Comprehensive Medical and Dental Program (CMDP)
Actuarial Memorandum

I. Purpose:

The purpose of this actuarial memorandum is to demonstrate that the Comprehensive Medical and Dental Program (CMDP) 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 adjustment to the capitation rates effective from January 1, 2014 through December 31, 2014 (CYE 14).

II. Base Period Experience:

Since CMDP has a relatively small membership base, multiple years and sources of data were used to increase the statistical credibility. For CYE 14 rate development, CMDP's encounter data was found to be credible for all service categories. The base year experience is the 2011 federal fiscal year (FFY 11) and 2012 federal fiscal year (FFY 12) encounter data for both prospective and Prior Period Coverage (PPC) CMDP members. The 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.

Trend rates were calculated from the encounter data and other sources on a unit cost and/or utilization basis by category of service (COS) and a cap was applied to limit the negative and positive trends to a reasonable level. Other data sources include Contractor financial statements, Center for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) Report estimates, AHCCCS fee for service (FFS) provider rate changes and Global Insight Prospective Hospital Market Basket Inflation Index (GI) information. No adjustment was made other than those described.

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 due to CMDP's relatively small membership base. Therefore, AHCCCS believes that having only two rate cells, prospective and PPC, is more actuarially sound than creating more rate cells.

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.

In general, the base period claim PMPMs are trended to the midpoint of the effective period or July 1, 2014. The next step involves adjusting for program changes and reinsurance offset. In the final step, the projected administrative expenses 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 Rates

The trend analysis includes encounter experience from October 2009 through September 2012. In addition to using encounter data, AHCCCS used information from CMS NHE Report estimates, GI information, and the trend analysis considered changes in AHCCCS' Professional and Outpatient Fee Schedules, Dental Fee Schedule, Transportation Schedule and other sources. AHCCCS developed utilization and unit cost trend estimates using the encounter data. These trends were developed by major category of service (COS), with a cap on the percentage increase and decrease to smooth out unreasonable trends. Once these trends were developed they were analyzed by comparing the results to the assumptions made for other AHCCCS programs.

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	3.0%	7.2%
Physician	0.4%	7.0%
Emergency Services	8.6%	n/a
Pharmacy	0.0%	n/a
Lab, X-ray, & med image	-1.0%	n/a
Outpatient Facility	7.8%	n/a
Durable Med Equip	10.0%	n/a
Dental	3.0%	n/a
Transportation	6.0%	n/a
NF, Home HC	9.5%	n/a
PT, Other Prof, Misc Med	5.0%	3.7%

IV. 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 July 1, 2014. The weighted midpoint of the base claims period varies by COS according to the weight assigned to each year in the base period.

V. State Mandates, Court Ordered Programs and Program Changes

No changes will take effect at this time.

VI. 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 through SFY 2013, encounter-reported COB cost avoidance grew from $7,500 to $554,000. AHCCCS continues to emphasize the importance of COB activities.

VII. Projected Net Claim PMPM

The projected gross claim PMPMs were adjusted for the program changes and reinsurance offset to obtain the net claim PMPM. There is no reinsurance offset or third party liability for PPC. For Prospective, the estimated reinsurance offset and third party liability is $9.48 PMPM. The projected net claim PMPMs are as follows:

Table II: Projected Net Claim PMPM

Service Category	Projected CYE 14 Claim Cost PMPM	
	Prospective	PPC
Hospital Inpatient	$29.18	$221.21
Physician	$42.81	$90.61
Emergency Services	$13.91	$0.00
Pharmacy	$22.58	$0.00
Lab, X-ray, & med image	$5.43	$0.00
Outpatient Facility	$37.37	$0.00
Durable Med Equip	$14.94	$0.00
Dental	$33.43	$0.00
Transportation	$4.78	$0.00
NF, Home HC	$0.33	$0.00
PT, Other Prof, Misc Med	$0.17	$100.59
Total	$204.93	$412.41
Less Reinsurance & TPL	($9.48)	$0.00
Net Claim Cost	$195.45	$412.41

VIII. Administrative Expenses

The PMPM administrative expense increased from $26.56 to $28.53 due to substantial membership growth and increased coordination of care with other AHCCCS programs. Both issues require additional hiring for administrative needs. 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.

IX. Proposed Capitation Rates and Their Impacts

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VII) and the projected administrative expenses PMPM (in section VIII), divided by one minus the two percent premium tax. Table III below shows the current and proposed capitation rates and the budget impact from CYE 13 to CYE 14 using the same membership base.

Table III: Proposed Capitation Rates and Budget Impact

Rate Cell	Projected CYE 14 Member Months	CYE 13 Rate (10/1/13 - 12/31/13)	CYE 14 Rate	Estimated CYE 13 Capitation	Estimated CYE 14 Capitation	Dollar Impact	Percentage Impact
Prospective	175,677	$223.79	$228.55	$39,314,746	$40,150,968	$836,222	2.1%
PPC	4,280	$370.18	$449.94	$1,584,245	$1,925,591	$341,346	21.5%
Total				$40,898,991	$42,076,559	$1,177,568	2.9%

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

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 payments to providers, except supplemental payments to hospitals including Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments, and Critical Access Hospital payments. GME is paid in accordance with state plan. DSH and Critical Access 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 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: Dual Eligibles (DE)

There are dual eligibles

AA.2.3: Spenddown

Not applicable, not covered under this contract.

AA.2.4: 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.2.5: Services that can be covered by a capitated entity out of contract savings.

Same as AA.2.4

3. Adjustments to the Base Year Data

AA.3.0 Adjustments to base year data

Please refer to Section II.

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 its 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 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.4.3: Locality/region

Please refer to Section II.

AA.4.4: 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

Please refer to Section II.

AA.5.2: Cost-neutral data smoothing adjustments

Please refer to Section VII.

AA.5.3: Risk-adjustment

There is no other risk adjustment.

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 VII.

AA.6.3: Risk corridor program

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

7. Incentive Arrangements

There is no incentive arrangement between AHCCCS and CMDP.

XI. 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 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 January 1, 2014.

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 CMDP and AHCCCS internal database. 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.

Matthew C. Varitek 11.22.2013

Matthew C. Varitek Date

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