Acute Care Updated Actuarial Memorandum for Contract Year Ending 2014 (CYE 14) Risk Adjustment

I. Purpose

This memorandum presents a discussion of the revision to the already approved CYE 14 acute capitation rates for contractually-required risk adjustment factors. These revised payments are retroactive to the start of the contract year (October 1, 2013) and will be the rates in effect through the end of the contract year (September 30, 2014). This is the sixth year Arizona Health Care Cost Containment System (AHCCCS) is implementing the risk adjustment model.

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 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 a revision once the impacts are known.

II. Overview of Risk Adjustment Methodology

The methodology for CYE 14, the first year of a new contracting period, is largely consistent with prior years. This method of risk adjustment uses risk scores resulting from the Optum (formerly Ingenix) Symmetry Episode Risk Group (ERG) Model, a nationally recognized model. This risk adjustment methodology, implemented on a statewide basis, is budget neutral to AHCCCS.

The ERG model assigns each member to one or more of the 167 ERGs based on diagnostic and procedural information available on medical and pharmacy post-adjudicated claims (i.e. encounters). An ERG profile for each member is created by considering age, gender and the ERGs to which they have been assigned. A relative health status weight is associated with each age, gender and ERG category.

Eligibility Groups

AHCCCS will risk adjust most of the prospective risk groups which include: SSI with and without Medicare, TANF, and AHCCCS Care. The following rates will not have a claims based risk adjustment model applied:

1. Newly Eligible Adults Rates (population started 1/1/14)
2. Delivery Supplemental Payment Rates
3. Option 1 & 2 Transplant Rates
4. SOBRA Family Planning Rates (population ended 12/31/13)

Model Calibration

The model was calibrated in 2009 to the Arizona Medicaid population. AHCCCS is using an ERG version that has the same number of risk markers as the version that was calibrated. Given that there were no changes in the number of and general definition of risk markers, the risk weights were not updated. AHCCCS intends to re-calibrate the risk weights when AHCCCS moves to an ERG version that has additional risk markers.

When the model was calibrated in 2009, the following costs were not reflected in the condition or demographic weights in the calibrated model:

1. Prior Period Coverage (PPC)
2. Behavioral health services covered by Arizona Department of Health Services (ADHS)
3. Costs above reinsurance thresholds for which the Contractors were not at risk
4. Children's rehabilitative services
5. Maternity costs covered by the Delivery Supplement

The diagnoses on all claims (including those identified above) are used for purposes of identifying conditions, but the costs not at risk were excluded for purposes of determining the risk weights. This process captures the additional complexity/cost for at-risk conditions due to the presence of an underlying not-at-risk (i.e. behavioral) condition.

Risk weights were developed by age/gender category and for all of the 167 ERG condition categories. Three sets of risk weights were developed for the 167 ERG condition categories (TANF <1 was handled differently – see section below): 1) TANF and AHCCCS Care, 2) SSI without Medicare, and 3) SSI with Medicare. Only members with at least six months of experience in the base period and at least one month of experience in the projection period were used in the calibration. Each member's contribution to the regression model and therefore the risk weights, was weighted according to the number of months that member was enrolled during the prospective period.

Model weights were based on statewide data. Risk adjustments will take place at the Geographical Service Area (GSA) and risk group level.

Risk scores calculated during the experience period will follow the individual during the rating period.

Member Inclusion and Risk Factors for New Members / Short Cohort (for all members except TANF <1 during the experience period)

Only members with at least six months of enrollment during the experience period ('long' cohort) will be given a claims based risk adjustment factor (average ERG risk score). Members with less than six months of enrollment during the experience period ('short' cohort) will be given a risk factor that is equal to 50% of their pure age/gender factor plus 50% of an adjusted plan factor. The adjusted plan factor is calculated by taking the average ERG risk score of the long cohort and dividing by the pure age/gender factor of the long cohort (relative health factor) and then

multiplying by the pure/age gender factor of the short cohort. The weighted average of the long cohort and the short cohort results in the average risk score for each Contractor, which will then be divided by the GSA average risk score to calculate the relative risk score.

Encounter Data Validation and Issues

AHCCCS regularly performs testing on encounters to identify any potential areas of concern. If AHCCCS identifies an area where encounters are not being submitted, AHCCCS contacts the Contractor and works with them to improve encounter submissions. AHCCCS monitors the encounters by reviewing encounter data by date of service and form type to identify potential issues. In addition, AHCCCS compares the Contractor's encounter data to their financials by quarter and compares how the Contractors look relative to one another. Additional testing was performed for the risk adjustment process which includes, but is not limited to, reviewing the average number of encounters per member per month, the encounter diagnosis information by Contractor, the portion of a Contractor's population that has zero encounters and the portion of the population scored. These results are then compared across the Contractors. Based on this review no encounter data was excluded from the risk adjustment analysis.

Risk Adjustment for TANF <1

Risk adjustment for TANF under age one (newborns) is necessarily different than risk adjustment for other risk groups. Instead of an individual approach where risk adjustment factors follow individual members, an aggregate, concurrent approach was used. This approach assumes that historic relationships in newborn risk will continue into the future. While the specific newborns in any Contractor will change from the experience period to the rating period, this approach assumes that Contractors attract newborns with a consistent health status mix.

Based on Arizona data for the newborn Medicaid populations, a series of conditions that resulted in material variations among newborns due to the frequency, cost and nature of those conditions were identified. This analysis resulted in eleven general risk marker categories that will be used to differentiate the health status and therefore risk of newborns.

Members with sufficient experience are identified during the experience period (October 1, 2012 through September 30, 2013). Sufficient experience is defined as being born in the experience period, with at least three months of enrollment during the experience period or enrolled at the time of death. Members with sufficient experience are assigned a risk score.

Newborns not meeting the enrollment criteria described above are assigned 50% of the average relative risk adjustment for those meeting the eligibility criteria and 50% of a 1.00 factor. Each Contractor's risk score for newborns within a GSA will be calculated as the weighted average of the risk scores for newborns who met the above eligibility criteria during the experience period and those who did not.

Because both Contractors in GSA 6 were new to that area effective October 2013, both Contractors will receive 1.000 risk scores for all TANF members less than one year of age. In addition, there is one Contractor new to GSA 12 with no exiting

contractors, thus this Contractor will also receive a 1.000 risk score for the TANF less than one population.

Implementation

Since CYE 14 was a bid year, the mix of Contractors and GSA coverage for the AHCCCS program changed October 1, 2013. Some members transitioned to new Contractors during the first few months of the contract year. Therefore, AHCCCS chose to delay the implementation of risk adjusted rates, allowing the membership time to stabilize. Risk scores, which are factored at the individual member level, will be applied to the members' Contractor of enrollment from October 2013 through January 2014. January 2014 membership will then be used in the projection of membership for the remaining months of CYE 14 which considers enhanced auto assignment and expansion and restoration.

AHCCCS will apply 100% of the risk adjustment factors for CYE 14 to the previously approved capitation rates to develop the revised capitation rates. This adjustment will be retroactive to the start of the contract year (October 1, 2013).

III. Proposed Revised CYE 14 Capitation Rates and Resulting Impact

The goal of the risk adjustment process is to better align the capitation payments with the acuity of the members. This process is budget neutral to the state; the adjustments impact contractors from an overall impact on previously approved capitation rates ranging from -7.7% to 4.9%. Individual Contractor capitation rates will be impacted as shown in Section B of the contracts. Note that the October 1, 2013 rates were changed effective January 1, 2014 and April 1, 2014, therefore in Section B there are three sets of adjusted capitation rates, however, the same risk factors are used for each set of rates.

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.

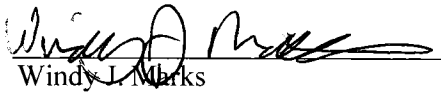
The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are 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 proposed actuarially sound capitation rates that are associated with this certification are effective for the twelve-month period retroactive to October 1, 2013.

The actuarially sound capitation rates are based on a projection of future events. It may be expected that actual experience will vary from the developed rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the Contractors, the AHCCCS internal databases and analysis performed by Wakely Consulting (based on data supplied by AHCCCS). I have accepted the data without audit and have relied upon the Contractor auditors, other AHCCCS employees and Wakely Consulting 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 acute program, Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS 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.



04/29/14

Windy J. Marks — Date

Fellow of the Society of Actuaries
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