Children's Rehabilitative Services (CRS) Updated Actuarial Memorandum

I. Purpose

This memorandum presents a discussion of the revision to the already approved Contract Year Ending 2015 (CYE 15) CRS capitation rates. Please see Attachment A for the actuarial memorandum of the already-approved CRS capitation rates which detail the original rate build up.

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).

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.

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, if applicable. 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, if applicable.

Additional adjustments were made to the expenditure and/or member months 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 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 six month impact to the CRS program is a statewide increase of approximately $1.14 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	Fully Integrated	Partially Integrated/BHS	Partially Integrated/Acute	CRS Only	Total
CYE 15 Projected MMs (4/1/15 - 9/30/15)	106,737	38,748	1,012	6,988	
Approved CYE 15 Rate (10/1/14)	$779.16	$502.99	$693.10	$416.93	
Proposed CYE 15 Rate (4/1/15)	$789.59	$504.21	$702.32	$416.94	
Estimated Approved CYE 15 Capitation	$83,165,650	$19,490,006	$701,670	$2,913,521	$106,270,848
Estimated Proposed CYE 15 Capitation	$84,278,711	$19,537,326	$711,003	$2,913,600	$107,440,640
Dollar Impact on CYE15 estimated current capitation	$1,113,061	$47,320	$9,332	$79	$1,169,791
Percentage Impact on CYE 15 estimated capitation	1.3%	0.2%	1.3%	0.0%	1.1%

V. Actuarial Certification of the Capitation Rates

I, Matthew C. Varitek, 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 CRS and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the CRS 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 CRS program, Medicare and 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.

SIGNATURE ON FILE	*02/12/2015*
Matthew C. Varitek	Date

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

ATTACHMENT A

Children's Rehabilitative Services (CRS)
Actuarial Memorandum for CYE 2015

I. Purpose

The purpose of this actuarial memorandum is to demonstrate that the Children's Rehabilitative Services (CRS) capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

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.

The historical CRS carve-out program provided specialty services to children with special health care needs. Children qualified for CRS based on particular diagnoses. The same member received other acute care services through a different Contractor or through the American Indian Health Plan (AIHP), and they received behavioral health services through a Regional Behavioral Health Authority (RBHA) or a Tribal Regional Behavioral Health Authority (TRBHA).

Effective October 1, 2013, AHCCCS integrated all services for most Acute Care Program children with CRS conditions through one CRS Contractor with the goals of improved member outcomes, reduced member confusion, improved care coordination, and streamlined administration. This model continues to qualify children for CRS based on particular diagnoses. At the same time, children with CRS conditions who are enrolled in the elderly and physically disabled long term care program, and who today have integrated acute, behavioral health and long term care services, began to receive their CRS related services through the Arizona Long Term Care System (ALTCS) Contractors.

II. Overview of Rate Setting Methodology and Base Period Experience

The medical component of the contract year ending 2015 (CYE 15) rates were developed as a rate update to the acute care, behavioral health, and specialty care components of the CRS Integrated rates. The administrative component of the CYE 15 rates are the rates awarded as part of the competitive bid process for the CYE 14 Request for Proposal (RFP). The CYE 15 rates cover the twelve month contract period of October 1, 2014 through September 30, 2015.

There are four permutations of the program enrollment, hereafter called "coverage types" and described as follows:

- A Fully Integrated member will receive acute care, behavioral health, and specialty care for CRS conditions through the sole CRS contractor.

- A Partially Integrated-BH member will receive behavioral health and specialty care through the sole CRS contractor. These members are typically enrolled with the Developmentally Disabled (DD) or the Comprehensive Medical and Dental Program (CMDP) for their acute care services.

- A Partially Integrated-Acute member will receive acute care and specialty care through the sole CRS contractor. These members are typically Native Americans receiving behavioral health services through a TRBHA.

- A CRS Only member will only receive specialty care through the sole CRS contractor. These members are typically enrolled in the American Indian Health Plan (AIHP), receiving acute care in a fee-for-service environment, and receiving behavioral health services through a TRBHA.

Since CRS has a relatively small membership base, multiple years and sources of data were used to increase the statistical credibility. For CYE 15 rate development, CRS' encounter data was found to be appropriate to estimate medical expense trend for all service categories. The encounter data used for calculating trends includes encounters with dates of service between October 1, 2010 and March 31, 2013. Completion and credibility factors were added to the encounter data. The per member per month (PMPM) claim costs observed for all categories of service were then adjusted to reflect program changes and reimbursement reductions that were effective subsequent to the experience periods used.

The assumed trend rates were developed from an internal data extract ("databook") that tracks historical enrollment, as well as utilization counts and unit costs for encounters adjudicated by AHCCCS. Other data sources include Contractor financial statements, AHCCCS Fee-For-Service rate changes, anticipated Arizona Department of Health Services (ADHS) transportation increases, programmatic changes, and CMS statistics on national health expenditures (NHEs).

Because of the relatively small membership base and statewide disbursement of members, segregating the CRS population into different rate cells with similar risk characteristics would lead to a statistical credibility problem. Therefore, AHCCCS believes that a single CRS capitation rate for each coverage type leads to a more actuarially sound rate than creating additional rate cells.

The experience includes all Medicaid eligible expenses for CRS Medicaid eligible individuals. In addition, the experience includes reinsurance amounts. For CYE 15 the CRS capitation rates will be reconciled using a tiered reconciliation methodology. See Section XI for additional information. There are no other incentives or risk sharing arrangements.

The base period claim PMPMs for each of the acute, behavioral, and specialty components are built up from utilization and unit cost data for the experience period,

adjusted for completion estimates, adjusted for programmatic and AHCCCS Fee-For-Service (FFS) provider rate changes, and trended to the midpoint of the effective period, April 1, 2015. The trended PMPMs for each component are added together as appropriate for each of the four coverage types described in this Section. The administrative expense from CYE 14 RFP, risk/contingency, reinsurance offset and premium tax are then added to the projected claim PMPMs to obtain the capitation rates. Each step is described in the sections below.

III. Projected Trend Assumptions

PMPM trend rates were calculated from the encounter data experience for CYE 11, CYE 12 and CYE 13 dates of service. Financial statements for the same time periods were used to validate the encounter data and trends. The trend rates shown below in Table I do not include AHCCCS FFS provider rate changes.

The trend rates used in projecting the claim costs are as follows:

Table I: Annual Trend Rates by Program Component and Service Category

Program Component	Service Category	PMPM Trend
Acute Care	Inpatient	1.5%
Acute Care	Outpatient	6.5%
Acute Care	Professional	4.9%
Acute Care	Pharmacy	0.1%
Acute Care	Long-Term Care	-4.7%
Acute Care	Dental	2.7%
Behavioral Health	Inpatient	-2.2%
Behavioral Health	Professional	4.8%
Behavioral Health	Pharmacy	2.4%
Specialty Care	Inpatient	-6.9%
Specialty Care	Outpatient	4.0%
Specialty Care	Professional	4.3%
Specialty Care	Pharmacy	0.8%
Specialty Care	Long-Term Care	5.0%
Specialty Care	Dental	-5.0%

IV. Projected Gross Claim PMPM

The claims PMPMs for each contract year in the experience period were trended from the midpoint of the contract year to the midpoint of the rating period. The midpoint of the rating period is April 1, 2015.

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

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 instead of the tiered per diem inpatient reimbursement system in accordance with 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-DRGs is budget neutral to the state, but does vary by Program. In addition to the methodological change there are additional changes to what qualifies as reinsurance. For additional information on those changes see section VII. The estimated impact to the CRS Integrated program of the methodological change and the reinsurance changes is an increase of approximately $6.9 million.

Movement of High-Cost Member from DDD
The Contractor for the CRS program advised AHCCCS that one high-cost member previously enrolled in the DDD program had moved into the CRS Integrated program effective October 1, 2013. This member incurred over $14 million in services during the three-year period aligned with the base data for the trend calculation, though most of the costs were reinsured. The move took place after the CYE 14 rates for CRS were calculated. As such no adjustment existed in the CYE 14 rates that serve as the starting point for the CYE 15 rates. The estimated impact net of reinsurance to the CRS Integrated program of the member movement is an increase of approximately $1.2 million.

Automated Visual Screenings
Effective October 1, 2014, AHCCCS is providing coverage for automated visual screenings for children age one to three years of age and a lifetime limit of one. Children ages four to five years of age may have a second screening if shown to be developmentally disabled or otherwise incapable of cooperating with traditional visual screening techniques. The estimated impact to the CRS Integrated program is an increase of approximately $16,000.

Provider Rate Changes
Effective October 1, 2014, AHCCCS is changing FFS provider rates for certain providers based either on access to care needs, Medicare fee schedule rates, and/or legislative mandates. Arizona Department of Health Services (ADHS) 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 unit cost (inflation) trends were adjusted appropriately for these changes. The estimated to the CRS Integrated program is an increase of approximately $1.3 million.

Primary Care Provider (PCP) Payment Increase
Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act, 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 to CMS for approval of AHCCCS methodology. There is no impact to the CYE 15 capitation rates.

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 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 increase to cap rates is included.

VI. Projected Net Claim PMPM

The base period utilization, unit costs, and net claims' PMPMs are trended forward and adjusted for AHCCCS fee schedule changes, state mandates, court ordered programs and program changes to arrive at the CYE 15 utilization, unit costs and net claims' PMPMs.

VII. Projected Reinsurance Offsets

The projected CYE 15 reinsurance offsets were developed using CYE13 encounter data and reinsurance payment information. The projected CYE 15 reinsurance offsets take into consideration that a single threshold for reinsurance will apply to the total encounters incurred under all of the program components for which each member is enrolled. The implementation of the DRG method of payment will no longer allow Contractors to split encounters that cross contract years. The reinsurance offset estimate is therefore adjusted to reflect the impact of the DRG payment structure as well as for the cases that will no longer receive reinsurance payments due to the inability to split encounters.

VIII. 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 to SFY 2014, encounter-reported COB cost avoidance grew from $34,000 to $7.3 million. Additionally, in CYE 14 the CRS Contractor cost-avoided $792,000 in the nine months ending March 31, 2014, in 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.

IX. Administrative Expenses and Risk Contingency

The administrative expense PMPM bid as part of the CYE 14 RFP was adjusted by AHCCCS to cover additional administrative responsibility and is built into the rates. The risk contingency load is set at 1%.

X. Proposed Capitation Rates and Their Impact

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VI) less the reinsurance offsets (in section VII), the awarded administrative expenses, and the risk contingency PMPM (in section IX), divided by one minus two percent for premium tax. Table II below summarizes the projected member months, proposed capitation rates, and estimated total capitation by coverage type and in total on a statewide basis.

Table II: Proposed Capitation Rates by Coverage Type

Rate Cell	Fully Integrated	Partially Integrated/BHS	Partially Integrated/Acute	CRS Only	Total
CYE 15 Projected MMs	211,689	76,848	2,008	13,859	
CYE 14 Rate (10/1/13)	$741.22	$478.75	$656.43	$393.96	
CYE 15 Rate	$779.16	$502.99	$693.10	$416.93	
Estimated CYE 14 Capitation	$156,907,539	$36,790,823	$1,317,978	$5,459,971	$200,476,312
Estimated CYE 15 Capitation	$164,940,187	$38,654,003	$1,391,604	$5,778,308	$210,764,103
Dollar Impact on CYE14 estimated current capitation	$8,032,648	$1,863,180	$73,626	$318,337	$10,287,791
Percentage Impact on CYE 14 estimated capitation	5.1%	5.1%	5.6%	5.8%	5.1%

XI. CMS Rate Setting Checklist

1. Overview of rate setting methodology

AA.1.1: Actuarial certification

Please refer to Section XII.

AA.1.2: Projection of expenditure

Please refer to Section X.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Competitive Procurement contracting method.

AA.1.5: Risk contract

The contract is an at risk contract, however there are some provisions for reconciliation and reinsurance. The reconciliation is as follows:

Profit	MCO Share	State Share	Maximum Contractor Profit
<=3%	100%	0%	3.0%
>3% and <=6%	50%	50%	1.5%
>6%	0%	100%	0%
Total			4.5%

Loss	MCO Share	State Share	Maximum Contractor Loss
<=3%	100%	0%	3.0%
>3%	0%	100%	0%
Total			3.0%

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to providers, except for DSH, GME, and Critical Access Hospitals (CAH). GME is paid in accordance with state plan. DSH and CAH 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, III, V, VII and IX.

XII. Actuarial Certification of the Capitation Rates

I, Matthew C. Varitek, 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, 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 the health plan 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.

This certification letter assumes the reader is familiar with the CRS 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.

SIGNATURE ON FILE *08/28/2014*

Matthew C. Varitek Date

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