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, 2011 through December 31, 2011 (CYE11).

AHCCCS is anticipating implementation of significant reductions to inpatient and outpatient hospital reimbursement via rate reductions and adult benefit limitations on April 1, 2011. Other provider types will also be impacted by sizeable rate reductions. The capitation rates for all affected risk groups will be adjusted via a contract amendment to account for the savings resulting from these reductions to hospital reimbursement and other possible services. A contract amendment including revised rates is anticipated to be submitted to CMS for approval at a later date.

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 CYE11 rate development, CMDP's encounter data was found to be credible for all service categories, except pharmacy, dental and hospital inpatient. For all service categories, except pharmacy, dental and hospital inpatient, the base year experience is the 2009 federal fiscal year (FFY09) encounter data for both Prospective and Prior Period Coverage (PPC) CMDP members. During the base data period, CMDP experienced submission problems with pharmacy encounters as its Pharmacy Benefit Manager (PBM) was not transmitting/formatting the data correctly. CMDP also experienced problems with dental and hospital inpatient encounters. Due to these issues Arizona Health Care Cost Containment System (AHCCCS) did not feel it was appropriate to fully use the pharmacy, dental or hospital inpatient encounter data as the base data. Instead of using 100%of encounters, AHCCCS used a blend of the 2009 state fiscal year (SFY09) and the 2010 state fiscal year (SFY10) financial statements for the pharmacy and dental service categories, and for hospital inpatient used a blend of FFY09 encounters, SFY09 financials and SFY10 financials.

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 financial data, Center for Medicare and Medicaid Services (CMS) National Health Expenditure Report estimates, fee schedule changes and Global Insight Prospective

Hospital Market Basket Inflation Index (GI) information. No adjustment was made other than the ones already described.

CMDP has a relatively small membership base and the members are 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, AHCCCS believes that having only two rate cells, Prospective and Prior Period Coverage (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% gain 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, 2011. The next step involves adjusting for program changes, reinsurance offset and third party liability. 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 2006 through September 2009. Where financial data is used (i.e. pharmacy, dental and hospital inpatient service categories) the data is from October 2006 through June 2010. In addition to using encounter and financial data, AHCCCS used information from CMS National Health Expenditure (NHE) Report estimates, GI information, and 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 reports and studies (for example the CMS NHE report).

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	3.7%	7.2%
Physician	5.8%	5.8%
Emergency Services	1.7%	N/A
Pharmacy	0.0%	N/A
Lab, X-ray, & med image	0.3%	N/A
Outpatient Facility	5.1%	N/A
Durable Med Equip	0.1%	N/A
Dental	0.0%	N/A
Transportation	5.8%	N/A
NF, Home HC	11.3%	N/A
PT, Other Prof, Misc Med	5.0%	4.8%

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 July 1, 2011. The midpoint of the base claims period varies depending on the weighting of encounter data (FFY09 time frame) and financial data (SFY09 and SFY10).

V. State Mandates, Court Ordered Programs and Program Changes

Outlier Hospital Reimbursement Rates

This amendment of State law, passed in the 2007 legislative session, changes the methodology for the payment of claims with extraordinary operating costs per day. It stipulates that AHCCCS shall phase in, over three years, the use of the most recent statewide urban and rural average Medicare or Medicare approved cost-to-charge ratios to qualify and pay extraordinary operating costs starting October 1, 2007. Now that the phase-in is complete, those cost-to-charge ratios are updated annually. In addition, routine maternity charges are now excluded from outlier consideration. CMDP is rebased every year, therefore the base data will not include the full impact of this change and thus has been factored in. The statewide impact to the CMDP program is a savings of approximately $60,000. The statewide impact is a 0.21% decrease.

Hospital Inpatient and Outpatient Rate Freeze
State legislation, Laws 2010, 7th Special Session, Chapter 10, Section 25, mandates that "for rates effective October 1, 2010 through September 30, 2011, (AHCCCS) shall not increase the institutional or non-institutional schedule rates above the rates in effect on September 30, 2010." This produces a savings of approximately $200,000 to the CMDP program.

H1N1 Influenza
A new influenza A, H1N1, was detected in the U.S. in April 2009. In June 2009, the World Health Organization signaled that a pandemic of H1N1 flu was underway. AHCCCS contractors have been urging members to get immunized against H1N1. The CDC's Advisory Committee on Immunization Practices (ACIP) recommends that certain groups at highest risk for infection or complications be the initial targets for vaccination. Pregnant women and children are in the initial target group thus, because they make up a significant portion of the AHCCCS membership, it is anticipated that vaccination-related costs will rise in CYE 11.. AHCCCS also expects increased utilization for those members infected with H1N1, and those who have flu-like symptoms. A review of encounter data for H1N1-related codes shows increased utilization over prior years' regular flu- related codes. The statewide impact of H1N1-related activity in CYE11 is anticipated to be approximately $25,000.

Administration of Vaccine for Children (VFC) Vaccines
A correction to the AHCCCS Fee Schedule in 2009 resulted in an increase in payment for administration of VFC vaccines for CMDP. The full impact is not included in the base data, and therefore has been added in. The statewide impact in CYE11 is anticipated to be approximately $96,000.

Therapies
Therapies for children ages 0-3 years who are victims of a substantiated report of neglect or abuse have historically been primarily funded by other payers. Given current economic conditions, payers are shifting costs to the most appropriate payers, thus CMDP is seeing an increase in therapy utilization and payments. The statewide impact of this shift in CYE11 is anticipated to be approximately $160,000.

Human Papillomavirus (HPV) Vaccine Administration
Federal law requires that AHCCCS cover the human papillomavirus (HPV) vaccine as part of the EPSDT benefit package for all females aged 11-20. The law was recently revised to include males aged 11-20. Therefore, the costs for males aged 11-20 has been included in the CYE11 capitation rates.

For males and females through age 18, the vaccine is covered under the Vaccines for Children Program described in Section D: Program Requirements of the contract. Contractors are only responsible for the administration costs through age 18, but are responsible for both vaccine and administration above age 18.

AHCCCS estimated the added costs for males to be approximately $119,000 for CYE11.

VI. Projected Net Claim PMPM

The projected gross claim PMPMs were adjusted for the program changes, reinsurance offset, and third party liability 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 $7.70 PMPM. The projected net claim PMPMs are as follows:

Table II: Projected Net Claim PMPM

Service Category	Projected CYE11 Claim Cost PMPM	
	Prospective	PPC
Hospital Inpatient	$ 35.43	$ 240.04
Physician	$ 50.23	$ 63.23
Emergency Services	$ 10.86	$ -
Pharmacy	$ 24.01	$ -
Lab, X-ray, & med image	$ 7.28	$ -
Outpatient Facility	$ 16.41	$ -
Durable Med Equip	$ 8.73	$ -
Dental	$ 36.93	$ -
Transportation	$ 5.87	$ -
NF, Home HC	$ 1.18	$ -
PT, Other Prof, Misc Med	$ 10.82	$ 97.11
Total	$ 207.75	$ 400.38
Less Reinsurance & TPL	$ (7.70)	$ -
Net Claim Cost	$ 200.05	$ 400.38

VII. Administrative Expenses

The administrative expense increased from $27.91 to $31.37, due to a one time increase for information system upgrades. This increase is based on actual and projected administrative data provided by CMDP as well as financial statement data and expected future administrative expenses.

VIII. Proposed Capitation Rates and Their Impacts

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VI) and the projected administrative expenses PMPM (in section VII), divided by one minus the two percent premium tax. Table III below shows the current and proposed capitation rates and the budget impact from CYE10 to CYE11 using the same membership base.

Table III: Proposed Capitation Rates and Budget Impact

Rate Cell	Projected CYE11 Member	CYE10 Rate	CYE11 Rate	Estimated CYE10	Estimated CYE11	Dollar Impact	Percentage Impact
Prospective	116,169	$ 243.52	$ 236.14	$ 28,289,475	$ 27,432,148	$ (857,327)	-3.0%
PPC	2,794	$ 392.20	$ 440.56	$ 1,095,807	$ 1,230,925	$ 135,118	12.3%
Total				$ 29,385,282	$ 28,663,073	$ (722,209)	-2.5%

IX. CMS Rate Setting Checklist

1. Overview of rate setting methodology

AA.1.1: Actuarial certification

Please refer to Section X.

AA.1.2: Projection of expenditure

Please refer to Section VIII.

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 V.

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

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 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 VII.

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 VI.

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. 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.

The FFY09 encounter data was assumed to be 95% complete; therefore a completion factor was added. The audited financial statements may include outstanding claim liabilities, which were audited and believed to be reasonable by CMDP auditors.

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

Please refer to Section II.

AA.5.2: Cost-neutral data smoothing adjustments

Please refer to Section VI.

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 VI.

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.

X. Actuarial Certification of the Capitation Rates:

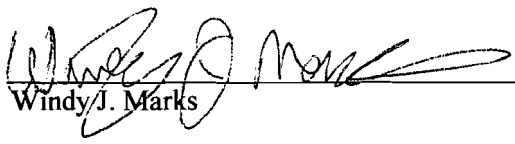
I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards 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, 2011.

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.



Windy J. Marks

12/02/10

Date

Fellow of the Society of Actuaries
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