

**Arizona Long Term Care System (ALTCS),
Department of Economic Security /Division of Developmental
Disabilities (DES/DDD) Actuarial Memorandum**

I. Purpose

This memorandum presents a revision to the capitation rates for the Arizona Long Term Care System (ALTCS)/Division of Developmental Disabilities (DDD) program, for the period October 1, 2011 to June 30, 2012. 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.

The proposed capitation rates incorporate portions of Arizona Governor Brewer's plan to preserve the State's Medicaid program with reforms that will drive down costs by an estimated \$500 million in the State General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget adoption and is subject to Federal approval. Initiatives included in the Governor's Medicaid reform plan addressed in this memorandum include limited benefit changes and reductions in provider reimbursement rates.

II. Overview of Changes

Inpatient Day Limit

As part of the Governor's Medicaid reform plan, effective October 1, 2011 AHCCCS will be limiting inpatient days to 25 days per the twelve month period of October 1 through September 30 each year for members age 21 and older. Exceptions to this limit include:

- Psychiatric stays;
- Burn diagnoses at a governmentally-operated hospital with a specialized burn unit in Maricopa County;
- Transplant stays at facilities with specialty contracts with AHCCCS, when paid as part of component pricing;
- Same day admit/discharge services; and
- Stays at IHS/638 facilities.

For adult members with Medicare, AHCCCS will continue to pay cost-sharing for Qualified Medicare Beneficiaries (QMB) when the 25 day limit is reached. AHCCCS will not pay cost-sharing for non-QMB Medicare members for days beyond the 25 day limit. The estimated statewide savings is approximately \$412,700.

Hospital Outliers

As part of the Governor's Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, language authorizing inpatient outlier payments was eliminated and AHCCCS was provided the authority to establish reimbursement methodologies "notwithstanding any other law." AHCCCS chose to maintain an outlier payment

methodology for one year – with modifications – effective October 1, 2011. Those modifications include:

- Increasing cost thresholds by 5 percent; and
- Reducing CCRs by a percentage equal to a hospital's increase to its charge master based on any/all increases since April 1, 2011.

The impact of these changes is a savings of \$163,400 statewide.

Reduction in Provider Reimbursement

As part of the Governor's Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, AHCCCS is given the authority to reduce fee schedule rates for all providers up to 5%. Therefore, effective October 1, 2011, AHCCCS will reduce all provider reimbursement, with few exceptions, by 5%, including all payment ratios utilized for provider reimbursement (e.g., all Cost-to-Charge Ratios (CCRs), By Report Percentages (BR), etc.). The decreases are included in the trend amounts by category of service as mentioned below and in total are approximately \$30.5 million statewide.

Reduction in Respite Hours

As part of the Governor's Medicaid reform plan, effective October 1, 2011, the number of respite hours for adults and children receiving ALTCS Services will be reduced from 720 to 600 hours per the twelve month period of October 1 through September 30 each year. The statewide impact of this change is \$3.7 million.

Transportation

Reductions to transportation rates effective October 1, 2011, are included in the Governor's Medicaid reform plan and authorized in Laws 2011, Chapter 31. This brings the AHCCCS reimbursement of ADHS-regulated ambulance rates to 68.59% of the approved rates. In accordance with this legislation, ambulance rate increases approved by ADHS after July 1 annually will not be included in AHCCCS' October 1 fee schedule until the following year in order to provide AHCCCS predictability in expenditures. Since ADHS approved ambulance rate increases (as requested by providers) through July 1, 2011, the impact of this reduction is less than the full 5%, at 4.8% or \$5,000

Acute Services Request for Proposal (RFP)

The acute services component of the DDD program is subcontracted to health plans via a competitive RFP process every five years. CYE12 represents an RFP year for these subcontracts. Through the competitive process, contracts were awarded with new rates for an effective date of October 1, 2011. All previous acute subcontractors were awarded contracts for the same counties in which they previously served. The result of this RFP is a 3% increase in the acute component of the capitation rates.

Projected Experience Adjustment

The projected experience adjustments are based on a comparison of YTD financial statements submitted by DDD and the July 1, 2011 capitation rates by component (i.e. institutional, HCBS, administrative expense, etc.). Any component with a differential greater than 5% was reviewed. Per this review it was determined that two components (institutional and administrative) warranted an experience adjustment. The impact of the experience adjustment on a statewide basis is -6.3% for

institutional services and -8.3% for administrative expenses, or a reduction of \$4.4 million overall.

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 2010, encounter-reported COB cost avoidance grew by greater than 123%, from \$16 million in SFY 2008 to \$36 million in SFY 10. Additionally, DDD cost-avoided more than \$23 million in additional 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.

III. Proposed Capitation Rates and Their Impacts

Table I below summarizes the changes from the current approved CYE12 capitation rates and the estimated budget impact, effective for the period October 1, 2011 through June 30, 2012 on a statewide basis.

Table I: Proposed Capitation Rates and Budget Impact

Rate Cell	Based on Projected Member Months		Based on Projected Member Months				
	October 1, 2011 - June 30, 2012		October 1, 2011 - June 30, 2012		October 1, 2011 - June 30, 2012		
		CYE12 Current Rate	CYE12 Updated Rate	Estimated CYE12 Current Capitation	Estimated CYE12 Updated Capitation	Dollar Impact	Percentage Impact
DDD	218,510	\$ 3,265.76	\$ 3,095.80	\$ 713,601,218	\$ 676,463,258	\$ (37,137,960)	-5.20%
Behavioral Health	218,510	\$ 106.23	\$ 103.31	\$ 23,212,317	\$ 22,574,268	\$ (638,049)	-2.75%
Targeted Case Management	40,077	\$ 85.96	\$ 85.96	\$ 3,445,024	\$ 3,445,024	\$ -	0.00%
Total				\$ 740,258,559	\$ 702,482,550	\$ (37,776,009)	-5.10%

DDD rate reflect full premium tax
 BH does not reflect premium tax

IV. Actuarial Certification of the Capitation Rates

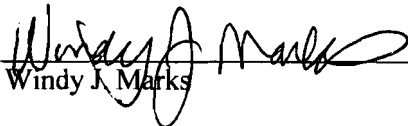
I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by 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 nine-month period beginning October 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 DES/DDD and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the DES/DDD 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

09-01-11
Date

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