarially sound capitation rates were developed, covering six geographic service areas. They include:

RBHA	Area(s) Served
Community Partnership of Southern Arizona (CPSA)	Pima County
Cenpatico Behavioral Health of Arizona (Cenpatico 2, Cenpatico 3 and Cenpatico 4)	Yuma, LaPaz, Graham, Greenlee, Santa Cruz, Cochise, Pinal and Gila counties
Northern Arizona Regional Behavioral Health Authority (NARBHA)	Mohave, Coconino, Apache, Navajo and Yavapai counties
Magellan Health Services (MHS)	Maricopa County

II. Overview of rate-setting methodology

Mercer assisted BHS with the development of a risk-based capitation rate methodology for RBHAs that complies with the Centers for Medicare & Medicaid Services (CMS) requirements and the regulations under the Balanced Budget Act of 1997. As it relates to the rate-setting methodology checklist and Medicaid managed care regulations (42 CFR 438.6) effective August 13, 2002, CMS requires that capitation rates be “actuarially sound.” CMS defines actuarially sound rates as meeting the following criteria:

- Have been developed in accordance with generally accepted actuarial principles and practices
- Are appropriate for the populations to be covered and the services to be furnished under the contract
- Have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board

Actuarially sound capitation rates were developed for the contract period July 1, 2011, through June 30, 2012, covering SFY12. Mercer has utilized actuarially sound principles and practices in the development of these capitation rates.

The goal of capitation rate development is to take experience that is available during the base period and convert that experience, using actuarial principles, into appropriate baseline data for the contract period. Once the baseline data is determined, adjustments including

trend, any unusual service utilization changes and provisions for administration, and underwriting profit/risk/contingency are applied in order to determine actuarially sound capitation rates. The capitation rate development process was divided into the following steps.

1. Calculate base data
   - Collect, analyze and adjust SFY10 RBHA financial statements, as well as SFY10 RBHA-submitted encounter data
   - Utilize actual member months from SFY10 and the adjusted SFY10 total claim costs to calculate adjusted SFY10 per-member-per-month (PMPM) values
   - Apply any budget-neutral relational modeling factors (see Section IV)

2. Calculate SFY12 actuarially sound rates
   - Apply trend factors to bring Base SFY10 claim costs forward to SFY12
   - Adjust for any changes occurring between the base period and prior to the contract period [such as First 72 Hours Inpatient Coverage, Prior Period Coverage (PPC), Copayments and the April 1, 2011, Provider Fee Schedule (Rate) Reduction]
   - Apply acuity adjustment (if necessary) to account for changes in behavioral health penetration rates
   - Certify actuarial equivalence of the populations
   - Add provisions for administration and underwriting profit/risk/contingency

The end result of this capitation rate development process, completed jointly by BHS and Mercer, is actuarially sound capitation rates for SFY12.

Actuarially sound capitation rates were developed for each of the following population and RBHA combinations, shown in the next table.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Children – non-CMDP	$34.01	$47.54	$44.24	$36.94	$48.88	$30.38	$35.37
Children – CMDP	$1,546.41	$1,214.47	$1,171.09	$1,584.21	$716.02	$712.10	$928.46
SMI	$43.84	$59.15	$30.58	$38.20	$42.46	$86.05	$66.20
GMH/SA	$27.81	$48.72	$42.06	$27.13	$53.20	$33.42	$36.16

The rate development schedules are shown in Attachment A.

III. Base data

The base data consisted of adjusted financial statements from all RBHAs for the July 1, 2009, through June 30, 2010, time period. The financial statement expenses were reduced by the following factor for each RBHA and population: a 0.5% reduction for assumed RBHA increased efficiency and effectiveness in the management of service utilization. This 0.5% reduction decreased total costs by $4,857,801.

Two changes which took place during SFY10 needed to be incorporated within the SFY10 base costs since their financial impact was not fully reflected within the RBHA financial statements due to ramp-up during the course of the year. The two adjustments are for High Needs Children and Transition Age Youth. Both of these adjustments are now complete, so for the SFY13 capitation rates utilizing SFY11 base data, there will be no need for these separate additional components.

High Needs Children

The High Needs Children service expansion added additional case managers throughout the State to continue progress towards the goal of one case manager for every 15 high needs children. Of these case managers, the vast majority are behavioral health technicians and the remainder are behavioral health professionals. Adequate case management is required to coordinate the variety of necessary covered behavioral health services, especially for children with complex needs.

The incremental PMPM increases applied to the non-CMDP and CMDP Children's populations for this utilization adjustment are as follows.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Non-CMDP	$0.43	$0.64	$1.05	$0.50	$0.80	$0.06	$0.29
CMDP	$21.37	$13.51	$30.03	$24.74	$15.57	$1.73	$8.05

The statewide impact to the program for the incremental High Needs Children adjustment is an increase of approximately $2,926,875. The PMPMs and dollars are down significantly from those incorporated within the SFY11 capitation rates since a large portion of the costs are already reflected within the SFY10 financial statements.

Transition Age Youth

The Jason K. Settlement Agreement stipulates that class members shall have services though age 20. In Arizona, at the age of 18, young adults enrolled in the public behavioral health system are transferred from the Children's system to the Adult system. While enrolled in the Children's behavioral health system, they have the benefit of a case manager to assist in service planning and coordination of services, and are able to utilize an array of covered services to support them and their family in learning to cope with their behavioral health issues. This funding allows for these services to be more fully utilized by the individual in the Adult system, by providing case managers and generalist support services similar to those received in the Children's system.

The incremental PMPM increases applied to the SMI and GMH/SA populations for this utilization adjustment are as follows.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
SMI	$0.02	$0.02	$0.02	$0.01	$0.02	$0.01	$0.01
GMH/SA	$0.32	$0.34	$0.43	$0.23	$0.44	$0.26	$0.29

The statewide impact to the program for the incremental Transition Age Youth adjustment is an increase of approximately $2,137,500. The PMPMs and dollars are down significantly from those incorporated within the SFY11 capitation rates since a large portion of the costs are already reflected within the SFY10 financial statements.

Zip code changes

In addition, effective July 1, 2010, there were adjustments to the zip codes included in each of the geographic service areas. This change was made in order to achieve consistency with the geographic service areas in the AHCCCS program. Base data was appropriately shifted to reflect changes/updates to the geographic service areas. The overall net impact on the base data across all RBHAs was budget neutral.

The following table shows the base data adjustment for the zip code changes by RBHA and population:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS
Children – non-CMDP	$0.11	($0.01)	$0.00	($0.16)	($10.41)	$0.90
Children – CMDP	$0.00	$0.00	$0.00	$0.00	($87.48)	$9.08
SMI	$0.01	$0.00	$0.00	$0.00	($4.19)	$0.44
GMH/SA	$0.01	$0.01	($0.05)	$0.00	($5.56)	$0.59

Encounter data completeness

BHS has for several years stressed the importance of timely and accurate encounter data submission by the RBHAs for capitation rate setting (among other valuable uses). An adjustment to the base data was made which incorporated the relative level of completeness of the encounter data submitted by the RBHAs. Two GSAs were found to have relatively low encounter data dollar amounts submitted. As a result, a 0.98 factor was applied to both of these GSA's adjusted base data. This adjustment was uniform across all four populations. No encounter data adjustments were made to the remaining four GSAs. The total statewide dollar impact of the adjustment was $4,519,952.

"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/ALS/OBHL, in lieu of services in an inpatient non-specialty hospital, with unit cost savings of approximately 48.3% and total yearly cost savings of approximately $200,000. These savings are already reflected in the base data.

The following table shows the base data PMPM for in lieu of services by RBHA:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS
Title XIX	$0.00	$0.01	$0.00	$0.01	$0.01	$0.01

BHS has periodically performed reviews of the RBHA-submitted data and has determined that the data does not include any other non-covered services.

IV. Budget neutral relational modeling

While in aggregate the population and adjusted financial data were fully credible in the base period, there were distortions between CMDP and non-CMDP Children which required additional smoothing. Mercer applied budget neutral relational modeling to account for these variances. No dollars were gained or lost through this process.

V. Trend

Trend is an estimate of the change in the cost of providing a specific set of benefits over time, resulting from both unit cost (price) and utilization changes. Trend factors are used to estimate the cost of providing services in some future year (contract year) based on the cost incurred in a prior (base) year.

In order to determine actuarially sound capitation rates, Mercer projected the base data forward to reflect utilization and unit cost trend by population. Mercer calculated trends from the historical financial and encounter data. The historical data that was used as a basis for trend development did not appropriately reflect the costs related to the separate service utilization and fee schedule changes described below. Mercer also utilized its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs. Although the trends were developed using several years of historical data, the trend factors were applied only to the SFY10 base data, bringing it forward 24 months to SFY12. The following trend estimates were used for the capitation rates.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Children – non-CMDP	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Children – CMDP	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
SMI	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
GMH/SA	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%

VI. Service utilization and fee schedule changes

BHS and Mercer reviewed changes made during SFY11 that would unusually affect service utilization or provider unit cost. It was determined that due to expected changes in utilization or unit cost of specific existing covered services, adjustments to the base data would need to be made to account for these changes.

SFY11

The following adjustments have taken place during the contract period of SFY11.

First 72-hours coverage

Effective October 1, 2010, the first 72 hours of inpatient coverage became the financial responsibility of the contracted RBHAs. Historically, Arizona Medicaid (AHCCCS) acute care health plans had been financially responsible for the first 72 hours of inpatient coverage. This adjustment represents a shift of dollars from the AHCCCS program contractors to the RBHAs. No material SFY10 child dollars (non-CMDP or CMDP) were found within the data, so no adjustment was made for those populations.

The PMPM increases applied to the SMI and GMH/SA populations for this utilization adjustment are as follows:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
SMI	$0.00	$0.07	$0.00	$0.00	$0.01	$0.05	$0.04
GMH/SA	$0.01	$0.18	$0.02	$0.01	$0.05	$0.11	$0.09

The statewide impact to the program for this adjustment is an increase of approximately $985,304.

Prior period coverage

Effective October 1, 2010, AHCCCS acute care health plans were no longer responsible for behavioral health services provided during the PPC timeframe. These services became the responsibility of ADHS and are now part of the BHS capitation rate. This change results in a statewide decrease to the acute care program of approximately $4.3 million and increases the BHS program by the same amount.

The PMPM increases applied to the non-CMDP Children and GMH/SA populations for this utilization adjustment are as follows:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Children – Non-CMDP	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01	$0.01
GMH/SA	$0.30	$1.29	$0.14	$0.14	$0.16	$0.55	$0.55

Copayments

Effective October 1, 2010, AHCCCS implemented hard (mandatory) copayments on certain services for adults in the Transitional Medical Assistance Program (TMA). In addition, AHCCCS modified soft copayments (non-mandatory) for adults in the non-TMA/non-TWG Title XIX population. These copayments were minimal and no adjustments were made as a result. However, effective November 1, 2010, AHCCCS reinstated hard copays for adults in the MED and non-MED populations (collectively TWG), after a long-standing court injunction on TWG copays was lifted. There are a myriad of exclusions for adult copays related to both specific services and specific members as detailed in contract. The estimated savings resulting from these copayments are approximately $1.3 million statewide.

The PMPM decreases applied for this unit cost adjustment are as follows.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
GMH/SA	($0.17)	($0.17)	($0.17)	($0.17)	($0.17)	($0.17)	($0.17)

Provider fee schedule reduction effective 4/1/11

BHS implemented a 5% provider rate decrease effective April 1, 2011, for all provider types, excluding inpatient and pharmacy. The PMPM decreases applied to the Title XIX populations for this unit cost adjustment are as follows.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Non-CMDP	($1.34)	($1.86)	($1.88)	($1.52)	($1.80)	($1.14)	($1.37)
CMDP	($63.32)	($53.27)	($61.35)	($61.37)	($29.05)	($26.91)	($37.62)
SMI	($1.48)	($1.68)	($1.19)	($1.06)	($1.53)	($3.11)	($2.26)
GMH/SA	($0.99)	($1.56)	($1.62)	($0.89)	($1.62)	($0.98)	($1.13)

The statewide impact to the program for the Provider Rate Reduction adjustment is a decrease of approximately $39,770,353 for SFY12.

VII. Behavioral health penetration – Acuity adjustment

A slight decrease in penetration in many populations of the behavioral health program has been observed and is projected for these populations. Smaller proportions of those eligible are accessing the behavioral health system in these instances. The decreases in many of the populations have contributed to the overall projected decrease in utilization for these populations and are reflected in overall claim costs. These changes, as well as any projected increase in penetration, were applied as an acuity adjustment to the SFY12 PMPM claim costs, and represent a difference due to decreased or increased penetration (those enrolled, compared to those eligible). This component of the rate development does not adjust for any normal unit cost or utilization trends, which are handled above.

The acuity factors that were applied are as follows.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS
Children – non-CMDP	1.028	1.014	1.046	1.006	1.019	1.013
Children – CMDP	1.013	1.005	1.005	0.989	1.062	0.976
SMI	1.000	0.998	0.965	1.000	0.996	0.990
GMH/SA	0.992	1.016	0.996	1.000	0.998	0.991

The statewide impact to the program for the acuity adjustment is a decrease of approximately $1,593,894.

VIII. Interpretive services administration

The actuarially sound capitation rates developed include provisions for RBHA interpretive services administration. Interpretive services are covered by TXIX and are provided by the RBHAs to TXIX members. The interpretive services administrative factors were determined based on aggregate RBHA first half SFY11 financial experience. A consistent percentage by population was applied to each RBHA.

Population	Children – non-CMDP	Children - CMDP	SMI	GMH/SA
All TXIX	1.56%	0.11%	0.23%	0.44%

The statewide impact to the program for interpretive services is an increase of approximately $6,286,346.

IX. Administration and underwriting profit/risk/contingency

The actuarially sound capitation rates developed include provisions for RBHA administration. Mercer used its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs in determining appropriate loads for administration and underwriting profit/risk/contingency. Mercer also reviewed current RBHA financial reports. The component for administration and underwriting profit/risk/contingency is calculated as a percentage of the final capitation rate. A 9% load was added across all populations, which is the same as was applied to the SFY11 rates.

X. Risk corridors and performance incentive

BHS has in place a risk corridor arrangement with the RBHAs that provides motivation for the RBHAs to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for the RBHAs to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

The proposed SFY12 BHS risk corridor approach provides for gain/loss risk-sharing symmetry around the service revenue portion of the capitation rates. This risk corridor model is designed to be cost neutral, with no net aggregate assumed impact across all payments. The RBHAs' contracts also provide for a potential 1% performance incentive. In Mercer's professional opinion, the risk corridor and performance incentive methodologies utilized by BHS are actuarially sound.

XI. Tribal FFS claims estimate

Mercer received and reviewed projected SFY12 tribal claims data from BHS. In addition, an adjustment for the shift of responsibility for the PPC timeframe from AHCCCS to ADHS was made. This adjustment totaled $18,840. Based on this information, Mercer and BHS project that Title XIX tribal claim costs for SFY12 will be approximately $73 million.

XII. BHS administration/risk/contingency

AHCCCS has placed BHS Administration at financial risk for the provision of BHS covered services for SFY12. Accordingly, the capitation rates were developed to include compensation to BHS for the cost of ensuring the delivery of all BHS covered services. The capitation rates paid to BHS include a 3.41% load, which was negotiated between AHCCCS and BHS Administration. The load represents 2% premium tax and a 1.41% administrative load for the BHS costs of ensuring the efficient delivery of services in a managed care environment.

XIII. Development of statewide capitation rates

Statewide capitation rates were developed by blending the SFY12 capitation rates for each RBHA using projected SFY12 member months, the estimated dollar amount of SFY12 tribal claims and the administrative percentage add-on component for BHS.

The statewide capitation rates are shown in Attachment B.

XIV. CMS rate-setting checklist (July 22, 2003)

Item #/Description	**Reference to certification letter language**
AA.1.0 Overview of rate-setting methodology	Sections I – II
AA.1.1 Actuarial certification	Section XV
AA.1.2 Projection of expenditures	Attachment C
AA.1.3 Procurement, prior approval and rate setting	Contract
AA.1.5 Risk contracts	Contract
AA.1.6 Limit on payment to other providers	Contract
AA.1.7 Rate modifications	N/A
AA.2.0 Base Year Utilization and Cost Data	Sections III and IV
AA.2.1 Medicaid Eligibles under the contract	Section III
AA.2.2 Dual Eligibles	Contract
AA.2.3 Spend-down	N/A
AA.2.4 State Plan Services only	Section III
AA.2.5 Services that may be covered by a capitated entity out of contract savings	N/A
AA.3.0 Adjustments to the Base Year Data	Sections V – XII
AA.3.1 Benefit differences	N/A

Item #/Description	Reference to certification letter language
AA.3.2 Administrative cost allowance calculations	Sections VIII, IX and XII
AA.3.3 Special populations' adjustments	Section XI
AA.3.4 Eligibility adjustments	N/A
AA.3.5 DSH payments	N/A
AA.3.6 Third Party Liability	Contract
AA.3.7 Copayments, Coinsurance and Deductibles in capitated rates	Contract
AA.3.8 Graduate Medical Education	N/A
AA.3.9 FQHC and RHC reimbursement	Contract
AA.3.10 Medical Cost/Trend inflation	Sections V
AA.3.11 Utilization adjustments	Section VI and VII
AA.3.12 Utilization and Cost Assumptions	N/A
AA.3.13 Post-Eligibility Treatment of Income	N/A
AA.3.14 Incomplete data adjustment	Section III
AA.4.0 Establish rate category groupings	Section II
AA.4.1 Age	Section II
AA.4.2 Gender	N/A
AA.4.3 Locality/Region	Section I
AA.4.4 Eligibility categories	Section II
AA.5.0 Data smoothing	Section III
AA.5.1 Special Populations and assessment of the data for distortions	Section IV
AA.5.2 Cost-neutral data smoothing adjustment	Section IV
AA.5.3 Risk adjustment	N/A
AA.6.0 Stop Loss, Reinsurance, or Risk-Sharing arrangements	Section X
AA.6.1 Commercial Reinsurance	N/A
AA.6.2 Simple stop loss program	N/A
AA.6.3 Risk corridor program	Section X
AA.7.0 Incentive arrangements	Section X

XV. Certification of final rates

In preparing the rates shown above and attached, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by BHS and the RBHAs. BHS and the RBHAs are responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the above and attached rates, including risk-sharing mechanisms, incentive arrangements, or other payments, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates developed by Mercer are actuarial projections of future contingent events. Actual RBHA costs will differ from these projections. Mercer has developed these rates on behalf of BHS to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

RBHAs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by the RBHAs for any purpose. Mercer recommends that any RBHA considering contracting with BHS should analyze its own projected medical expense, administrative expense and other premium needs for comparison to these rates before deciding whether to contract with BHS.

This certification letter assumes the reader is familiar with the BHS program, Medicaid eligibility rules and actuarial rating techniques. It is intended for BHS 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.

If you have any questions concerning our rate setting methodology, please feel free to contact me at 602 522 6510.

Sincerely,

Michael E. Nordstrom, ASA, MAAA
Partner

MEN:lgm

Enclosures

Copy:
Cynthia Layne, ADHS
Sundee Easter, Mercer
Mike Miner, Mercer
Rob O'Brien, Mercer