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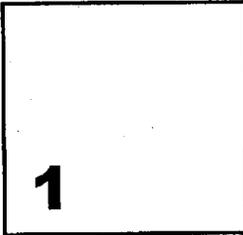
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**County Organized Health
System (COHS)
Fiscal Year 2009 – 2010
Rate Range Development and
Certification
State of California**

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Rate methodology

Overview

Capitation rate ranges for DHCS' County Organized Health System (COHS) managed care program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). For rate range development for the COHS Managed Care Organizations (MCOs), we primarily used the COHS plans' reported Rate Development Template (RDT) data for calendar year 2007 (CY07). We also reviewed CY07 COHS MCO-reported encounter data, and CY07 ad hoc claims data reported by the COHS MCOs. The most recently available (at the time the rate ranges were determined) Medi-Cal-specific financial reports submitted to the Department of Managed Health Care (DMHC) were also considered in the rate range development process.

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for the fiscal year 2010 (FY09 – 10) contract period. Additional adjustments were then applied to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- Observed changes in the population case-mix and underlying risk of the MCOs from the base data period
- Dollar-neutral smoothing
- Trend factors to forecast the expenditures and utilization to the contract period
- Administration and Underwriting Profit/Risk/Contingency loading

A single and consistent process of developing capitation rate ranges was used for the COHS program. DHCS will offer final rates within the actuarially sound rate ranges with each MCO. Each MCO has the opportunity and responsibility to independently review

the rates offered by DHCS, and to determine whether the rates are acceptable based on their individual financial requirements.

The various steps in the rate range development are described in the following paragraphs.

Base data

The information used to form the base data for the COHS rate range development was primarily the 2007 Rate Development Template (RDT) data, submitted by each COHS plan to DHCS. This data was reviewed for consistency and reasonableness within each plan. It was also reviewed for consistency and compatibility with the each plan's Medi-Cal specific financial reporting (required by DMHC). We also considered MCO encounter data, and MCO ad hoc claims data. The base data included utilization and unit cost detail by category of aid (COA), by county, and by 12 consolidated provider types or categories of service (COS) including:

- Inpatient Hospital
- Outpatient Facility
- Emergency Room
- Long Term Care (LTC)
- Lab/Radiology
- Primary Care Physician
- Specialty Physician
- Pharmacy
- Federally Qualified Health Center (FQHC)
- Other Medical Professional
- Transportation
- All Others

Utilization and unit cost information from the plan RDT submission was reviewed at the COA and COS detail levels for reasonableness. We examined the reasonable and appropriate levels of utilization, unit cost, and pmpm amounts that were established in last year's (FY08 – 09) rate development process, for each COS within each COA. In general, the pmpm amounts from the RDT data were compared to the pmpm amounts by COS within each COA. The allocation by COS within each COA was examined, and compared to the FY08 - 09 relative costs by COS. When the CY 2007 RDT amounts pmpm were unreasonable by COS, they were re-allocated based on the FY08 - 09 amounts; however, the re-allocation did not alter the overall CY 2007 RDT pmpm amounts within a given COS (no net dollar impact).

All selected base data was adjusted (as appropriate) to reflect the impact of historical program changes within this period. This is discussed further in the Program Changes section. The DMHC financial reporting Revenue, Expenses and Net Worth exhibits for each MCO that were available at the time the rate ranges were determined, were reviewed and analyzed by DHCS and Mercer Human Resources Consulting (Mercer).

A requirement of 42 CFR 438.6(c)(4)(ii) is that all payment rates under the contract are based only upon services covered under the State Plan to Medicaid-eligible individuals. As described above, RDT data served as the starting base data for rate setting. Encounters undergo edits within DHCS to ensure quality and the appropriateness of the data for rate-setting purposes. Base period MCO eligibility (described below) and encounter data were pulled consistent with service code mappings from DHCS, including lists of excluded services such as abortion. DHCS has relied on data and other

information provided by the MCOs in the development of these rate ranges. We have reviewed the data and information utilized for reasonableness, and we believe the data and information to be free of material error and suitable for rate range development purposes for the populations and services covered under the COHS contracts. DHCS or Mercer did not audit the data or information and, if the data or information is materially incomplete or inaccurate, our conclusions may require revision. However, DHCS did perform alternative procedures and analysis that provide a reasonable assurance as to the data's appropriateness for use in capitation rate development under the State Plan.

Category of Aid (Aid Code) groupings

The base data sets used to develop the COHS FY08 – 09 capitation rate ranges were divided into cohorts that represent consolidated COA (or Aid Code) groupings which inherently represent differing levels of risk. These 12 COA cohorts are (alphabetically):

- Adult
- Aged/Dual Eligible
- Aged/Medi-Cal Only
- AIDS/Dual Eligible
- AIDS/Medi-Cal Only
- BCCTP
- Disabled/Dual Eligible
- Disabled/Medi-Cal Only
- Family
- LTC/Dual Eligible
- LTC/Medi-Cal Only
- Omnibus Budget Reconciliation Act (OBRA)

The two AIDS rates, as well as the OBRA rates, do not apply in all COHS counties.

Because the COHS program is structured such that only one MCO operates in each county, the distribution of risk between multiple plans is eliminated. Also, coverage is mandatory for virtually all COAs within a COHS county, which also eliminates any selection bias concerns on the part of the participating MCO.

Graduate Medical Education

Regarding Graduate Medical Education (GME) costs and 42 CFR 438.6(c)(5)(v) (along with item AA.3.8 of "Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03"), there are no provisions in the COHS managed care contracts regarding GME. The COHS MCOs do not pay specific rates that contain GME or other GME-related provisions. As COHS data serves as the base data, GME expenses are not part of the COHS capitation rate development process.

Rate smoothing

The COHS program is large, covering several hundred thousand lives. In aggregate, each MCO has a fully credible population base for rate-setting purposes. However, there are a number of COAs within each county for which there is concern over specific COA credibility.

After the initial calculation of projected FY09-10 rates, other smoothing took place as follows.

First, the initial rate calculations for Dual and Medi-Cal Only (MCalO) were compared to the FY08-09 Dual/MCalO rates for the Aged, Disabled, and Long Term Care (LTC) COA. The FY09-10 Dual/MCalO rate relationship within each of these COA (Aged, Disabled, LTC) was re-allocated to preserve the Dual/MCalO relationship from FY08-09. This method indirectly causes the FY09-10 rates to reflect the smoothing techniques that were employed in the FY08-09 rates. The Dual/MCalO smoothing was calculated in a revenue-neutral manner to each Plan (no expected revenue dollars were gained or lost in this process).

Second, the BCCTP and OBRA (where available) rates were re-allocated with the Adult/Family rate, to preserve the relative relationship of the FY08-09 rates. Again, this rate smoothing was calculated in a revenue-neutral manner.

Note that a major change from FY08-09 rates is that the FY09-10 rates combine the Adult and Family COAs into one rating group (i.e. the Adult and Family COAs have the same rate).

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the FY09 – 10 rate range development for the COHS program, DHCS relied on trend recommendations provided by Mercer. Mercer developed trend rates for each provider type or COS, separately by utilization and unit cost components.

Trend information and data were gathered from multiple sources including the MCO encounter data, the MCO requested ad hoc data, MCO financial statements, Medi-Cal fee-for-service experience, historical California Medical Assistance Commission (CMAC) adjustments, Consumer Price Index (CPI) and multiple industry reports. Mercer also relied on professional judgment based upon extensive experience in working with the majority of the largest Medicaid programs in the country. Base data used was trended forward 30 months to the mid-point of the rating period.

Annual mid-point claim cost trends, across all MCOs, all COAs and all 12 COS, average about ½ percent for utilization and 2¼ percent for unit cost or 2¾ percent per member per month (PMPM). The weighted COS PMPM trends vary from a high of about 7 percent for Hospital Outpatient and Emergency Room to a low of about 1 percent for "Other Medical Professional Services" and "All Other Services". Note trends for the LTC provider type are 0.0 percent for both utilization and unit cost. Due to the high level of legislatively-mandated changes surrounding LTC, Mercer has handled LTC trends through the Program Changes portion of the methodology. Given the recent financial information available at the time the rate ranges were developed, the range for the claim

cost trend component is +/- ¼ percent per year for each of the utilization and unit cost components, or roughly +/- ½ percent PMPM per year. Over the 2.5 years from CY07 to FY09 – 10, this contributes almost +/- 1.25 percent to the upper and lower bounds.

Program changes/other adjustments

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. As part of the FY09 – 10 rate range development for the COHS program, DHCS relied on Program Changes recommendations provided by Mercer. Following are the program changes (with effective dates) that were viewed to have a material impact on capitation rates, and which were reviewed, analyzed and evaluated by Mercer with the assistance of DHCS' Managed Care Division and Fiscal Forecasting and Data Management Branch staff:

- LTC rate adjustments – multiple dates
- Hospice rate increases – January 2008
- Family planning – January 2008
- Home tocolytic therapy – October 2008
- Provider payment reduction – July 2008
- Mirena IUC – July 2008
- Post-stabilization services – October 2008

Any program changes with an effective date prior to January 1, 2007, were treated as retrospective changes.

Administration and Underwriting Profit/Risk/Contingency loading

DHCS requested FY 09 -10 that Mercer recommend amounts for administration and profit/risk/contingency loading.

The administration loading for each of the MCOs was developed separately. The administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium). These percentages were developed from a review of the MCOs' historical reported administrative expenses. Mercer utilized its experience and professional judgment in determining the recommended percentages to be reasonable. Administration load averages 5½ percent across all COHS MCOs. This varies by COHS, with a low of 4.9 percent for CalOptima, and a high of 7 percent for Health Plan of San Mateo. Given the recent financial information available at the time the rate ranges were developed, the range for the Administration component is +/- 0.25 percent upper/lower bound from the mid-point value. For San Mateo only, DHCS and the COHS have negotiated an additional administrative expense of 5.50 percent under a Quality Improvement Fee (QIF) contractual requirement, through 9/30/2009.

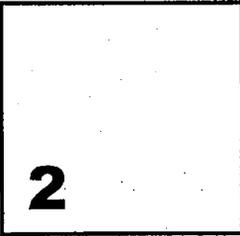
DHCS reviewed the recommended administration amounts from Mercer. Generally, DHCS used the recommended amounts, with the restriction that decreases in the overall administration percent from FY08-09 rates to FY 09-10 rates, for a given plan, were

limited to about ½ percent. The percentage allocations to each COA in the FY 09-10 rates were calculated by preserving the relative administration allocations that were used in the FY 08 – 09 rates, for a given plan. This method therefore reflects the allocation of fixed and variable components that were used in the FY 08 – 09 rates.

The Underwriting Profit/Risk/Contingency load is 3.0 percent at the mid-point, 2.0 percent at the lower bound and 4.0 percent at the upper bound. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions. Mercer has concluded that the assumptions surrounding the Underwriting Profit/Risk/Contingency load, as well as income an MCO generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical health plan.

Rate ranges

DHCS calculated rate ranges, which were developed using an actuarially sound process. The COA-specific rate ranges were developed using a combination of a modeling process which varied the medical expense (i.e., risk) trend, the administration loading percentage, and the Underwriting/Profit/Risk/Contingency loading percentage to arrive at both an upper and lower bound capitation rate. The final contracted rates agreed to between DHCS and each MCO fall within the rate ranges.



Rate range certification

I certify that the COHS FY09 – 10 rate ranges were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rate ranges are actuarial projections of future contingent events. Actual results will differ from these projections. DHCS has developed these rate ranges to demonstrate compliance with the CMS requirements under 42 CFR § 438.6(c) and in accordance with applicable law and regulations. MCOs are advised that the use of these rate ranges, or the resulting final rates within these ranges, may not be appropriate for their particular circumstance and DHCS disclaims any responsibility for the use of these rate ranges or rates by the MCOs for any purpose. DHCS recommends that any MCO considering contracting with DHCS should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rate ranges and resulting rates before deciding whether to contract with DHCS. Use of these rate ranges and resulting rates for any purpose beyond that stated may not be appropriate.

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