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MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

3131 East Camelback Road, Suite 300
Phoenix, AZ 85016
602 522 6500 Fax 602 957 9573
www.mercer.com

February 14, 2008

Mr. Steve Soto
California Department of Health Care Services
Medi-Cal Managed Care Division
1501 Capital Avenue
PO Box 997413, MS 4400
Sacramento, CA 95899-7413

FINAL

Subject: County Organized Health System Expansion: San Luis Obispo County Rate Range Development and Certification for March 1, 2008, through June 30, 2009

Dear Mr. Soto:

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rate ranges for the County Organized Health System (COHS) expansion into San Luis Obispo county for use during a March 1, 2008, through June 30, 2009, contract period. This letter presents an overview of the analyses and methodology used in Mercer's managed care rate range development for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS). This rate development for San Luis Obispo county was an expansion of the current COHS managed care counties and was developed based upon fee-for-service data with appropriate adjustments to reflect managed care rate ranges. In Mercer's opinion, the capitation rate ranges developed result from an actuarially sound process and should, along with Managed Care Organization (MCO) investment income and any reinsurance or stop-loss cash flows, provide for all reasonable, appropriate and attainable costs.

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California Department of Health Care Services

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If you have any questions on any of the above, please feel free to contact Mike Nordstrom at 602 522 6510, Jim Meulemans at 602 522 8597 or Branch McNeal at 602 522 6599.

Sincerely,

Handwritten signature of Michael E. Nordstrom in blue ink, with the text "ASA, MAAA" written in blue ink to the right of the signature.

Michael E. Nordstrom, ASA, MAAA

Handwritten signature of James J. Meulemans in blue ink, with the text "ASA, MAAA" written in blue ink to the right of the signature.

James J. Meulemans, ASA, MAAA

MEN:JJM

Copy:
Russ Hart, DHCS
Stuart Busby, DHCS
Arlene Livingston, DHCS
Branch McNeal, Mercer
Kevin Lurito, Mercer
Sundee Easter, Mercer

February 14, 2008

County Organized Health
System (COHS)
Expansion: San Luis Obispo
March 1, 2008 – June 30, 2009
Rate Range Development and
Certification
State of California

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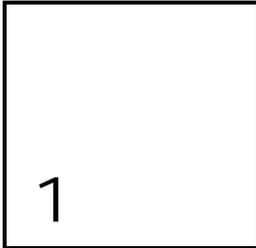


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Rate methodology

Overview

Capitation rate ranges for California Department of Health Care Services' (DHCS') County Organized Health System (COHS) managed care program expansion into San Luis Obispo county were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). For rate range development for the San Luis Obispo county expansion, Mercer used fiscal years 2004 and 2005 (FY03 – 04 and FY04 – 05) fee-for-service data.

Adjustments were made to the fee-for-service base data to match the covered population risk and the State Plan approved benefit package for the March 1, 2008, through June 30, 2009, contract period. Additional adjustments were then applied to the fee-for-service data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- Budget neutral relational modeling for smoothing
- Trend factors to forecast the expenditures and utilization to the contract period
- Administration and underwriting profit/risk/contingency loading

The above adjustments, prior to the administration and underwriting profit/risk/contingency loading, produced fee-for-service equivalent utilization per thousand, unit cost and per member per month (PMPM) amounts for each category of service (COS) within each category of aid (COA). These individual components were then reviewed and adjusted to reflect managed care impacts that would be expected with the expansion of the managed care COHS program to San Luis Obispo county.

A single and consistent process of developing capitation rate ranges was used for the COHS program expansion. DHCS will offer final rates within the actuarially sound rate ranges to the MCO. The 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 for the base data was FY03 – 04 and FY04 – 05 fee-for-service data. The fee-for-service data included utilization and unit cost detail by COA, by FY and by 13 consolidated provider types or COS including:

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

FY03 – 04 and FY04 – 05 (July 2003 through June 2005) make up the base data period. The data was completed to account for incurred but not reported claims based on lag triangle analysis. The pharmacy data was also adjusted to account for appropriate rebates. 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. Mercer blended these two years at a one-third (FY03 – 04) and two-thirds (FY04 – 05) ratio. Prior to blending the two years of data, the FY03 – 04 data was first trended forward to FY04 – 05 based on retrospective trend factors so that the two years were on the same time period for future trending to the March 1, 2008, through June 30, 2009, contract period.

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, fee-for-service data served as the base data for rate setting. Fee-for-service data undergoes a substantial number of edits within DHCS to ensure quality and the appropriateness of the data for rate-setting purposes. Base period member eligibility (described below) and fee-for-service data were pulled consistent with service code mappings from DHCS, including lists of excluded services such as abortion. Mercer has relied on data and other information provided by DHCS' Managed Care Division and Fiscal Forecasting and Data Management Branch 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 expansion contract. 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, Mercer 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 rate ranges for the COHS expansion into San Luis Obispo county were divided into cohorts that represent consolidated COA (or Aid Code) groupings which inherently represent differing levels of risk. These 11 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

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.

Data smoothing

The fee-for-service data used in the rate development was large, covering approximately 25,000 lives. In aggregate, San Luis Obispo county has a fully credible population base for rate-setting purposes. However, there are a number of COAs within San Luis Obispo county for which there is concern over specific COA credibility. In those instances, Mercer analyzed data and information on a more aggregate level, and from this developed factors or relativities to overcome any excessive variation brought on by small membership or extraordinary (high or low) utilization or unit costs. Adjustments were made via a budget-neutral relational modeling process. No dollars were gained or lost in this process.

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 March 1, 2008, through June 30, 2009, contract period rate range development for the COHS expansion program, 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 Medi-Cal fee-for-service experience, MCO encounter data, MCO requested ad hoc data, MCO financial statements, historical California Medical Assistance Commission (CMAC) adjustments, Consumer Price Index (CPI) and multiple industry reports. Mercer also relied on professional judgment based upon our experience in working with the majority of the largest Medicaid programs in the country. Base data used was trended forward 46 months to the mid-point of the rating period.

Annual mid-point claim cost trends, across San Luis Obispo county, all COAs and all 13 COS, average 1.8 percent for utilization and 2.4 percent for unit cost or 4.2 percent PMPM. The weighted COS PMPM trends vary from a high of 7.0 percent for Pharmacy (1.026 for utilization times 1.043 for unit cost equals 1.070118 or 7.0 percent) to a low of 3.9 percent for “All Others.” 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. The range for the claim cost trend component is +/- 0.25 percent per year for each of the utilization and unit cost components, or roughly +/- 0.5 percent PMPM per year. Over the nearly four year period from FY04 – 05 to the March 1, 2008, through June 30, 2009, contract period, this contributes a little over +/- 1.9 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. The program changes incorporated in the development of the rate ranges were based on information provided by DHCS staff as of September 19, 2007. Following are the most material program changes (with effective dates) that were viewed to have an impact on capitation rates, and which were 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
- LTC quality assessment fee – August 2004
- HIV testing during pregnancy – January 2004
- Nurse-to-patient ratios for hospitals – multiple dates
- Drug coverage: SENSIPAR – April 2004
- Hospice rate increases – multiple dates
- Medicare Part D drug benefit – January 2006
- Drug coverage: HPV – May 2006
- Fluoride varnish – May 2006
- Anti-Fraud Expansion – July 2006
- Drug coverage: Albuterol – January 2007

Any program changes with an effective date prior to July 1, 2005, were treated as retrospective changes.

Managed care adjustments

Because the underlying base data was fee-for-service, we also applied managed care adjustments. The application of trend and program changes to the base fee-for-service data produced fee-for-service equivalent utilization per thousand, unit cost and PMPM amounts for each COS within each COA. These individual components were then reviewed and adjusted to reflect managed care impacts that would be expected with the expansion of the managed care COHS program to San Luis Obispo county. Similar to

the trend development, multiple sources were utilized in this managed care savings review.

Overall, the impact of the managed care adjustments was a seven percent reduction to the fee-for-service data. Factors producing the seven percent adjustment included reducing inpatient and outpatient utilization. As an example, inpatient utilization was reduced by ten percent for the family COA and 15 percent for the aged/disabled COAs. Other adjustments included increasing physician utilization to account for a higher level of care management. As an example, the physician utilization was increased 25 percent for the family COA and 50 percent for the aged/disabled COAs. Unit cost changes also occurred due to assumed provider contracting negotiations and also because of service mix change assumptions.

The range of managed care savings is +/- 2.5 percent per year for each of the utilization and unit cost components, or approximately +/- 5.0 percent PMPM at the lower and upper bounds.

Administration and Underwriting Profit/Risk/Contingency loading

The administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium). The percentage was developed from a review of the established COHS MCOs' historical reported administrative expenses. Mercer utilized its experience and professional judgment in determining this percentage to be reasonable. The administration load for the San Luis Obispo county expansion is 7.25 percent. The range for the Administration component is +/- 2.0 percent at the lower/upper bound from the mid-point value (9.25 percent at the lower bound and 5.25 percent at the upper bound). These administrative loading factors correlate to the greater/lesser range of managed care savings described above.

While the 7.25 percent is the overall targeted aggregate administrative percentages, the administrative expense associated with each COA vary from the overall percentages. The administrative component can be viewed in two pieces: a fixed component and a variable component. The fixed cost component represents items such as accounting salaries, rent and information systems, while the variable cost represents items such as claims processing and medical management per eligible. Allocating the administrative costs as a uniform percentage of each of the COAs is an appropriate method; however, it does not take into account the differences in fixed versus variable administrative costs for each.

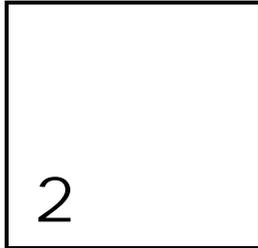
Certain COAs have capitation rates ten (or more) times larger than other COAs. In these instances, the uniform allocation methodology will produce an administrative component for the more expensive COA ten (or more) times larger than the administrative component for the less expensive COA. While a more expensive eligible is probably more administratively intensive, this ten (or more) to one relationship in administrative costs is most likely exaggerated.

If the fixed component of administrative costs is broken down and viewed on a PMPM basis, then this fixed dollar amount is a larger percentage of the capitation rate of the less expensive COA, and a smaller percentage of the capitation rate for the more expensive COA. This concept has been applied in a budget-neutral fashion (no administrative dollars have been gained or lost) to the capitation rates, whereby, the administrative percentage will be greater for less expensive COAs than the aggregate administrative percentage over the entire population. Similarly, the administrative percentage for the more expensive COAs will be less than the aggregate administrative percentage over the entire population.

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. Our conclusion is that our 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

To assist DHCS during its rate discussions with the MCO, Mercer provides DHCS 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, assumed managed care savings, 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 the MCO will fall within the rate ranges provided by Mercer.



Rate range certification

Mercer certifies that the rate ranges for COHS expansion in San Luis Obispo county for the March 1, 2008, through June 30, 2009, contract period 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 developed by Mercer are actuarial projections of future contingent events. Actual results will differ from these projections. Mercer has developed these rate ranges on behalf of DHCS to demonstrate compliance with the CMS requirements under 42 CFR § 438.6(c) and in accordance with applicable law and regulations. The MCO is 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 Mercer disclaims any responsibility for the use of these rate ranges or rates by the MCO for any purpose. Mercer recommends that the 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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