Acute Care Actuarial Memorandum

I. Purpose

The purpose of this actuarial memorandum is to demonstrate that the Acute Care 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 significant 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.

Already approved by CMS is the phase out of the Medical Expense Deduction (MED) program beginning May 1, 2011, effectively eliminating the program October 1, 2011, as it will not be renewed by the State under its revised Waiver Renewal request. CMS has also approved a phase out of the current Childless Adult program (referred to as the Non-MED population in this memorandum), which freezes enrollment for this eligibility category beginning July 8, 2011 and continues the program effective October 1, 2011 based on available funding. Other 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 Rate Setting Methodology

The contract year ending 2012 (CYE12) rates were developed as a rate update from the contract year ending 2011 (CYE11) capitation rates as adjusted April 1, 2011 and previously approved by CMS. The CYE12 rates cover the twelve month contract period of October 1, 2011 through September 30, 2012.

The Acute Care rates were developed from historical Acute Care data including Arizona Medicaid managed care encounter data (via an extract that provides utilization and cost data, referred to as the "databook"), as well as health plan financial statements. Other data sources include programmatic changes, anticipated Arizona Health Care Cost Containment System (AHCCCS) Fee For Service rate changes, anticipated Arizona Department of Health Services (ADHS) transportation increases, Center for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) Report estimates and Global Insight Prospective Hospital Market Basket Inflation Index (GI) information.

The contract between the AHCCCS and the health plans (HPs) specifies that the HPs may cover additional services. Non-covered services were removed from the databook and not included in the rates.

Trend rates were calculated from the databook 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. Unit cost trends were further refined by actual and anticipated changes in AHCCCS Fee For Service rates. These adjustments also include state mandates, court ordered programs and other program

changes, if necessary. Additional analysis was performed on all populations due to shifts in the economy and policy impacts that have caused deviations from the historical encounter data costs and trends. In order to capture these changes AHCCCS used more recent encounter data as well as the most recent financial data and applied an experience adjustment factor to all populations. For more information on trends and experience adjustments see Section III Projected Trend Adjustments and Section IV Projected Experience Adjustments.

The Acute Care program has a large membership base, which allows for the experience data to be analyzed by the different rate cells. These rate cells are comprised of members with similar risk characteristics. The rate cells were analyzed by major categories of aid (COA), i.e. risk groups, and COS. In addition, AHCCCS develops rates by Geographic Service Area (GSA).

The experience data includes only Acute Care Medicaid eligible expenses for Acute Care Medicaid eligible individuals, as well as reinsurance amounts. The Prior Period Coverage (PPC) rates and the Non-MED rates are reconciled to a maximum 2% profit or loss. In prior years, the MED rates were reconciled to a maximum 3% profit or loss. Since this population has been phasing out effective May 1, 2011, no reconciliation will be in place for CYE12. Additional payments are made for members giving birth via a Maternity Delivery Payment.

Effective with CYE12, all risk groups other than PPC and non-MED will be reconciled as follows:

Profit	MCO Share	State Share	Maximum MCO Profit
<=3%	100%	0%	3%
>3% and <=5%	75%	25%	1.5%
>5% and <=7%	50%	50%	1.0%
>7% and <=9%	25%	75%	0.5%
>9%	0%	100%	0%
Total			6.0%

Loss	MCO Share	State Share	Maximum MCO Loss
<=3%	100%	0%	3%
>3% and <=6%	50%	50%	1.5%
>6%	0%	100%	0%
Total			4.5%

The general process in developing the prospective rates involves trending the CYE11 capitation rates to the midpoint of the effective period, which is April 1, 2012. The next step involves applying programmatic and experience adjustments. This creates a CYE12 medical PMPM from which the reinsurance offsets are deducted. Following this calculation, the projected administrative expenses, risk/contingency margin and premium tax are added to the projected claim PMPMs to obtain the capitation rates. In the final step, a risk adjustment factor is applied creating budget neutral results. Each step is described in the sections below. In addition there are sections dedicated to the development of other rates including, but not limited to, the Maternity Delivery Payment and PPC rates.

III. Projected Trend Adjustments

The trend analysis includes both the financial data experience and the encounter data experience. Financial data experience is from the contract year ending September 2008 through March 2011. Encounter data experience is from the contract year ending September 2008 through September 2010. Encounter data was used from those plans that provided reasonably complete and accurate encounter submissions for the trend analysis. The resulting data provides an actuarially sound data set for which to trend the CYE11 rates forward. In addition to using encounter and financial data, AHCCCS used information from CMS NHE Report estimates, GI information, and changes in AHCCCS' Inpatient rates, Professional and Outpatient Fee Schedules, Dental Fee Schedule, Transportation Fee Schedule and other sources. AHCCCS developed utilization and unit cost trend estimates using the encounter data. These trends were developed by major COA and COS, with a cap on the percentage increase and decrease to smooth out exceptional trends.

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 30%, from $391 million in SFY 2008 to $509 million in SFY 10. Additionally, Acute Contractors cost-avoided more than $600 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.

In addition, unit cost trend estimates were based on AHCCCS fee schedule changes for the majority of the COS trends. 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 $136 million statewide.

Once these trends were developed they were analyzed by comparing the results to reports and studies (for example the CMS NHE report). The utilization and unit cost trend rates used in projecting the claim costs are summarized in Appendix I. The prospective PMPM trends are shown below in Table I. These trends do not reflect the impact of any program changes.

Table I: Prospective Average Annual PMPM Trends

PMPM Trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-6.2%	-1.6%	-6.7%	-5.3%
Outpatient Facility	-3.2%	-0.3%	0.0%	-3.2%
Emergency Room	-4.1%	-7.3%	-0.4%	-4.9%
Primary Care	-2.1%	-3.4%	-0.5%	-4.3%
Referral Physician	-0.4%	0.4%	0.3%	-5.6%
Other Professional	0.4%	-5.3%	-1.4%	1.4%
Pharmacy	7.0%	5.4%	4.9%	3.2%
Other	-5.8%	-4.5%	-3.3%	-4.9%

Hospital Inpatient Trends
Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the inpatient utilization varied from -5.1 to -2.7 percent annually, depending upon risk group. AHCCCS used encounter data, as adjusted for the rate decrease mentioned above, to develop the hospital inpatient unit cost trends. On a combined basis, the per member per month (PMPM) trends for inpatient hospital have been trended at -6.7 to -1.6 percent, depending upon risk group. These ranges are summarized in Appendix I.

Hospital Outpatient and Emergency Room Trends
AHCCCS used encounter data, as adjusted for the rate decrease mentioned above, to develop the hospital outpatient and emergency room unit cost trends. These trends were then adjusted for the rebase of the Outpatient Fee Schedule (OPFS) rates required by the Arizona Administrative Code. This rebase is required every five years and will be effective October 1, 2011. The utilization trends were developed using the data sources mentioned in Section II with emphasis on the AHCCCS encounter data. On a combined basis, the PMPM costs for hospital outpatient and emergency room have been trended at -7.3 to 0.0 percent, depending upon risk group. These ranges are summarized in Appendix I.

Physician and Related Service Trends
Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the assumed utilization for physicians and other professionals ranged from -0.1 to 9.2 percent annually, depending upon risk group and category of service. AHCCCS primarily used encounter data, as adjusted for the rate decrease mentioned above, to develop the physician and other professionals unit cost trends. On a combined basis, the PMPM costs for physicians and other professionals have been trended at -5.6 to 1.4 percent, depending upon risk group. These ranges are summarized in Appendix I.

Pharmacy Trends
Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the assumed pharmacy utilization increased by 1.1 to 7.3 percent, depending upon risk group. Based on a review of the same sources, unit costs have been trended at -2.2 to 4.3 percent. Pharmacy trends are not impacted by the

mandated fee schedule decreases on October 1, 2011. On a combined basis, the PMPM costs for pharmacy have been trended at 3.2 to 7.0 percent, depending upon risk group. These ranges are summarized in Appendix I.

Smoking Cessation
Starting October 1, 2008, in accordance with Laws 2008, Chapter 131, AHCCCS added coverage for eligible tobacco cessation products which include nicotine replacement therapy (NRT) and tobacco use medications for eligible Title XIX AHCCCS members who wish to stop tobacco use and who are enrolled in a tobacco cessation program offered by the Arizona Department of Health Services. This program has been effective for almost three years, therefore making it possible to review how actual experience compares to the initial projections. The review is based on encounter utilization and costs data for CYE10 and CYE11 (YTD). AHCCCS determined Acute members utilized less services than included in last year's projection. Based upon this analysis, AHCCCS is decreasing the amount included for tobacco cessation products in the capitation rates. The statewide impact to the Acute program for CYE12 is a decrease of approximately $742,000.

IV. Projected Experience Adjustments

Based on the recent rapid growth in the AHCCCS population resulting from previously unforeseen economic conditions in addition to the freeze of the non-MED risk group effective July 8, 2011, AHCCCS is applying an experience adjustment to the CYE12 capitation rates. The projected experience adjustments are calculated by risk group, by GSA for prospective and PPC populations.

The projected experience adjustments are a function of two components: a financial component and an encounter component. The financial component is based on four different views of the health plans' submitted financials: reported profit/loss for CYE10; reported profit/loss through March 31, 2011; reported CYE10 medical expense compared to the CYE10 medical expense built into the capitation rates adjusted for the CYE11 changes to medical expense; and reported CYE11 medical expense (for two quarters) compared to the CYE11 medical expense built into the capitation rates. The encounter component is based on three different views: CYE10 databook encounters (PMMIS point-in-time extract) over CYE10 medical expense built into the capitation rates adjusted for CYE11 changes to medical expense; CYE10 COGNOS encounters (up-to-date extract from data warehouse) over CYE10 medical expense built into the capitation rates adjusted for CYE11 changes to medical expense; and COGNOS encounters for two quarters of CYE11 over CYE11 medical expense in the capitation rates. These components were then analyzed to arrive at the necessary experience adjustments. These experience adjustments are applied to the final medical rate, before reinsurance, admin, risk contingency and premium tax. The impact of the experience adjustment on a statewide basis ranges from -6.3 to 0.4 percent, depending upon prospective and PPC risk group.

V. State Mandates, Court Ordered Programs, Program Changes and Other 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 twelve month period 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 $67.6 million.

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 $28.2 million statewide.

Childless Adult (non-MED) Freeze
As part of the Governor's Medicaid reform plan, effective CYE12 AHCCCS will change the nature of the Childless Adult (non-MED) program in Arizona from an open-ended entitlement program to one based on available funds. This change provides the State with the flexibility to manage enrollment based on available funding, including adding to enrollment if additional funds are made available. The reform plan includes a phase out of the current Childless Adult program, for which enrollment was frozen beginning July 8, 2011. Individuals enrolled prior to July 8, 2011 will retain their coverage, but no new individuals would be made eligible in this category unless additional funding becomes available. The impact of the freeze on enrollment is a reduction to the non-MED risk group of approximately $433 million. The estimated reduction in member months for CYE12 is approximate 964,360.

The elderly, and individuals meeting the federal definition of disability, were transitioned to either the SSI with or without Medicare risk groups. The CYE12

impact to the SSI with Medicare population is an increase of approximately $12.2 million and 58,300 member months. The impact to the SSI without Medicare population is an increase of approximately $38 million and 54,500 member months.

Elimination of MED Program
As part of the Governor's Medicaid reform plan, beginning May 1, 2011, enrollment for the MED program was frozen and no new applications are being accepted for this category pursuant to the MED Phase-Out Plan approved by CMS. Since eligibility for MED does not exceed 6 months, the May 1 freeze has the effect of eliminating the MED program by October 1, 2011. There may be rare instances in which an MED member's enrollment goes slightly beyond September 30, 2011, therefore included herein are MED rates that are equivalent to the CY11 MED rate as adjusted April 1, 2011.

Transition of Pediatric Costs
Effective June 1, 2011, St. Joseph's Hospital and Phoenix Children's Hospital (PCH) united the two organizations' pediatric programs at PCH for patients through age 14. AHCCCS' outpatient hospital Fee-For-Service rates for PCH are, in aggregate, higher than the payment rates for St. Joseph's Hospital. AHCCCS used historical encounter data to determine the fiscal impact of this alliance by extracting cost and utilization data for pediatric services at St. Joseph's and repricing them at the PCH rates. Because many of the services may be performed at other Phoenix-area hospitals, AHCCCS included only fifty percent of the increase in the capitation rates. The impact statewide is an increase of $1.5 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 $243,000.

Institution for Mental Disease (IMD) Waiver and In-Lieu of Services
Included in the base 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/ALS/OBHL, in lieu of services in an inpatient non-specialty hospital, thus no increase to cap rates is included.

VI. Prospective Projected Net Claim PMPM

The CYE11 utilization, unit costs and net claims PMPMs are trended forward and adjusted for experience trends, state mandates, court ordered programs and program changes to arrive at the CYE12 utilization, unit costs and net claims PMPMs for each COS and COA.

VII. Prospective Reinsurance Offsets

The CYE11 reinsurance offsets were reviewed by AHCCCS for appropriateness and reasonableness using reinsurance encounter and payment information. Appropriate adjustments were made to the reinsurance offsets based upon this review. All contractors remained at the same deductible levels as CYE12.

VIII. Prospective Administrative Expenses and Risk Contingency

The administrative expense remains at 8.0% for general administration, which was determined to be appropriate to cover the contractors' average expenses. The risk contingency load also remains the same for all rate cohorts at 1%.

IX. Prospective Proposed Capitation Rates and Their Impacts

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VI) less the reinsurance offsets (in section VII) and the projected administrative expenses and risk contingency PMPM (in section VIII), divided by one minus the two percent premium tax. The final adjustment, which is a budget neutral adjustment, is the risk adjustment factor (in Section X). Appendix II contains the proposed capitation rates and the budget impact for all capitation rates using projected CYE12 member months and actual health plan reinsurance deductible levels.

X. Risk Adjustment Factor

For CYE12, AHCCCS will be recalculating the risk factors to apply to the CYE 12 capitation rates once the appropriate data is available. It is expected that the adjustment will be applied to the rates on or around April 1, 2012 along with a retroactive adjustment to the rates effective October 1, 2011.

XI. Maternity Delivery Payment

The methodology followed in developing the Maternity Delivery Payment is similar to the methodology used in the development of the prospective capitation rates. This methodology involves updating CYE11 rates with utilization and unit cost trends and program changes. The impact is a 7.6% decrease per delivery to the overall global maternity payment rate over the CYE11 rate.

XII. Extended Family Planning Services (FPS)

The methodology followed in developing the FPS rate is similar to the methodology used in the development of the prospective capitation rates. This methodology involves updating CYE11 rates with utilization and unit cost trends and program changes. The impact is a 0.2% decrease to the overall global FPS rate over the CYE11 rate.

XIII. KidsCare Rates

Continuing with the methodology of previous years, AHCCCS contractors will be paid one blended capitation rate that includes experience from both the traditional TANF Medicaid population and the Title XXI SCHIP population. The rate cohorts whose experience is blended together are detailed as follows:

- TANF < 1 and KidsCare < 1;
- TANF 1– 13 M&F and KidsCare 1 – 13 M&F;
- TANF 14 – 44 F and KidsCare 14 – 18 F;
- TANF 14 – 44 M and KidsCare 14 – 18 M; and

The related member month, capitation rate and dollar information is as follows:

Kidscare Info	CYE12 Projected Member Months	Proj Cap Rate-CYE12	Total Annual Dollars CYE12 based CYE12 Proj MMs
KC <1	164	$ 465.50	$ 76,229
KC 1-13	101,070	$ 99.60	$ 10,066,537
KC 14-44F	25,778	$ 223.03	$ 5,749,375
KC 14-44M	27,758	$ 139.98	$ 3,885,631

XIV. Prior Period Coverage Rates (PPC)

PPC rates cover the period of time from the first day of retroactive eligibility to the date of eligibility determination. PPC rates are established using a similar methodology that was followed in developing the prospective capitation rates. The administration and risk contingency percentages are the same as prospective, i.e. 8% and 1%, respectively. The overall statewide impact is a decrease of 4.7%. The PPC rates are reconciled to a maximum 2.0% profit or loss in CYE12.

XV. Final Capitation Rates and Their Impact

Table II below summarizes the adjustments made to the CYE11 rates. The impact to contractors ranges from -8.7% to -5.7%. Individual health plan capitation rates will be impacted as shown in Section B of the contracts.

Table II: Adjustments to CYE11 Rates

AHCCCS Medicaid Managed Care Summary			
Adjustments to CYE12 Rates	Prospective	PPC	Weighted Average
Trend:			
1. Utilization	0.84%	0.22%	0.82%
2. Inflation	-3.68%	-3.35%	-3.67%
Experience Adjustment			
1. Total	-3.70%	-0.04%	-3.60%
Program Changes			
1. IP 25 Day Limit	-1.96%	-1.19%	-1.94%
2. Outpatient Fee Schedule Rebase	-0.13%	-0.05%	-0.13%
3. Smoking Cessation	-0.02%	0.00%	-0.02%
4. Transition of Pediatric Costs	0.05%	0.00%	0.04%
Misc			
1. Administration	-0.71%	-0.36%	-0.70%
2. Risk Contingency	-0.09%	-0.04%	-0.09%
3. Reinsurance Offset Change	1.42%	n/a	1.38%
Total Percentage Change	-7.76%	-4.75%	-7.68%

XVI. CMS Rate Setting Checklist

1. Overview of rate setting methodology

A.A.1.0: Overview of rate setting methodology

AHCCCS is performing a rate update from the rates in effect for contract year ending 2011 (CYE11) as adjusted April 1, 2011 and previously approved by CMS, under 42 CFR 438.6(c). Please refer to Section II.

AA.1.1: Actuarial certification

Please refer to Section XVII.

AA.1.2: Projection of expenditure

Please refer to Appendix II.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Sole Source contracting method.

AA.1.5: Risk contract

AHCCCS limits risk for the Non-MED and all PPC risk groups to 2% profit or loss. The remainder of the risk groups are reconciled as follows:

Profit	MCO Share	State Share	Maximum MCO Profit
<=3%	100%	0%	3%
>3% and <=5%	75%	25%	1.5%
>5% and <=7%	50%	50%	1.0%
>7% and <=9%	25%	75%	0.5%
>9%	0%	100%	0%
Total			6.0%

Loss	MCO Share	State Share	Maximum MCO Loss
<=3%	100%	0%	3%
>3% and <=6%	50%	50%	1.5%
>6%	0%	100%	0%
Total			4.5%

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to providers, except for Disproportionate Share Hospital (DSH), Graduate Medical Education (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 Sections II through V, VII, VIII, and X through XIV.

XVII. 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 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 the health plans and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the health plan 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 09/31/11

Windy J. Marks Date

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

Appendix I

Prospective Trends

Utilization per 1,000 trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-3.3%	-5.1%	-2.7%	-4.3%
Outpatient Facility	0.1%	4.4%	4.9%	2.1%
Emergency Room	-1.3%	-0.8%	4.4%	0.2%
Primary Care	2.7%	2.4%	4.4%	-0.1%
Referral Physician	6.0%	9.2%	8.1%	3.7%
Other Professional	4.4%	3.8%	4.9%	4.8%
Pharmacy	6.4%	1.1%	7.3%	3.4%
Other	n/a	n/a	n/a	n/a

Unit Cost Trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-3.0%	3.7%	-4.2%	-1.0%
Outpatient Facility	-3.3%	-4.5%	-4.7%	-5.2%
Emergency Room	-2.9%	-6.6%	-4.6%	-5.0%
Primary Care	-4.7%	-5.6%	-4.6%	-4.2%
Referral Physician	-6.0%	-8.1%	-7.2%	-8.9%
Other Professional	-3.8%	-8.8%	-6.0%	-3.3%
Pharmacy	0.6%	4.3%	-2.2%	-0.2%
Other	n/a	n/a	n/a	n/a

PMPM Trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-6.2%	-1.6%	-6.7%	-5.3%
Outpatient Facility	-3.2%	-0.3%	0.0%	-3.2%
Emergency Room	-4.1%	-7.3%	-0.4%	-4.9%
Primary Care	-2.1%	-3.4%	-0.5%	-4.3%
Referral Physician	-0.4%	0.4%	0.3%	-5.6%
Other Professional	0.4%	-5.3%	-1.4%	1.4%
Pharmacy	7.0%	5.4%	4.9%	3.2%
Other	-5.8%	-4.5%	-3.3%	-4.9%

Acute Capitation Rate Analysis (Renewal Rates--pending approval)
Point in Time Comparison--no member growth factor
CYE '12
APPENDIX II

		CYE12 Projected Member Months [1]	Cap Rate- '11 (4/1) based on CYE12 Proj Member Months	Total Annual Dollars CYE '11 (4/1) based on CYE12 Proj MMs	Cap Rate- CYE12 based on CYE12 Proj Member Months	Total Annual Dollars CYE12 based on CYE12 Proj MMs	Difference	% Increase
Title XIX Waiver Group								
	Prospective-MED	382	$ 1,337.16	$ 510,178	$ 1,337.16	$ 510,178	$ -	0.0%
	PPC-MED	100	$ 5,927.52	$ 590,031	$ 5,927.52	$ 590,031	$ -	0.0%
	Total MED	481		$ 1,100,208		$ 1,100,208	$ -	0.0%
	Prospective-non-MED	1,770,209	$ 451.15	$ 798,629,955	$ 397.17	$ 703,074,053	$ (95,555,901)	-12.0%
	PPC -non-MED	6,000	$ 737.81	$ 4,426,860	$ 737.81	$ 4,426,860	$ -	0.0%
	Total non-MED	1,776,209		$ 803,056,815		$ 707,500,913	$ (95,555,901)	-11.9%
	Total TWG	1,776,690		$ 804,157,023		$ 708,601,122	$ (95,555,901)	-11.9%
TXIX								
	<1	575,597	$ 489.94	$ 282,007,781	$ 465.50	$ 267,940,201	$ (14,067,580)	-5.0%
	1-13	5,291,537	$ 105.43	$ 557,886,745	$ 99.60	$ 527,037,084	$ (30,849,661)	-5.5%
	14-44F	2,710,430	$ 237.57	$ 643,916,875	$ 223.03	$ 604,507,222	$ (39,409,653)	-6.1%
	14-44M	1,321,227	$ 151.56	$ 200,245,215	$ 139.98	$ 184,945,402	$ (15,299,813)	-7.6%
	45+	446,121	$ 391.54	$ 174,674,067	$ 357.88	$ 159,657,647	$ (15,016,420)	-8.6%
	SSI w/Med	948,338	$ 137.11	$ 130,026,672	$ 133.19	$ 126,309,185	$ (3,717,486)	-2.9%
	SSI w/o Med	802,110	$ 778.35	$ 624,322,397	$ 714.24	$ 572,899,119	$ (51,423,279)	-8.2%
	SFP	48,072	$ 14.16	$ 680,693	$ 14.13	$ 679,250	$ (1,442)	-0.2%
	Delivery Supplemental Payment	35,196	$ 6,287.19	$ 221,284,489	$ 5,811.78	$ 204,551,917	$ (16,732,572)	-7.6%
	Total Prospective-non-TWG	12,178,628		$ 2,835,044,933		$ 2,648,527,028	$ (186,517,906)	-6.6%
	PPC'<1	17,683	$ 931.87	$ 16,478,679	$ 900.43	$ 15,922,711	$ (555,968)	-3.4%
	PPC'1-13	281,077	$ 54.66	$ 15,363,684	$ 52.97	$ 14,888,663	$ (475,021)	-3.1%
	PPC '14-44F	163,911	$ 194.08	$ 31,811,857	$ 184.58	$ 30,254,702	$ (1,557,155)	-4.9%
	PPC '14-44M	74,783	$ 156.16	$ 11,678,057	$ 147.78	$ 11,051,378	$ (626,679)	-5.4%
	PPC '45+	31,938	$ 318.92	$ 10,185,804	$ 291.04	$ 9,295,361	$ (890,443)	-8.7%
	PPC 'SSI w/Med	13,351	$ 130.66	$ 1,744,452	$ 119.82	$ 1,599,726	$ (144,726)	-8.3%
	PPC 'SSI w/o Med	27,805	$ 358.44	$ 9,966,595	$ 336.63	$ 9,360,158	$ (606,437)	-6.1%
	PPC All non-TWG rate codes	610,549		$ 97,229,128		$ 92,372,700	$ (4,856,428)	-5.0%
	Total Title XIX-non-TWG	12,789,177		$ 2,932,274,062		$ 2,740,899,728	$ (191,374,334)	-6.5%
Grand Total Capitation				**$ 3,736,431,085**		**$ 3,449,500,849**	**$ (286,930,236)**	-7.7%

[1] Population estimates for CYE12 are taken from DBF projections.

[2] Reinsurance levels are the same level for plans in CYE12 as CYE11 with two plans at the $35,000 level and the rest at $20,000