

## **Department of Economic Security /Division of Developmental Disabilities (DES/DDD) Updated Actuarial Memorandum**

### **I. Purpose**

This memorandum presents a discussion of the revision to the already approved Contract Year Ending 2015 (CYE 15) DES/DDD capitation rates. Please see Attachment A for the actuarial memorandums of the already-approved DES/DDD capitation rates which detail the original rate build up. Since these revisions only impact the acute and behavioral health component of the capitation rate, which are set on an October through September time frame, the revisions below will go through September 30, 2015.

This update to the capitation rates is required as a result of a new contract mandate requiring Contractors to pay the all-inclusive per visit Prospective Payment System (PPS) rates for Federally Qualified Health Centers/Rural Health Clinics (FQHCs/RHCs) and a requirement to cover incontinence briefs in order to prevent skin breakdown for adults in the Arizona Long Term Care Services (ALTCS) program.

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.

### **II. Overview of Changes**

Under federal law, the Arizona Health Care Cost Containment System (AHCCCS) is required to reimburse FQHCs and RHCs all-inclusive per visit PPS rates for FQHC/RHC services. Historically, this has been accomplished by a combination of Contractor and AHCCCS Administration fee-for-service claims' payments, quarterly supplemental payments made by the Administration, and an annual reconciliation also performed by the Administration to the PPS rate. Effective April 1, 2015, AHCCCS and its Contractors will begin reimbursing FQHCs and RHCs at the all-inclusive per visit rates on a per claim basis.

On December 15, 2014, the United States Supreme Court refused to hear AHCCCS' appeal of the Court of Appeals decision in *Alvarez v. Betlach* which upheld coverage of incontinence briefs for preventive purposes in the lawsuit brought by several adult ALTCS members. As a result of the Supreme Court action, incontinence briefs for ALTCS members age 21 years and older are also covered when medically necessary for preventive purposes.

### **III. Methodology for Calculating Capitation Adjustments**

#### **FQHC/RHC All-Inclusive PPS Rates**

AHCCCS will shift payment responsibility for FQHC/RHC PPS rates to the Contractors in order to properly account for FQHC/RHC expenditures for managed care enrollees. To identify the amount of full-funding needed for Contractors to pay the PPS rates on a per visit basis, it was necessary to identify the historical FQHC/RHC visits in order to distribute the quarterly supplemental and annual reconciliation payments made by the Administration.

The historical encounter data for FQHC/RHC expenditures was paid on a per service basis while the new mandate requires payment on a per visit basis, thus AHCCCS had to group the encounter service data to represent visits. A visit is defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

The visits from the historical encounter data were then used to develop the distribution of FQHC/RHC utilization by AHCCCS line of business (or program), Geographical Service Area (GSA) and risk group. Capitation rates were increased by the amount of the quarterly supplemental and annual reconciliation payments made by the Administration for managed care program visits, trended forward to federal fiscal year 2015. The trended Administration payment amounts were then multiplied by the visit distribution percentages by FQHC/RHC to determine the impact by program, GSA and risk group.

Additional adjustments were made to the data due to:

- The introduction of three new FQHCs/RHCs - historical encounter data is available since these providers were in place during the data period, but they did not have historical supplemental or reconciliation payments since they were not designated as FQHCs/RHCs until after the data period
- The integration of services in the Children Rehabilitative Services (CRS) program

The adjustments made to account for each of these unique situations are described below:

- The adjustment for the new FQHCs/RHCs involved projecting the reconciliation and quarterly supplemental payments from historical visits multiplied by the PPS rates and subtracting historical encounter payments
- The integration model necessitated a reassignment of historical encounter and member month data for members moved to the integrated program

The estimated impact of shifting payment responsibility from the Administration to the Contractors across all AHCCCS lines of business combined is budget neutral, but the estimated six month impact to the DES/DDD program is a statewide increase of approximately \$895,000.

### **Incontinence Briefs**

AHCCCS is adjusting capitation rates effective April 1, 2015, while including an assumption for new utilization going back to December 15, 2014 in its adjustment. The utilization assumption is based on the distribution of DES/DDD members by gender and age group, and an assumed prevalence rate of incontinence among members of each gender and age group. The prevalence rate assumptions begins with CYE 13 membership and encounter data for members age 18-20 who were already receiving a similar benefit and adjusts for older age groups as illustrated by the Urological Diseases in America (UDA) Project. The total rate impact assumes that the full benefit will be used by each member who is projected to utilize. The utilization assumption includes an adjustment for membership growth during CYE 14

and CYE 15. The unit cost assumption considers CYE 13 encounter data for members age 18 to 20 as described. The estimated six month impact to the DES/DDD program is a increase of approximately \$1.47 million.

#### IV. Proposed Revised Capitation Rates and Their Impacts

Table I below summarizes the changes from the current approved CYE 15 capitation rates and the estimated budget impact, effective for the period April 1, 2015 through September 30, 2015 on a statewide basis.

**Table I: Proposed Capitation Rates and Budget Impact**

Rate Cell	Based on Projected Member Months April 1, 2015 - September 30, 2015	CYE 15 (10/1/14) Approved Rate	CYE 15 (4/1/15) Proposed Rate	Based on Projected Member Months April 1, 2015 - September 30, 2015			
				CYE 15 (10/1/14) Approved Rate	CYE 15 (4/1/15) Proposed Rate	Dollar Impact	Percentage Impact
DDD	167,074	\$ 3,345.48	\$ 3,358.43	\$ 558,944,254	\$ 561,108,299	\$ 2,164,045	0.39%
Behavioral Health	167,074	\$ 122.38	\$ 124.18	\$ 20,446,542	\$ 20,747,182	\$ 300,640	1.47%
Targeted Case Management	26,197	\$ 123.61	\$ 123.61	\$ 3,238,278	\$ 3,238,278	\$ -	0.00%
<b>Total</b>				<b>\$ 582,629,074</b>	<b>\$ 585,093,758</b>	<b>\$ 2,464,685</b>	<b>0.42%</b>

*Behavioral Health does not reflect premium tax*

**V. 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 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 proposed actuarially sound capitation rates that are associated with this certification are effective for the six-month period beginning April 1, 2015.

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.

This certification letter assumes the reader is familiar with the DES/DDD program, Medicare and Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS, DES/DDD 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*

*02/12/2015*

Windy J. Marks

Date

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

# **ATTACHMENT A**



# **Department of Economic Security /Division of Developmental Disabilities (DES/DDD) Actuarial Memorandum**

## **I. Purpose**

The purpose of this actuarial memorandum is to demonstrate that the 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 July 1, 2014 through June 30, 2015 (CYE 15).

Arizona Health Cost Containment System (AHCCCS) intends to review and possibly update these capitation rates effective October 1, 2014 to include changes to the acute care and behavioral health services categories of the capitation rates. This rate update for July 1, 2014 does not include adjustments for anticipated reimbursement changes or program changes with effective dates after July 1, 2014. If appropriate, AHCCCS will include these adjustments in the rates updated effective October 1, 2014.

The Affordable Care Act (ACA) places an annual fee on the health insurance industry nationwide including most Medicaid health plans effective January 1, 2014. The fee will be allocated to health insurers based on their respective market share of premium revenue in the previous year. Due to the uncertainty of the actual fees and other unknowns, AHCCCS will not be adjusting the capitation rates for this fee at this time. AHCCCS intends to make a revision once the impacts are known, if applicable to DDD's sub-contractors.

## **II. Overview of Rate Setting Methodology**

The contract year ending 2015 (CYE 15) rates were developed as a rate rebase from the previously approved contract year ending 2014 (CYE 14) capitation rates.

Historical Medicaid managed care encounter data was used as the primary data source in development of the trends. Other data sources used in setting the actuarially sound rates include financial statements, supplemental information from DDD, Center for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) Report estimates and AHCCCS case management model.

Trend rates were calculated from 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. These adjustments also include state mandates, court ordered programs and other program changes, if necessary.

Ideally, the experience data should be analyzed by different rate cells which are comprised of members with similar risk characteristics. However, segregating the DDD population into different rate cells would lead to a statistical credibility problem due to the statewide disbursement of the relatively small membership base. DDD will have two separate rates – a regular DDD rate and a Behavioral Health rate.

The experience only includes DDD Medicaid eligible expenses for DDD Medicaid eligible individuals. In addition, the experience includes reinsurance amounts and share of cost.

The contract between AHCCCS and DDD specifies that DDD may cover services for members which are not covered under the State Plan; however those services are not included when setting capitation rates. AHCCCS will not include uncovered services in the DDD rates.

The general process in developing the rates involves trending the base data to the midpoint of the effective period, which is January 1, 2015. The next step involves the deduction of the reinsurance offsets and share of cost offset. Following this calculation, the projected case management, administrative expenses, risk contingency margin and premium tax are added to the projected claim per member per month (PMPM) to obtain the capitation rates. Each step is described in the sections below.

### **III. Base Period Experience**

AHCCCS used historical yearly encounter data for the time period from July 1, 2010 through December 31, 2013. The data was reviewed for accuracy, timeliness and completeness through encounter validation studies as well as studies comparing the encounter data to the Contractors' financial statements. Adjustments to the base data included, but were not limited to the following: completion factors, seasonality factors, historical programmatic changes and historical fee for service provider rate changes. Multiple years of data were used for projecting trends, but only the most recent data period SFY 14 (07/01/13 – 12/31/13) was used for the base period.

### **IV. Projected Trend Rates**

The trend analysis includes both the financial data experience and the encounter data experience. Financial data experience is from July 2009 through December 2013. Encounter data experience is from July 2010 through December 2013. The financial data trends were examined using both year over year and quarterly regression analysis. The encounter data trends were examined using monthly regression analysis, quarterly regression analysis and year over year data. In addition, standard sources of health care cost trends were examined, including the 2013 Actuarial Report on the Financial Outlook for Medicaid and the National Health Expenditure (NHE) Report published by CMS. The final utilization trends and historical unit cost



trends were selected based on a methodological blend of actuarial judgment and empirical methods. The projected unit cost trends were selected based on changes to provider rates. The projected unit cost rates reflect a two percent increase for developmental disabilities home and community based (HCBS) providers with an effective date of July 1, 2014.

The annual historical trend rates used in projecting the claim costs are identified in Table I. These trends do not reflect the two percent HCBS provider rate increase. No adjustments have been made to the Acute Care and Behavioral Health service categories. These two categories will be reviewed for a possible October 1, 2014 capitation rate adjustment.

**Table I: Annual Historical Trend Rates**

Service Category	DDD Rate	Behavioral Health
Institutional	0.15%	N/A
HCBS	1.78%	N/A
Acute Care	0.00%	N/A
Behavioral Health	N/A	0.00%

**V. State Mandates, Court Ordered Programs, Program Changes and Other Changes**

There are no new program changes or other mandates included in the rates at this time.

**VI. Projected Gross Claim PMPM**

The base utilization, unit costs and net claims PMPMs are trended forward and adjusted for state mandates, court ordered programs and program changes occurring after the end of the base period to arrive at the CYE 15 utilization, unit costs and net claims PMPMs for each component.

**VII. Projected Net Claim PMPM**

The projected gross claim PMPMs were adjusted for the recipients' share of cost (SOC) to obtain the net claim PMPM. The share of cost is \$5.50 for CYE 15. The share of cost was estimated based off of actual DDD SOC data, and was rebased for CYE 15. NOTE: the Reinsurance offset is included in the acute care component of the DDD rates. The acute component, reinsurance offset and behavioral health components are not being adjusted at this time. The projected net claim PMPMs are included in Table II.

**Table II: Projected Net Claim PMPM**

Service Category	Projected CYE 15 Claim Cost PMPM	
	DDD Rate	Behavioral Health
Institutional	\$ 119.82	N/A
HCBS	\$ 2,423.06	N/A
Acute Care	\$ 367.40	N/A
Program Changes	\$ -	\$ -
Behavioral Health	N/A	\$ 101.62
<b>Total</b>	<b>\$ 2,910.29</b>	<b>\$ 101.62</b>
Less Share of Cost	\$ (5.50)	N/A
<b>Net Claim Cost</b>	<b>\$ 2,904.79</b>	<b>\$ 101.62</b>

### **VIII. Case Management**

For DDD members the CYE 15 case management PMPM was developed using the AHCCCS case management model as well as looking at financials and supplemental case management cost reports from DDD. This is a similar methodology to previous years. The CYE 15 case management PMPM for the DDD population is \$153.62.

For the targeted case management (TCM) PMPM the AHCCCS case management model was used as well as actual cost information for this population provided by DDD. The assumptions in the model were refined by using data specific to this population. The CYE 15 TCM PMPM is \$123.61.

### **IX. 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 SFY 2008 through SFY 2013, encounter-reported COB cost avoidance grew by greater than 156%, from \$16 million to \$42 million. Additionally, DDD cost-avoided more than \$6 million in SFY ending 2013 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 therefore those services are excluded completely from capitation expenditure projections. AHCCCS continues to emphasize the importance of COB activities with DDD.

**X. Administrative Expenses and Risk Contingency**

For CYE 15 administrative expense AHCCCS analyzed DDD’s financial statements as well as supplemental information provided by DDD. The CYE 15 administrative expense for DDD is remaining flat at \$180.50. The risk contingency for DDD is 1.00%.

The Behavioral Health administrative expense is remaining the same and will be reviewed as part of a possible October 1, 2014 rate adjustment. The Behavioral Health risk contingency is 1.00%.

**XI. Proposed Capitation Rates and Their Impacts**

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VII), the projected case management (in Section VIII) and administrative expenses and risk contingency PMPM (in section X), divided by one minus the two percent premium tax. The premium tax for the behavioral health component is included in the DDD capitation rate. Table III shows the current and proposed capitation rates and the budget impact from CYE 14 (10/01/13 capitation rate) to CYE 15 using CYE 15 projected members.

**Table III: Proposed Capitation Rates and Budget Impact**

Rate Cell	Projected CYE 15 Member Months			Based on Projected CYE 15 Member Months		Dollar Impact	Percentage Impact
		CYE 14 (10/1/13) Rate	CYE 15 Rate	Estimated CYE 14 (10/1/13) Capitation	Estimated CYE 15 Capitation		
DDD	325,258	\$ 3,181.77	\$ 3,338.97	\$ 1,034,895,312	\$ 1,086,025,865	\$ 51,130,553	4.94%
Behavioral Health	325,258	\$ 118.14	\$ 118.14	\$ 38,424,642	\$ 38,424,642	\$ -	0.00%
Targeted Case Management	52,394	\$ 115.86	\$ 123.61	\$ 6,070,369	\$ 6,476,556	\$ 406,187	6.69%
<b>Total</b>				<b>\$ 1,079,390,323</b>	<b>\$ 1,130,927,063</b>	<b>\$ 51,536,740</b>	<b>4.77%</b>

*BH does not reflect premium tax*

## **XII. CMS Rate Setting Checklist**

### **1. Overview of rate setting methodology**

#### **AA.1.0: Overview of rate setting methodology**

AHCCCS is performing a rebase from the previously approved contract year ending 2014 (CYE 14) under 42 CFR 438.6(c). Please refer to Section II.

#### **AA.1.1: Actuarial certification**

Please refer to Section XIII.

#### **AA.1.2: Projection of expenditure**

Please refer to Section XI.

#### **AA.1.3: Procurement, prior approval and rate setting**

This is a sole source contracting method, between AHCCCS and DES/DDD.

#### **AA.1.5: Risk contract**

There is no risk sharing between AHCCCS and DES/DDD, in addition to the reinsurance contract. DES/DDD is responsible for all losses, except reinsurance and share of cost.

#### **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 Sections II through V and VII through X.

### **2. Base Year Utilization and Cost Data**

#### **AA.2.0: Base year utilization and cost data**

Please refer to Sections II and III.

#### **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 DDD specifies that DDD 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 Sections II, III and 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 X.

**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 payment was 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 payment 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 IV.

**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. The audited financial statements may include outstanding claim liabilities, which were audited and believed to be reasonable by DDD 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.4.3: 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 Sections II, III, IV and V.

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

Data was not adjusted for special populations.

### **AA.5.2: Cost-neutral data smoothing adjustments**

Please refer to Section VII.

### **AA.5.3: Risk-adjustment**

There is no 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 DDD, except the stop loss program (i.e. Reinsurance). DDD assumes all other risks.

## **7. Incentive Arrangements**

There is no incentive arrangement between AHCCCS and DDD.

### **XIII. 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 twelve-month period beginning July 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 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.

This certification letter assumes the reader is familiar with the DDD program, Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS, DES/DDD 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*

Windy J. Marks

05/30/14

Date

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



# Department of Economic Security /Division of Developmental Disabilities (DES/DDD) 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 revision to the capitation rates for the DES/DDD program, for the period October 1, 2014 to June 30, 2015. The revision is due to updates to the behavioral health (BH) and acute components, as well as programmatic changes that have occurred since these rates were initially developed.

Arizona Health Cost Containment System (AHCCCS) intends to update these capitation rates for January 1, 2015 to include changes in cost sharing and a shift in payment responsibility for services provided at Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as well as any other necessary changes.

The Affordable Care Act (ACA) places an annual fee on the health insurance industry nationwide including most Medicaid health plans effective January 1, 2014. The fee will be allocated to health insurers based on their respective market share of premium revenue in the previous year. Due to the uncertainty of the actual fees and other unknowns, AHCCCS will not be adjusting the capitation rates for this fee at this time, but intends to make retroactive capitation rate revision once the impacts are known.

## II. Overview of Changes

### **Behavioral Health (BH) Component Rate Development**

The BH component was rebased to follow the same methodology used in setting the non-DDD BH capitation rates. The base period data consisted of Regional Behavioral Health Authority (RBHA) financial statements and member month data provided by Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) for the October 1, 2012 through September 30, 2013 time period. This base data was adjusted for historical programmatic changes and provider fee schedule changes. The base data was then trended forward and adjusted by any new programmatic and provider fee schedule changes (see below) and the integration of DDD members eligible for Children's Rehabilitative Services (CRS). Finally, administration and risk contingency were applied to this rate to establish the final BH component rate.

### **Acute Care Component Rate Development**

DDD contracts with Managed Care Organization (MCO) subcontractors to provide acute care services for a majority of their members. The Native American population also receives Acute Care services in which DDD reimburses the providers directly. The Acute component rate consists of both MCO and Fee-For-Service (FFS) payments as well as a reinsurance offset for the MCOs. The Acute component rate change was based on a combination of a capitation rate analysis performed by AHCCCS and an MCO capitation rate analysis performed by Mercer. The capitation rate analysis adjusted base data by historical programmatic changes, provider fee scheduled changes and an adjustment for one high cost member who is no longer in the program. The base data was then trended forward and adjusted by any new programmatic and provider fee schedule changes (see below).

### **Behavioral Health Provider Fee Schedule Changes**

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) BHS implemented a 2% provider rate increase effective October 1, 2014 for multiple community-based, inpatient and residential services, but excluding transportation, laboratory and radiology, pharmacy, and electro-convulsive therapy services. The DDD BH capitation rates were adjusted to reflect this change. The estimated nine month statewide impact is an increase of approximately \$411,000.

### **AHCCCS Fee Schedule Changes**

Effective October 1, 2014, AHCCCS is changing FFS provider rates for certain providers based either on access to care needs, Medicare or ADHS fee schedule rates, and/or legislative mandates. The unit cost (inflation) trends were adjusted appropriately for these changes. The estimated nine month statewide impact is an increase of approximately \$272,000.

### **ADHS Ambulance Rates**

In accordance with A.R.S. §36-2239, AHCCCS is required to pay ambulance providers rates equal to a prescribed percentage of the amounts approved by ADHS. Currently AHCCCS' rates are equal to 68.59% of the ADHS rates per Laws 2013, First Special Session, Chapter 10. However, AHCCCS is required by this same section of law to increase this percentage to 74.74% of the ADHS rates for rates effective October 1, 2014. This mandated adjustment results in a 9% increase in payments, assuming all utilization stays the same. The legislation also updates the base ADHS rates that are used to calculate the payments, which will result in further increases greater than 9%. The estimated nine month impact is an increase of approximately \$216,000.

### **Diagnosis Related Group (DRG) Impacts**

Acute hospital inpatient stays with dates of discharge on and after October 1, 2014 will be paid using an All Patient Refined Diagnosis Related Group (APR-DRG) payment system (with certain exclusions). This payment system replaces the 20+ year tiered per diem inpatient reimbursement system in accordance with Arizona Revised Statutes (A.R.S.) § 36-2903.01 and Arizona Administrative Code (A.A.C.) R9-22-712.60 through 712.81. The impact of this move to APR-DRG is budget neutral to the state, but does vary by Program. In addition to the methodological change there are impacts to what qualifies for reinsurance since the DRG method of

payment will no longer allow Contractors to split inpatient encounters in most cases. The estimated, combined nine month impact of both the methodological and reinsurance change is an increase of approximately \$1.1 million

#### **Medically Preferred Treatment Options**

Effective October 1, 2014, AHCCCS will provide medically necessary orthotics services that are recognized as a preferred treatment option and are less expensive than other treatment or surgical options. More specifically, AHCCCS will reinstate orthotics instead of imminent surgery, or as necessary as a result of surgery, with prescribed criteria. There is no impact to rates as these orthotics are offered in place of more costly interventions.

#### **In-Lieu of Services**

Included in the base capitation 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/Arizona Licensing Services/Office of Behavioral Health License, in lieu of services in an inpatient non-specialty hospital, thus no impact to capitation rates is included.

#### **Primary Care Provider (PCP) Payment Increase**

Section 1902(a)(13)(C) of the Social Security Act, as amended by the ACA, requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. The AHCCCS managed care model, with strict requirements regarding actuarially-sound capitation rates, necessitates that Contractors be funded for expected cost increases due to primary care rate parity. AHCCCS proposes to provide Contractors the necessary funds to increase primary care payments by using Model 3: Non-risk Reconciled Payments for Enhanced Rates as referenced in the *Medicaid Managed Care Payment for PCP Services in 2013 and 2014, Technical Guidance and Rate Setting Practices* (Technical Guidance) document released by CMS.

In summary, under Model 3, prospective capitation rates would not be adjusted for the enhanced primary care payments. Rather, AHCCCS would query actual encounter data on a quarterly basis to calculate the total payments that eligible providers were paid for eligible services in order to reach the mandated enhanced payment rates. Once the data on this report is verified, AHCCCS would pay the Contractors the calculated additional payment amounts. A more detail explanation of the process and methodology can be found in the Actuarial Certification submitted March 2013 to CMS for approval of AHCCCS methodology. There is no impact to the CYE 15 capitation rates.

### III. Proposed Capitation Rates and Their Impacts

Table I below summarizes the changes per rate cell with the estimated budget impact. The table summarizes the change from the current approved CYE 15 capitation rates to the proposed updated CYE 15 capitation rates, effective for the period October 1, 2014 through June 30, 2015 on a statewide basis.

**Table I: Proposed Capitation Rates and Budget Impact**

Rate Cell	Based on Projected Member Months October 1, 2014 - June 30, 2015	CYE 15 (7/1/14) Approved Rate	CYE 15 (10/1/14) Proposed Rate	Based on Projected Member Months October 1, 2014 - June 30, 2015			
				CYE 15 (7/1/14) Approved Rate	CYE 15 (10/1/14) Proposed Rate	Dollar Impact	Percentage Impact
DDD	247,094	\$ 3,338.97	\$ 3,345.48	\$ 825,039,228	\$ 826,647,810	\$ 1,608,582	0.19%
Behavioral Health	247,094	\$ 118.14	\$ 122.38	\$ 29,191,677	\$ 30,239,355	\$ 1,047,678	3.59%
Targeted Case Management	39,296	\$ 123.61	\$ 123.61	\$ 4,857,417	\$ 4,857,417	\$ -	0.00%
<b>Total</b>				<b>\$ 859,088,322</b>	<b>\$ 861,744,582</b>	<b>\$ 2,656,260</b>	<b>0.31%</b>

*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, 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 DES/DDD, ADHS/BHS, the AHCCCS internal databases and analysis performed by Mercer (based on data supplied by DES/DDD). I have accepted the data without audit and have relied upon the DES/DDD auditors, ADHS/BHS auditors, other AHCCCS employees and Mercer for the accuracy of the data and analysis.

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 DDD program, Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS, DES/DDD 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*

Windy J. Marks

*08/29/14*

Date

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

