



November 26, 2008

Ms. Vanessa Baird
California Department of Health Care Services
Medi-Cal Managed Care Division
1501 Capital Avenue, PO Box 997413
MS 4400
Sacramento, CA 95899-74163

FINAL

Subject: County Organized Health System (COHS) Fiscal Year 2008 – 2009 Rate Range Development and Certification

Dear Ms. Baird:

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 use during the fiscal year 2008 – 2009 (FY08 – 09) COHS contract period. The FY08 – 09 contract period begins July 1, 2008, and ends June 30, 2009. 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). Note that this rate range development process constituted a rebasing of the capitation rates. 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. Across all of the COHS MCOs, the mid-point capitation rate change is 6.8 percent above current rates, weighted on member months from the 2008 – 2009 budget figure estimates from May 2008.

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If you have any questions on any of the above, please feel free to contact Mike Nordstrom at +1 602 522 6510, Jim Meulemans at +1 602 522 8597 or Branch McNeal at +1 602 522 6599.

Sincerely,



Michael E. Nordstrom, ASA, MAAA



James J. Meulemans, ASA, MAAA

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County Organized Health
System (COHS)
Fiscal Year 2008 – 2009
Rate Range Development and
Certification
State of California

MERCER

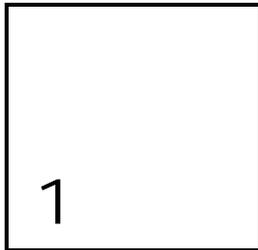


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Rate methodology

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 MCOs, Mercer used a combination of calendar years 2005 and 2006 (CY05 and CY06) COHS MCO-reported encounter data, and state fiscal year 2005 (SFY05) and CY06 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 2009 (FY08 – 09) 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
- 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

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 MCO encounter data, requested MCO ad hoc claims data and DMHC required Medi-Cal-specific financial reporting. The encounter and ad hoc claims data included utilization and unit cost detail by COA, by county, by CY 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-specific encounter and ad hoc data was reviewed at the COA and COS detail levels for reasonableness. Ranges of reasonable and appropriate levels of utilization and unit cost were then established for each COS within each COA. Averages of the reasonable and appropriate levels were also established for the encounter and the ad hoc data. This process in essence produced four potential data elements of utilization and unit cost for each COS within each COA: 1) plan-specific encounter data, 2) plan-specific ad hoc data, 3) average encounter data, and 4) average ad hoc data. These four data elements were then applied credibility factors dependent upon the plan-specific data being reasonable and appropriate, and also based on the enrollment size of the population of the COA.

CY05 and CY06 (January 2005 through December 2006) make up the base data period. 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-fourth (CY05) and three-fourths (CY06) ratio. Prior to blending the two years of data, the CY05 data was first trended forward to CY06 based on retrospective trend factors so that the two years were on the same time period for future trending to the FY08 – 09 period. 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.

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, MCO encounter 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. Mercer has relied on data and other information provided by the MCOs and DHCS 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. 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 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.

Data 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. 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 FY07 – 08 rate range development for the

COHS 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 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 our 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 1.4 percent for utilization and 2.5 percent for unit cost or 3.9 percent per member per month (PMPM). The weighted COS PMPM trends vary from a high of 10 percent for Transportation (1.0 for utilization times 1.10 for unit cost equals 1.10 or 10 percent) to a low of 2.8 percent for “Other Medical Professional 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 +/- 0.25 percent per year for each of the utilization and unit cost components, or roughly +/- 0.5 percent PMPM per year. Over the 2.5 years from CY06 to FY08 – 09, 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. The program changes incorporated in the development of the rate ranges were based on information provided by DHCS staff. 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
- Carve-out of ED drugs for Medi-Cal Only – October 2005
- Hospice rate increases – multiple dates
- Medicare Part D drug benefit – January 2006
- Oxygen limits and DME reimbursements – September 2006
- Family planning – January 2007
- Prenatal screening – January 2007
- Drug coverage: HPV – January 2007
- Restoration of provider rate decrease – January 2007
- Drug coverage: Albuterol – January 2007
- Genetic disease testing – July 2007
- Home tocolytic therapy – July 2007

- 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

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 percentages to be reasonable. Administration load averages 5.81 percent across all COHS MCOs. This varies by COHS, with a low of 5.36 percent for CalOptima, and a high of 7.42 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.

While the above are 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.

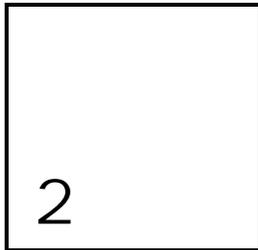
If the fixed component of administrative costs is broken down and viewed on a PMPM basis, then this fixed dollar amount is a larger percentage of the capitation rate of the less expensive COA, and a smaller percentage of the capitation rate for the more expensive COA. This concept has been applied in 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 each 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, 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 provided by Mercer.



Rate range certification

Mercer certifies that the COHS FY08 – 09 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 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. 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 Mercer disclaims any responsibility for the use of these rate ranges or rates by the MCOs for any purpose. Mercer 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.

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

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